



FEDERAL REPUBLIC OF SOMALIA

THE MINISTRY OF HEALTH

IMPROVING HEALTHCARE SERVICES IN SOMALIA (P172031)

**ENVIRONMENTAL AND SOCIAL MANAGEMENT
FRAMEWORK (ESMF)**

**UPDATED FOR SECOND ADDITIONAL FINANCING
PROJECT (P178876)**

Cleared on November 5, 2025

TABLE OF CONTENTS

TABLE OF CONTENTS.....	II
LIST OF TABLES	IV
LIST OF FIGURES.....	V
ACRONYMS AND ABBREVIATIONS.....	VI
EXECUTIVE SUMMARY	1
INTRODUCTION AND PROJECT CONTEXT.....	17
PROJECT CONTEXT	17
IMPROVING HEALTHCARE SERVICES IN SOMALIA PROJECT	22
PROJECT DEVELOPMENT OBJECTIVE AND COMPONENTS	23
PROJECT BENEFICIARIES	26
THE PROJECT EXPECTED RESULTS	26
SCOPE AND METHODOLOGY OF THE ESMF.....	28
PURPOSE AND SCOPE OF THE ESMF	28
ESMF JUSTIFICATION	28
ESMF PRINCIPLE	29
METHODOLOGY.....	29
POLICY, LEGISLATIVE AND INSTITUTIONAL FRAMEWORKS	32
OVERVIEW	32
SOMALIA NATIONAL LAWS, POLICIES AND LEGISLATIONS	32
LAWS AND REGULATIONS IN FEDERAL MEMBER STATES OF SOMALIA	38
INSTITUTIONAL CAPACITY FOR ENVIRONMENTAL MANAGEMENT	39
INTERNATIONAL CONVENTIONS AND AGREEMENTS SIGNED OR RATIFIED BY SOMALIA	41
WORLD BANK ENVIRONMENT AND SOCIAL STANDARDS	42
WORLD BANK GROUP EHS GUIDELINES	50
GAP ANALYSIS.....	51
ACTION PLAN FOR CAPACITY ENHANCEMENT IN E&S RISK MANAGEMENT.....	61
PROJECT’S BIOPHYSICAL AND SOCIOECONOMIC SETTINGS	65
OVERVIEW	65
ENVIRONMENTAL CONTEXT	65
CLIMATE	65
ECOSYSTEMS	66
SOCIO-ECONOMIC ENVIRONMENT	67
CONSULTATIONS AND GRIEVANCE MECHANISM.....	73
CONSULTATIONS	73
PROJECT’S GRIEVANCE MECHANISM(GM)	74
GRIEVANCES RELATED TO GBV/SEAH	78
WORLD BANK’S GRIEVANCE SERVICE.....	78
POTENTIAL ENVIRONMENTAL & SOCIAL RISKS & IMPACTS AND MANAGEMENT MEASURES	80
INTRODUCTION	80
ENVIRONMENTAL RISKS AND IMPACTS	80
SOCIAL RISKS AND IMPACTS	84
E&S RISKS SCREENING.....	90
PREPARATION OF E&S ASSESSMENT INSTRUMENTS.....	91
MITIGATION AND MONITORING MEASURES	92
ENVIRONMENTAL AND SOCIAL MONITORING BY CONTRACTORS	113
ENVIRONMENTAL LIABILITIES OF CONTRACTORS.....	114

ROLES AND RESPONSIBILITIES OF IMPLEMENTING ENTITIES.....	116
INTRODUCTION.....	116
PROJECT COORDINATION AND IMPLEMENTATION UNIT (PCIU).....	116
ROLES AND RESPONSIBILITIES OF THE MINISTRY OF HEALTH (FGS).....	116
PROJECT MANAGEMENT STRUCTURE	118
WORLD BANK ROLES AND RESPONSIBILITIES.....	119
BUDGET FOR IMPLEMENTING THE ESMF	126
UPDATING THE ESMF.....	127
DISCLOSURE OF ENVIRONMENTAL AND SOCIAL RISK MANAGEMENT INSTRUMENTS.....	127
MONITORING AND REPORTING.....	129
ANNEX 1: WORLD BANK ENVIRONMENTAL AND SOCIAL STANDARDS	131
ANNEX 2: INDICATIVE ENVIRONMENTAL SCREENING CHECKLIST.....	133
ANNEX 3: SCOPE OF AN EHS AUDIT OF EXISTING HEALTHCARE FACILITY	135
ANNEX 4: DRAFT TERMS OF REFERENCE FOR A CONTRACTOR ESMP FOR A HEALTHCARE FACILITY..	136
ANNEX 5: SAMPLE GRIEVANCE REGISTRATION FORM	138
ANNEX 6: INDICATIVE ENVIRONMENTAL STEWARDSHIP FRAMEWORK FOR CONTRACTORS.....	139
ANNEX 7: INFECTION CONTROL AND WASTE MANAGEMENT PLAN	142
ANNEX 8: INDIVIDUAL STAKEHOLDERS CONSULTED DURING THE DEVELOPMENT OF THE ESMF	153
ANNEX 9: STAKEHOLDERS CONSULTATION MEETING FOR AF FP 17TH OF JUNE, 2025. SOMALIA	158
ANNEX 10: STAKEHOLDERS CONSULTATION MEETING FOR AF FP 18TH OF JUNE, 2025 SOMALILAND.....	164
ANNEX 11: MINUTES VIRTUAL STAKEHOLDER CONSULTATIONS ON THE E&S INSTRUMENTS FOR THE DAMAL CAAFIMAAD PROJECT, 3RD FEBRUARY 2021	167
ANNEX 12: STAKEHOLDERS CONSULTATION MEETING & MINUTES FOR PROJECT AF - 27 JUNE 2023	171
ANNEX 13: INCLUSION PLAN.....	177
ANNEX 14: GBV ACTION PLAN	180
ANNEX 15: TOR FOR FMS SOCIAL/GBV SPECIALISTS.....	192
ANNEX 16: TOR OF SENIOR ENVIRONMENTAL SPECIALIST FGS	195
ANNEX 17: TOR FOR FGS GBV SPECIALIST.....	198
ANNEX 18: TOR OF SENIOR SOCIAL SPECIALIST FGS.....	200
ANNEX 19: TOR FOR A CONTRACTOR’S E&S ASSESSMENT & MANAGEMENT PLAN (ESMP).....	203
ANNEX 20: DRAFT TOR FOR E&S CAPACITY ASSESSMENT	205

LIST OF TABLES

TABLE 1: SOMALIA'S KEY HEALTH INDICATORS.....	20
TABLE 2: DELIBERATIONS UNDERTAKEN IN THE PREPARATION OF THIS ESMF.....	30
TABLE 3: SUMMARY OF APPLICABLE WORLD BANK ENVIRONMENT AND SOCIAL STANDARDS (ESSs).....	43
TABLE 4: GAP ANALYSIS FOR ESSs.....	52
TABLE 5: E&S CAPACITY ASSESSMENT PER PHASE	61
TABLE 6: CAPACITY BUILDING PLAN.....	62
TABLE 7: CAPACITY BUILDING WORKPLAN.....	63
TABLE 8: GRIEVANCE RESOLUTION TIMELINES	76
TABLE 9: PROJECT COMPONENTS AND ENVISAGED ENVIRONMENTAL RISKS AND IMPACTS	82
TABLE 10: SOCIAL RISKS AND IMPACTS ASSOCIATED WITH PROJECT COMPONENTS (PARENT & AF)	86
TABLE 11: PROPOSED MITIGATION AND MONITORING PLAN FOR ENVIRONMENTAL-RELATED RISKS AND IMPACTS	95
TABLE 12: POTENTIAL ENVIRONMENTAL AND SOCIAL RISKS AND MITIGATION MEASURES (AF2 FAMILY PLANNING ACTIVITIES)	107
TABLE 13: PROPOSED MITIGATION AND MONITORING PLAN FOR GENERAL SOCIAL-RELATED RISKS AND IMPACTS....	108
TABLE 14: INSTITUTIONAL ARRANGEMENTS FOR E&S	119
TABLE 15: INDICATIVE BUDGETARY REQUIREMENTS FOR IMPLEMENTING THE ESMF (PARENT PROJECT & AF)	126

LIST OF FIGUERS

FIGURE 1: PROPOSED IMPLEMENTATION ARRANGEMENTS FOR THE DAMAL CAAFIMAAD PROJECT	14
FIGURE 2: MAP OF SOMALIA, SHOWING POSSIBLE PROJECT BENEFICIARY REGIONS	17
FIGURE 3: STRUCTURE OF GRIEVANCE MECHANISM	77
FIGURE 4: PROPOSED IMPLEMENTATION ARRANGEMENTS	125
FIGURE 5: INCIDENT REPORTING MATRIX	130

ACRONYMS AND ABBREVIATIONS

Abbreviation	Description
AFRO	Regional Office for Africa
AF	Additional Financing
ANC	Antenatal care
ARAP	Abbreviated Resettlement Action Plan
ARI	Acute respiratory infection
CBO	Community-based organization
CERC	Contingency Emergency Response Component
CHC	Community Health Committee
CHS	Community Health and safety
CoC	Code of Conduct
CPF	Country Partnership Framework
CPR	Contraceptive prevalence rate
CSO	Civil Society Organization
DG	Director General
E&S	Environment and Social
EHS	Environmental Health and Safety
EHSGs	Environmental Health and Safety Guidelines
EHSMP	Environmental Health and Safety Management Plan
EMF	Environmental Management Framework
EMRO	Regional Office for the Eastern Mediterranean
EPHS	Essential package of health services
ESAMP	Environmental and Social Assessment and Management Plan
ESCP	Environment and Social Commitment Plan

Abbreviation	Description
ESF	Environment and Social Framework
ESIA	Environmental and Social Impact Assessment
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Assessment and Management Plan
ESS	Environment and Social Standards
EU	European Union
FP	Family Planning
FCV	Fragility, Conflict & Violence
FGM/C	Female genital mutilation/circumcision
FGS	Federal Government of Somalia
FMS	Federal Member State
FRS	Federal Republic of Somalia
GBV	Gender-based Violence
GDP	Gross Development Project
GFF	Global Financing Facility
GHG	Greenhouse Gas
GIIP	Good International Industry Practice
GIS	Geographic Information System
GM	Grievance mechanism
GNI	Gross National Income
GRM	Grievance Redress Mechanism
HCF	Healthcare Facilities
HCI	Human Capacity Index
HSSP	Health Sector Strategic Plan

Abbreviation	Description
IA	Implementing Agency
IC	Infection Control
IDA	International Development Association
IDPs	Internally displaced person
IFWMP	Infection Control and Waste Management Plan
INGOs	International Non-Governmental Organizations
IP	Implementing Partner
IPF	Investment Project Financing
IPV	Intimate partner violence
IVAs	Independent Verification Agents
JHNP	Joint Health and Nutrition Programme
LMP	Labour Management Procedures
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
MIS	Management Information System
MoH	Ministry of Health
MoLSA	Ministry of Labour and Social Affairs
MSDs	Material Safety Data Sheets
MTR	Medium Term Review
NBSAP	National Biodiversity Strategy and Action Plan
NDP	National Development Plan
NGO	Non-governmental Organization
NSAs	Non-state actors
OHS	Occupation health and safety

Abbreviation	Description
OHSE	Occupation health and safety and Environmental
OOP	Out-of-pocket
OP	Operational Policy
OPM	Office of the Prime Minister
PAPs	Project affected persons
PCIU	Project Coordination and Implementation Unit (FGS level)
PDO	Project Development Objective
PFM	Public Financial Management
PHC	Public Health Care
PHUs	Primary Health Units
PLWDs	People living with disabilities
PMT	Project Management Team (FMS level)
POM	Project operational manual
PWDs	Persons living with disabilities
RAP	Resettlement Action Plan
RCRF	Recurrent Cost and Reform Financing (WB funded project)
RPF	Resettlement Planning Framework
RWH	Rainwater harvesting
SBA	Skilled birth attendants
SCD	Systematic Country Diagnostic
SDG	Sustainable Development Goal
SEA	Sexual Exploitation and Abuse
SEAH	Sexual Exploitation, Abuse and Harassment
SecMF	Security Management Framework

Abbreviation	Description
SecMP	Security Management Plan
SEP	Stakeholder Engagement Plan
SHDS	Somali Health and Demographic Survey
SOPs	Standard Operating Procedures
TA	Technical Assistance
TBAs	Traditional Birth Attendants
TFR	Total fertility rate
ToR	Terms of Reference
TPM	Third Party Monitoring Agent
TTL	Task Team Leader
WB	World Bank
WBG	World Bank Group
WHO	World Health Organization
WM	Waste Management

EXECUTIVE SUMMARY

Introduction. After a prolonged civil war and follow-on civil strife, the health of the Somali people has suffered greatly. Armed conflict has destroyed the little health infrastructure that was there, resulting in poor access to essential health services for majority of the population. Largely in the hands of the private sector, Somalia’s health sector is generally described as a dysfunctional health system that operates mostly outside the purview of the health authorities (where they exist). It is mostly characterized by poor infrastructure, inability on the part of the different governmental authorities to deliver services, and an absence of equity.

Government expenditure on health has been generally insignificant, hovering at 4 percent of total government expenditures annually since 1997 (WHO, 2004): today, this is estimated at just 4.7 percent.¹ Real per capita expenditure on health is approximately US\$13 per person per year (2019), far below Sub-Saharan Africa’s average of US\$204 (2017 estimate). As a result, most financing to the health sector comes from aid financing, which, according to a World Bank study reached up to US\$10 per capita in 2006 (World Bank, 2008), which, while a considerable amount compared to other fragile states, is still insufficient “to address the population’s needs and to meet the high operational costs of working in such a logistically challenging environment.”² In all this, an important point to note that is that policies in the health sector are either absent or, where they exist, incoherent. At least 60% of health services are estimated to be delivered by the private sector. However, they are unregulated due to weak Government regulatory capacity. There is also a scarcity of actionable health information.

As a result, health indicators in Somalia are among the lowest in the world, and lag behind even by sub-Saharan Africa standards. For example, the immunization coverage rate for measles is 46 percent countrywide and even lower in hard-to-reach areas (WHO, 2015)³. Only one in three Somalis has access to safe water; one in every nine Somali children dies before their first birthday; and the maternal mortality ratio is 850 deaths per 100,000 live births.⁴ As a result, Somalia’s health indicators remain among the worst in the world, with an average life expectancy of 56 years, and other indicators lagging those in the WHO AFRO region.

In addition, the country has one of the lowest life expectancies in the world, estimated at 53 and 56 years for males and females, respectively. This is compounded by severe poverty. About 77 percent of Somalis live on just US\$1.9 per day, according to the World Bank’s Somalia High Frequency Survey, published in

¹ World Health Organisation, 2004. World Health Report – Somalia. Accessed on June 14, 2020, at <https://www.who.int/whr/2004/annex/country/som/en/>

² World Bank, 2008. A Review of the Health Sector Aid Financing to Somalia. World Bank Working Paper no. 142. Accessed on June 1, 2020, at <http://documents.worldbank.org/curated/en/457601468103478205/pdf/439750PUB0Box310only109780821375174.pdf>

³ World Health Organisation, 2015. Humanitarian Response Plans Somalia in 2015. Accessed on May 10, 2020, at <http://origin.who.int/hac/donorinfo/somalia.pdf>

⁴ *Ibid*

2019.⁵ Yet households spend disproportionately significant amounts of their incomes annually on healthcare. Studies done by the World Bank show that annual out-of-pocket expenditures on healthcare in Somalia averages US\$110, representing between 20 and 30 percent of the per capita income for households.

This has exposed an already vulnerable population to high disease burden (both communicable and non-communicable) and malnutrition. The country is therefore off-track in reaching the Sustainable Development Goals by a wide margin (Warsame *et al.*, 2015).⁶ According to Warsame et al., as of 2015, there were 46 major health facilities in Somalia including seven referral hospitals, 27 district hospitals, 248 maternal and child health clinics and 544 dispensaries. In 2006, only 9 percent of births were attended by skilled health personnel (Global Health Observatory, 2020):⁷ this has now improved to 32 percent as of 2019 (Somalia Health and Demographic Survey, 2019).⁸

The Somali government has acknowledged the poor state of the health sector and is engaging development partners to improve health outcomes for its people. In 2013, for the first time, the Ministry of Health (MoH) developed zone-specific Health Sector Strategic Plans (HSSP, 2013-2016) for Somaliland, Puntland and South-Central Somalia. This was an important step in building the government’s capacity to improve access to health services for the people of Somalia (Federal Government of Somalia, 2016).⁹

Improving Somalia’s health sector. Much of the country’s healthcare facilities are beset by systemic problems, including poor staffing, lack of appropriate equipment, and inequity in geographical distribution, with a disproportionate focus on urban centers. Generally, the national public health system has been dysfunctional for over three decades now, with only non-state actors bridging the yawning gaps in healthcare services in a sector that is almost entirely private (Warsame *et al.*, 2015). All these have had huge implications for the lives and livelihoods of Somalis.

Somalia’s Ninth National Development Plan sets three main priorities for improving health access and outcomes. These include

- (a) institutional oversight and strengthening, which includes setting the legal and oversight frameworks at the Ministry of Health, and at the level of state and municipal government health bodies.
- (b) focusing on most pressing health challenges, including maternal and early childhood health, reducing malnutrition and childhood stunting, and greater access to clean water and sanitation (in homes as well as in health facilities).

⁵ World Bank, 2019. Somalia Poverty and Vulnerability Assessment: Findings from Wave 2 of the Somali High Frequency Survey. Accessed on June 6, 2020, at <https://openknowledge.worldbank.org/handle/10986/32323>

⁶ Warsame, A., Handuleh, J., and Patel, P. 2015. Prioritization in Somali health system strengthening: a qualitative study. In *International Health*, 8(3):ihv060

⁷ See <https://www.uhpartnership.net/country-profile/somalia/> for more details

⁸ Federal Government of Somalia, 2019. The Somali Health and Demographic Survey. Accessed on June 14, 2020, at https://somalia.unfpa.org/sites/default/files/pub-pdf/FINAL%20SHDS%20Report%202020_V7_0.pdf

⁹ Federal Government of Somalia, 2016. Comprehensive Multi Year Plan for Immunization System. Available at https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/somalia/national_cmyp_somalia.pdf

- (c) focusing on the most vulnerable, especially rural citizens along with Internally Displaced Persons (IDPs), and those in newly liberated areas, who have the least access to health care.

The plan calls on Somalia to coordinate with development partners to ensure better health services coverage. Specifically, the NDP pledges that the government will partner with non-state providers to rehabilitate or construct health clinics, and to increase distribution of Essential Package of Health Services (EPHS). Towards this, in 2019, Somalia became a Global Financing Facility (GFF) country, which will go a long way in reducing health sector fragmentation and strengthening the government’s stewardship role.

Basing his recommendations on the 2013 Somali Joint Health and Nutrition Programme,¹⁰ overseen by UNICEF and the Health Consortium for Somali People, Warsame (2014), in his seminal study on “opportunity for health systems strengthening in Somalia”, calls for interventions in six distinct areas. These are (1) strengthening leadership and governance; (2) increasing health workforce quality and quantity; (3) delivering equitable health services through functioning health facilities; (4) developing a nationally financed and locally prioritized health financing system; (5) ensuring provision of appropriate and sufficient health products; and (6) establishing a comprehensive monitoring and evaluation system.¹¹

The National Transformation Plan (NTP) 2025-2029 identifies the health sector as a central pillar of Somalia's development agenda, focusing to expand access, improve quality, and build resilience. It sets out six core priorities for the next five year:

- a) Maternal and Child Health: Reducing preventable death remains a central priority. The plan pledges to expand access to safe deliveries, antenatal and neonatal care, immunization, and nitridation support. Specific targets include lowering maternal mortality, infants, and under-five mortality.
- b) Building a Skilled Health Workforce: Somalia's NTP underlines the need to rain, regulate, and deploy qualified health workers, both generalist and specialists.
- c) Strengthening Health Systems and Infrastructure: The plan calls for rehabilitation and expansion of health facilities services and investments in reliable power, water, sanitation waste management systems. With over 40% of facilities currently lacking these basics, the NTP highlights resilient and climate-sensitive infrastructure.
- d) Nutrition and Immunization: With 1.5 million Somali children affected by malnutrition, and immunization coverage below 50%, the plan priorities integrated nutrition programmes.
- e) Governance, Financing, and Data Systems: the NTP commits to increasing public health spending to at least 10% of the national budget and mobilizing USD 200 million in private sector financing. It emphasizes stronger governance at federal and state levels and scaling up of digitized health information platforms.

¹⁰ For more details on this programme, please see http://www.unicef.org/somalia/reallives_13941.html

¹¹ Warsame, A. 2014. Opportunity for health systems strengthening in Somalia. The Lancet, Vol. 2, Issue 4. Available at [https://doi.org/10.1016/S2214-109X\(14\)70010-5](https://doi.org/10.1016/S2214-109X(14)70010-5)

f) Emergency Preparedness and Research: The plan calls for strengthening the National Institute of Health, expanding Public Health Emergency Operations Centres from 7 to 18, and building biomedical research capacity.

Improving Healthcare Services in Somalia Project. Also known as “*Damal Caafimaad*” in Somali language,¹² the project seeks to improve coverage of essential health and nutrition services for underserved populations¹³ in project areas and to develop capacity of the Ministry of Health to manage health and nutrition services. The project will support EPHS delivery in select regions and will coordinate with other partners who will support EPHS delivery in complementary regions. The project is expected to be implemented over the course of a period running from June 2021 to June 2026 in selected geographical areas in Somalia.

In addition, the project will support capacity building for Ministries of Health (MoH) across the country’s federal member states, in addition to the Federal MoH. A robust primary health system is essential for detecting and responding to outbreaks. The EPHS includes outbreak detection and response within the package. In addition, primary and secondary care facilities are critical for the referral chain to tertiary services including COVID-19 critical care centers, which are supported by the Somali Crisis Recovery Project.

The project will be implemented by the Ministry of Health, Somalia. The mission of the ministry is to “ensure the provision of quality essential health and nutrition services for all people in Somalia, with a focus on women, children, and other vulnerable groups.” The ministry also seeks to “strengthen the national and local capacity to deliver evidence-based and cost-effective services based on the EPHS and Primary Health Care approach.”¹⁴ The ministry adopted the EPHS framework in 2009 and has tried to implement it in the country with the support of the Joint Health and Nutrition Programme, supported by multiple donors and UN organizations.

The proposed project is in line with the Somalia National Development Plan’s Pillar 4 (“Social Development”), which calls for investments to achieve outcomes related to “improved health”, “improved social protection,” and “governance strengthening.” In the long-term, the project will also help in the achievement of peace and stability, as the interventions will help develop confidence in national institutions (including the Ministry of Health) and its enhanced capacity to deliver primary healthcare outcomes for the population in Somalia.

Development objectives. The Project Development Objective (PDO) of the project is to “improve the coverage of essential health and nutrition services in project areas and strengthen stewardship capacity of Ministries of Health.” The project has four components:

¹² *Damal* is a Somali word that refers to *Acacia stenocarpa*, sometimes also known as *Vachellia seyal*, which grows in Somalia. *Caafimaad* in Somali means “health.”

¹³ Underserved populations in this context means “women and children and persons living in project target areas, including hard-to-reach and difficult environments, i.e., IDPs and nomads” (reference from project’s Project Appraisal Document)

¹⁴ More details on the Ministry of Health available on <https://moh.nomadilab.org/ministry/>

■ **Component 1:** *Expanding the coverage of a prioritized EPHS in selected geographic areas (US\$60 million: IDA US\$43 million and GFF US\$17 million)* will finance delivery of an essential package of health and nutrition services in selected geographic areas. Somalia’s EPHS will focus on the provision of:

- child health services (routine immunization, micronutrient supplementation, promotion of infant and child feeding and nutrition referral);
- maternal and neonatal health services, including testing and interventions during ANC visits, basic and comprehensive emergency obstetric and new-born care (BEmONC and CEmONC), and family planning;
- FGM/C and sexual and gender-based violence (SGBV) services (awareness raising, Case management, Provisions of Clinical Management of Rape, Psychosocial support services and Counselling,); and
- Disease surveillance (strengthening and maintaining disease surveillance and response as well as preparedness and response to disease outbreaks).

This component will be implemented in Nugaal (Puntland State), Bakool and Bay (South-West State, or SWS), and Hiraan regions (Hirshabelle State). Three delivery platforms are envisaged for extension of EPHS to Somalis, including:

- *Government contracting service delivery to non-state actors:* Considering limited service delivery capacity in the public sector, the Government has agreed that the main health service delivery modality under the proposed Project will be Government contracting of health services in public facilities, to be implemented by NGOs.
 - *Strengthening government service delivery system to expand service coverage:* Upon the request from the Government, this is likely in a small scale in the selected regions of Puntland, where there is existing government service delivery capacity.
 - *In urban areas, the Project may support Government contracting of private sector networks as a pilot.* This modality aims to facilitate effective Government engagement with private sector service providers to enhance delivery of high-impact health and nutrition services in select geographic areas.
- **Sub-component 1.1: Family Planning Services:** FP is supported through a GFF trust fund allocation of approximately US\$5.5 million, with a focus on service access, quality, and social risk mitigation. Therefore, the proposed AF2 will support Component One in expanding the coverage of high-impact health and nutrition services in specific geographic areas (US\$90.25M total: US\$62.5M IDA (including US\$5.5M for Somaliland), US\$18.50M GFF, US\$4.25M GCF and US\$5.0 GFF Challenge Fund AF). The government will amend the ongoing contract with PSI to include the provision of FP services through the private sector in Mogadishu (Banadir region), Hargeisa (Somaliland), Kismayo (Jubaland), and Garowe (Puntland) using the USD 5.0 million AF from GFF Challenge Fund. These urban areas, characterized by high population density, underserved family planning needs, and a growing network of private sector providers, will benefit from this initiative. Building on the parent project, the AF aims to reduce intervention costs, expand services, increase information dissemination, and enhance long-term sustainability. PSI will collaborate with existing private sector networks to: Expand access to contraceptives, both financially and physically, Increase

the variety of contraceptives available in the private sector, Create synergies with other ongoing health projects, Leverage learnings from previous projects to integrate FP services into existing maternal and sexual and reproductive health (SRH) services, such as antenatal care (ANC), post-abortion care (PAC), and postnatal services

- **Component 2: *Strengthening government’s stewardship and management capacity to enhance service delivery (US\$12 million: IDA US\$6 million and GFF US\$6 million)*** – in this component, the project will support the development of government stewardship capacities at both the Federal and FMS levels to enhance quality service delivery. The activities will be implemented under five sub-components:
 - *Sub-component 2.1: Health Information and Management Systems (HMIS) and Data Use for Decision Making:* In this sub-component, the project will finance interventions meant to improve data timeliness, quality, and use. The project will also initiate the Logistics Management Information System (or LMIS in short) framework to contribute to the long-term goal of ensuring a high-functioning health information system producing regular, quality, reliable data that are used for routine decision making.
 - *Sub-component 2.2: Public Financial Management (PFM), Contract Management and Health Financing:* The project will support the implementation of recently developed Public Finance Management (PFM) roadmap by funding short-term activities including the development of contract management quality control guidelines, contract management capacity development and support, PFM technical assistance and capacity development for planning and budgeting as well as budget execution capacity at the FGS and FMS levels.
 - *Sub-component 2.3: Private Sector Development and Regulatory Reforms:* The project will map private sector providers and networks to inform organizational development/capacity building interventions. Interventions under this sub-component will also support the building of the organisational capacities of selected private providers and their networks. The project will establish public-private dialogue mechanism and building dialogue capacity both at the FGS and at selected FMS on health matters. To address the weak policy environment, the project will undertake a rapid assessment of the regulatory landscape. Based on the findings of the assessment, the project will support measures to address policy and regulatory reform gaps, including defining regulatory roles between the FGS and the FMSs. In addition, there will be interventions to establish regulatory and accreditation bodies for medicines, health workers, and health facilities, including the National Health Professionals Council and the National Medicines Regulatory Authority.
 - *Sub-component 2.4: Organizational Development:* This sub-component will finance activities aimed at the development of systems and process for decision making, internal information sharing, internal communication, external communication, and information management. The project will also enhance the capacity for planning, learning and review including development and implementation of systems and processes for regular review and learning.
- **Component 3: *Project Management, M&E, Knowledge Management, and Learning (US\$11 million)*** – This component will finance activities for routine project management. They include coordination, administration, communication, management, procurement, M&E, and dissemination of project activities at both FGS and FMS levels. A third-part monitor will be hired to undertake rigorous monitoring of project activities and impact.

- **Component 4: Contingency Emergency Response Component (CERC)** – This component is included in the project, in accordance with the World Bank’s Investment Project Financing (IPF) Policy, paragraphs 12 and 13, for situations of urgent need of assistance (for example, Ebola or other epidemics or outbreaks of public health importance, or other disasters, which cause major adverse economic and social impacts). To trigger this component, the Government needs to declare an emergency or provide a statement of fact justifying the request for the activation of the use of emergency funding. The Government may request the World Bank to re-allocate undisbursed Project funds to support response and reconstruction. An Emergency Response Operations Manual will be prepared by the Government as a condition of disbursement and annexed to the Project’s Operations Manual.

The proposed Additional Financing (AF) will retain the original four components: (1) Expanding the coverage of high-impact health and nutrition services in select geographic areas; (2) Strengthening Government’s stewardship to enhance service delivery; (3) Project Management and Knowledge Management and Learning; and (4) a Contingency Emergency Response Component (CERC).

In addition, the proposed Additional Financing (AF) from the Green Climate Fund Cooling Facility of US\$4.25 million to the Damal Caafimaad project will promote the adoption and use of climate friendly cooling equipment and appliances in the health sector and strengthen cold chain capacity necessary for expanding the delivery of maternal and child health services, especially immunization. In particular, the proposed AF will finance the following:

1. Under Component 1, the proposed AF will provide additional US\$4.00 million increasing the component cost from US\$75.50 million to US\$79.50 million. The AF will finance investments in climate friendly cold chain equipment, specifically purchases of Solar Direct Drive (SDD) refrigerators along with equipment for solar power generation and cooling for selected PHUs and health centers. Based on initial assessment, the AF will procure SDD refrigerators for 200 health facilities in six regions including Primary Health Units which the government intends to upgrade to provide immunization services. No air conditioners will be purchased by the project as part of the AF.
2. Under Component 3, the proposed AF will provide additional US\$0.25 million increasing the component cost from US\$6.00 million to US\$6.25 million. The AF will finance technical assistance to improve the policy environment for climate friendly cold chain and power. Specifically, the support will focus on the development of policies and mechanisms to dispose of obsolete cold chain equipment, such as kerosene powered cold chain equipment, and systems to ensure continuous maintenance and security for SDDs and solar power systems.

Environment and Social Management Framework. This document presents the Environmental and Social Management Framework (ESMF) for the proposed Improving Healthcare Services in Somalia (sometimes also referred to simply as “the Project” or by use of the Somali name for the project, *Damal Caafimaad*), including the Additionally Financed interventions and activities.

The ESMF focuses on identifying and characterizing the relevant Environmental and Social (E&S) risks and impacts the project is likely to face, including environmental hazards, labor issues, stakeholder engagement, social exclusion and gender-based risks. The associated instruments, including the Labour Management Procedures (LMP) and Security Management Framework (SecMF), will be included in all bidding and other contractor management related documents at project implementation.

The main objective of this ESMF is to develop procedures for environmental and social screening and assessment of activities and interventions that are to be funded within the framework of the proposed parent project and AF. The ESMF ensures that the project activities scheduled for implementation are compliant with the relevant requirements of national¹⁵ and state-level¹⁶ policies, regulations and legislations (including primary health care, EPHS standards, waste management procedures, labor code, among others) as well as the World Bank Environment and Social Standards (ESSs). The Framework has also highlighted existing weaknesses in E&S risk management at the level of the ministries responsible for health matters at both levels of government, and provides an action plan for mitigating these structural weaknesses.

This ESMF not only sets out the principles, rules, guidelines and procedure to assess the E&S impacts of interventions to be funded by the project, but also highlights the various responsibilities of the various actors in the project. This ESMF, therefore, directly applies to those activities that will be financed by the parent project and AF, or which are associated or implemented as a result of overall project interventions. This ESMF also highlights the appropriate World Bank’s Environment and Social Standards and relevant existing Somalia environmental relations laws which activities and sub-projects financed by, or related to, the project has to conform to.

The ESMF also contains an overview of the baseline environmental conditions in the states identified for support under the project, identifies and characterizes potential E&S risks and impacts that might arise out of the implementation of the project’s activities (“sub-projects”) and proposes mitigation and enhancement measures. This ESMF will, therefore, be the basis for the preparation of the site-specific Environment and Social Management Plans (ESMPs) or Environmental and Social Impact Assessment studies (ESIAs, if required) during project implementation phase.

Project Environmental Baseline. The project will likely be implemented in a number of Federal Member States of Somalia, including Nugaal in Puntland State, Bakool and Bay in South-West State (SWS), and Hiraan in Hirshabelle State. The final selection of target areas will be agreed by project appraisal. The criteria for geographic selection are based on objective criteria, including population size, accessibility (based on 2019 polio program accessibility data), poverty data from the Somalia High Frequency Survey (SHFS), health service delivery data from the Somalia Health and Demographic Survey, and current partner support.

The activities to be implemented under the project include the delivery of a sub-set of high-impact health and nutrition services in line with EPHS 2020 in selected regions, including pharmaceutical procurement, procurement of key equipment, supportive supervision, HMIS management, and regional capacity development. Other activities envisaged include routine monitoring and evaluation, policy and regulatory reforms, and the establishment of licensing regulations and bodies for health products.

Policy, Legal and Institutional Frameworks. The project is required to meet the health sector laws of Somalia, as well as E&S management systems in place in the country. The key legal instrument for management of E&S affairs in Somalia is the Constitution, especially Article 25 (“Environment”), Article

¹⁵ Federal Government of Somalia

¹⁶ The respective policies of the federal states that are to be included for support in the project

27 (“Economic and Social Rights”), Article 29 (“Children”), Article 43 (“Land”), Article 44 (“Natural Resources”), Article 45 (“Environment”) and Article 52 (“Cooperative Relationships Between the Various Federal Member State Governments”).

Article 52 of the Constitution lays the framework for cooperation between the centre (the FGS) and the fringes (the FMSs), and makes it clear that the health sector is a matter for mutual cooperation. Article 27 of the Provisional Somali Constitution states that “every [Somali] has the right to healthcare, and no one may be denied emergency healthcare for any reason, including lack of economic capability” (Article 27, clause 2).

Article 25 of the Constitution states that “[every Somali] has the right to an environment that is not harmful to their health and well-being, and to be protected from pollution and harmful materials.” The article proceeds to declare that “[every Somali] has the right to have a share of the natural resources of the country, whilst being protected from excessive and damaging exploitation of these natural resources.”

Article 45 (in Chapter 3 – “Land, Property and Environment”) exhorts “all people in ... Somalia” to “participate in the development, execution, management, conservation and protection of the natural resources and environment.”

Article 43, on its part, provides guidelines on environmental and social safeguards that can be observed. However, there are no standing environmental and/or social safeguards in terms of legislated and or drafted regulations. The Article also affirms that the federal government shall give priority to the protection, conservation, and preservation of the environment against anything that may cause harm to natural biodiversity and the ecosystem.

The Federal Government of Somalia developed the Ninth National Development Plan (NDP) covering the period from 2020-2024. Chapter 8.3 is dedicated to the health and nutrition sector, with a vision clearly enunciated that all people in Somalia should get access to improved health services. The recent National Transformation Plan 2025-2029 thisThe policy identified the health sector as a central pillar for Somalia development agenda focusing on eight six targets for the health sector. The Federal Government of Somalia has developed the second Health Sector Strategic Plan. The HSSP is based on the NDP, and follows the same goals and targets, and provides broader interpretation of the actions that needs to be taken. Furthermore, the Somali National Medicines Policy was developed, and endorsed in 2014. The National Medicines Supply Chain Masterplan for Somalia was finalized in 2015, while the Medicines Regulatory Authority established in 2016.

The project is also structured to meet the requirements of the Somalia-WHO Country Cooperation Strategy.¹⁷ In particular, the project interventions will contribute to the achievement of:

¹⁷ More details are available at https://apps.who.int/iris/bitstream/handle/10665/136871/ccsbrief_som_en.pdf;jsessionid=220403634A9968509EB6382FE6BD779C?sequence=1

- Strategic Priority 1 (“Communicable Diseases”): through implementing activities that will reduce the burden of communicable diseases, and by way of child health services (routine immunization; micronutrient supplementation) that are planned in the project
- Strategic Priority 2 (“Non-Communicable Diseases”): this will be achieved through planned investments in primary health care, knowledge and documentation activities, and strengthening the capacity of Somali authorities to prevent and manage NCDs and their risk factors
- Strategic Priority 3 (“Health through the Life Course”): the proposed project has significant focus on maternal, new-born, and child health; the project also proposed to strengthen coordination between participating FMSs and development partners on maternal, neonatal, and child health
- Strategic Priority 4 (“Health System and People-Centred Healthcare Services”): The proposed project has a focus on strengthening the existing weak health systems by infusing both technical (personnel) as well as policy and regulatory frameworks in order to ensure greater well-being of the people of Somalia.

Environmental Risks and Risk Rating. The environmental risk classification for the project is Substantial under the World Bank ESF, mainly because of the risks linked to the management of biomedical waste but also because of the risks linked to small scale renovation of health facilities. In addition, health and safety risks also need to be taken into account given the limited capacity of the PCIU and the PMTs on these issues. The main environmental impacts of health activities supported under this project may come during the rehabilitation and operational phases of the project from the possible heavy consumption of energy and water resources, pollution, possible greenhouse gas emissions, use and disposal of toxic chemicals, and production of wastes and wastewater and their disposal.

The project activities with environmental risks proposed under the project include construction activities, such as possible small-scale rehabilitation and/or refurbishment of health centres, as well as lifecycle infection control and the possible use of designated waste disposal pits or medical incinerators (especially in large urban centres) or other waste management facilities for medical waste disposal. Generally, there are no waste management and disposal systems in public health facilities in Somalia. As a result, improper disposal of bio-medical waste by health centres, hospitals, primary health centres, community health centres and diagnostic centres pose a health hazard to the general public.

The project activities will produce hazardous waste, such as mercury-containing items (thermometers) contaminate the environment; ash residue, which, if not properly disposed of, can contaminate groundwater at unlined waste disposal pits. On the other hand, significant amounts of pathologic waste with high moisture content requires significant energy to combust properly etc. Due diligence will be carried out to ensure that the siting, design and operation of waste management pits do not exacerbate environmental risks and impacts, however it is anticipated that they will be within existing health facilities.

The use of medical waste incinerators requires trained operators, monitoring of waste segregation, appropriate waste transportation to site, and ash residue disposal. There are few trained operators in the country, and there is limited experience generally with modern medical waste management systems. The project will support the health facilities in designing and establishing SOPs based on WHO and WB standards, including WB ESHS guidelines.

Social Risks and Risk Rating. The social risks from this project are rated substantial, taking into account the following key risks and impacts: (i) potential of exclusion of disadvantaged and vulnerable groups from project benefits and elite capture; (ii) potential risks of increased social tension in the community (for example, on types and/or how services are delivered, or siting of services); (iii) conflict and security risks for project workers, patients and the community. Potential security risks include targeting of health workers and project staff by parties involved in conflict; risks to health workers and other project staff due to conflict; and inability of both workers and community members to access project areas due to conflict; (iv) labour risks, including occupational health and safety (OHS) risks, sexual exploitation and abuse (SEA), sexual harassment (SH), and other forms of gender-based violence (GBV) that may occur in recruitment or retention of skilled or unskilled female workers and the delivery of services; (v) contextual risks of operating in a conflict zone and a complex social context where effective and inclusive community consultations, stakeholder engagement, and community participation and safety of staff are challenging.

The GBV/SEAH risk of the project is assessed as substantial. In addition, the risk of stakeholder engagement is also adjudged substantial. This is mainly due to the current context in Somalia, which is characterized by lack of trust between key groups in society, compounded by high levels of contestation and violence, which presents a high risk for the Project in relation to the stakeholder environment.

The existing policies, legislation and institutional frameworks on social services, including policies on social, health and civil service sectors, and World Bank's ESF provide a framework that can facilitate the implementation of social safeguards and GBV Specialist for the project. The existing labour laws are aligned to the provisions stipulated in Environment and Social Standard 2 (ESS2) although the key challenge in Somalia is lack of enforcement. The Provisional Constitution (2021) makes provisions that guarantee human rights of all people including the disadvantaged and vulnerable groups and the right to healthcare and other social services. The Somalia Health Sector Strategic Plan (HSSP) takes a pragmatic approach to the provision of essential package of health services (EPHS) including community-based health services across the FMSs and regions of Somalia but the EPHS' implementation is limited to some regions due to funding gaps and insecurity.

Multiple mechanisms are outlined on how to mitigate the potential social risks including: (i) ensuring that all the specific risks are identified and addressed in the ESMPs of all the contractors and implementing partners; (ii) stakeholders are actively involved in the project as guided by the Stakeholder Engagement Plan (SEP); (iii) the LMP, Inclusion Plan and GBV Action Plan are fully implemented (note that the Inclusion Plan is part of the SEP and of this ESMF, while the GBV Action Plan has been annexed to this ESMF only); (iv) the grievance management (GM) procedures developed for the project is operationalized; and (v) there is robust monitoring through a third party. In addition, a SecMF will be prepared by the project team to address all issues related to security of the project workers, users of health facilities, equipment and materials. High level mitigation measures will include: strong involvement of both FGS and FMS authorities throughout project preparation; effectively using the Global Financing Facility (GFF) -supported country platform for improved coordination among stakeholders; and closely engaging with Office of the Prime Minister (OPM) in addition to the MoH, to better manage FGS-FMS relationships.

Overall Risk Rating. The Ministry of Health's ability to apply World Bank environmental standards is limited, due to absence of experienced technical capacity for environmental safeguards at the ministry. In

addition, the country risks are extensive due to political and security considerations; the ability for the World Bank to supervise environmental risks management is limited. There are also extensive social risks identified during the project preparation and consultations. Therefore, the overall environmental and social risk rating is “**Substantial**” under World Bank’s Environmental and Social Risk Classification system (ESRC).

Applicable Environmental and Social Standards. Due to the dearth of applicable environmental laws and regulations at both national and state levels in Somalia, the project will apply the World Bank Environment and Social Framework¹⁸, and will, therefore, not rely on Somalia’s national environment management frameworks. The following environmental and social standards will be relevant to the activities implemented under the project:

- ESS1 (“Assessment and Management of Environmental and Social Risks and Impacts”)
- ESS2 (“Labour and Working Conditions”)
- ESS3 (“Resource Efficiency and Pollution Prevention and Management”)
- ESS4 (“Community Health and Safety”)
- ESS6 (“Biodiversity Conservation and Sustainable Management of Living Natural Resources”)
- ESS8 (“Cultural Heritage”)
- ESS10 (“Stakeholder Engagement and Information Disclosure”)

Therefore, the project will comply with the ESSs, where potential E&S risks and impacts are anticipated. Where possible, the project will put premium on implementing alternative measures to avoid, minimize, mitigate, manage or compensate adverse environmental impacts. Avoidance measures will be prioritized over mitigatory or compensatory measures. Additionally, the project will enhance positive impacts in project selection, location, planning, design, implementation and management.

Potential Environmental and Social Benefits of the Project. The implementation of activities under the project as proposed will have several environmental benefits. The environmental benefits of the project include:

- less pollution loads due to improved solid waste management
- enhanced capacity for environmental management at the participating health facilities

Mitigation Measures and Monitoring. In order to address the potentially adverse environmental and social risks and impacts, an E&S screening process has been proposed under this ESMF. This will be applied in such a way as to ensure that potential negative risks and impacts of the project are prevented or mitigated appropriately, and positive impacts are enhanced. The Ministry of Health will play a key role in ensuring that the proposed mitigation measures in this ESMF are implemented.

¹⁸ For better understanding of the World Bank’s ESF, please visit <https://projects.worldbank.org/en/projects-operations/environmental-and-social-framework/brief/environmental-and-social-standards>

To mitigate these risks during project implementation, key ESF instruments will be prepared and activated in the life of the project. These are as follows:

- Stakeholder Engagement Plan (SEP), which will set out effective and transparent management of consultation, communication and information disclosure processes to guide the health sector reforms process;
- An Environment and Social Commitment Plan (ESCP), which will summarize the Borrower's commitments and obligations to adopt and implement the environmental management measures specified in this document for project implementation; and
- This Environmental and Social Management Framework (ESMF) which provides the overall framework for the management of environmental risks and impacts of the project. The ESMF also includes an Infection Control and Waste Management Plan (ICWMP).
- Contractor Environmental and Social Management Plan (C-ESMP), to be developed and implemented by the contractors running the health facilities, and which will be structured to cover environmental risks and impacts during both the (minor) construction and operational phases of the healthcare facilities. The C-ESMPs will meet contractual EHS requirements.
- Labour Management Procedures (LMP).
- Security Management Framework (SecMF).

Project Implementation Arrangements. A Project Coordination and Implementation Unit (PCIU) has been set up as the responsible implementing entity in the Federal MoH (FMoH). In the long term, the PCIU aims to serve as a single coordination and management unit for development partner financing and activities in the FMoH. The PCIU is responsible for overall project coordination, implementation, and day-to-day management and monitoring of the project. This includes: (i) ensuring project activities are implemented on day-to-day basis as agreed, and in compliance with the World Bank technical and fiduciary guidelines; (ii) leading technical, operational, and fiduciary functions, especially contracting and contract management; and (iii) coordinating and overseeing project implementation and management in the respective FMS, including monitoring and evaluation of project activities, capacity building, and ensuring compliance to social and environmental safeguard requirements.

At the FMS level, each FMS will form a Project Management Team (PMT) at the state's MoH, based in the respective capital of the state. The PMT will be primarily responsible for project management at FMS-level, including managing and tracking implementation progress, identifying opportunities for implementation improvements and solving day-to-day issues that may delay implementation. Key responsibilities of the PMT include reviewing project activity design, technically supporting implementation agencies, project M&E, and coordinating with the FMoH PCIU. Overall, the Project Manager in each PMT will coordinate efforts within their respective governments, across other World Bank-financed projects in the health sector, as well as between the FGS and the FMS. Health facility contractors running the supported health centers will be required to have EHS staff, and, in addition, will be required to develop and implement an EHS and environmental management capacity building plan.

Figure 1 below expresses in visual form the implementation arrangements for the proposed parent Project and AF.

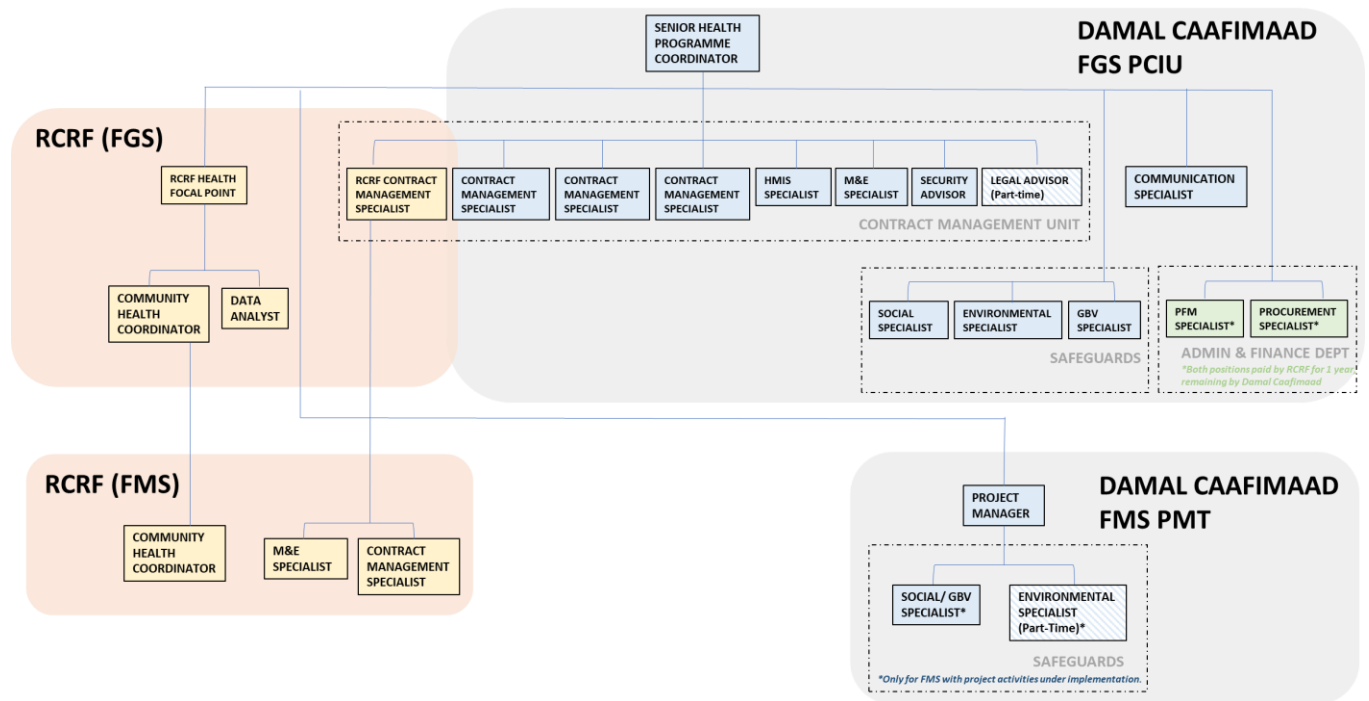


Figure 1: Proposed implementation arrangements for the Damal Caafimaad Project

Public Consultations and Disclosure. The WB’s ESS10 requires public consultation with affected groups and other stakeholders about the project E&S impacts. This is with a view of taking their suggestions and inputs into account in the project design. The details of stakeholder engagement are presented in the Stakeholder Engagement Plan (SEP). The Project Management has conducted a series of virtual individual consultations and workshops, which had been attended by a range of stakeholders including government staff, civil society organizations, academia, and NGOs specifically working in the health sector under the parent project. The aim of these consultations was to solicit insights on the potential social risks and mitigation measures related to the implementation of the ‘Damal Caafimaad’ parent project. The stakeholder consultation workshops engaged 39 individuals, 6 of whom were women. For the purpose of validating E&S SGs documents of the AF interventions and activities, a virtual consultation with key stakeholders and representatives of the community was held on June 27, 2023. Feedback was received from stakeholders and beneficiaries about the parent Project and AF interventions and activities, including on medical waste management and social considerations for placenta pit placement, workplace issues, OHS during HCF rehabilitation phase, exclusion, GBV/SEAH, and many others. This input is reflected in detail in this final revised version of the ESMF.

Cost Implications of the ESMF. Low capacity within the implementing FGS teams in Mogadishu as well as in the federated states risks undermining the ability of the project team to roll out in a timely and effective manner the interventions (i.e., of parent Project and AF) proposed in this ESMF. To mitigate this risk, the project will contribute to developing capabilities of the Ministry of Health to oversee the execution and delivery of the mitigation measures proposed in this ESMF.

Technical capacities for environmental and social risk management in the MoH are limited; as such, an external third party may be appointed to support the ministry to administer the bulk of project activities on behalf of the state governments, which will be contracted at the start of the project. As a result of extensive capacity needs assessment of implementing parties, definitive and discrete measures will need to be taken to enhance safeguards capacity to improve overall E&S performance during project implementation; this will essentially include safeguards training for PCIU and PMT members. This ESMF includes an action plan for engendering and enhancing E&S risk management at the two levels of management. The indicative budget proposed to implement this ESMF over the life of the project, including for provisioning security services is estimated at USD 2 Million (*see Table 14 in this ESMF for detailed breakdown*).

Grievance Redress Mechanism. The FMoH will set up a project-specific Grievance Redress Mechanism (GRM) for people to report concerns or complaints, if they feel unfairly treated or are affected by any of the activities scheduled for implementation. In addition to this ESMF, the Project GRM is detailed in SEP document. The mechanism will include amongst other things:

- provide information about project implementation;
- provide a forum for resolving grievances and disputes at the lowest level;
- resolve disputes relatively quickly before they escalate to an unmanageable level;
- facilitate effective communication between the project and affected persons;
- win the trust and confidence of project beneficiaries and stakeholders and create productive relationships between the parties.

The mechanism is envisaged to be at multiple levels and will address such complaints, including logging, tracking, and resolving grievances promptly during and after the implementation of the project. The MoH will have dedicated persons or team to be responsible for setting up and maintaining the GRM that allows the general public in the project area and affected communities or individuals to file complaints and to receive responses in a timely manner. The entry point for all grievances will be the social specialists at the FGS and FMS levels who will receive grievances by phone, text or email to publicized mobile phone lines and email addresses at both FMS and FGS levels, ensuring confidentiality and sensitivity in handling them to avoid any retaliation or harm to the complainant. The social safeguards specialists will acknowledge, log, forward, follow-up grievance resolution and inform the complainant of the outcome. The system will also record and consolidate complaints and their follow-up. This system will be designed for handling complaints perceived to be generated by the project or its personnel. The complainants have the right to remain anonymous, in which case their identifying details will not be logged. The FGS social specialist will carry out training of FMS social officers and contractors on complaints handling and reporting. The LMP will outline a separate GM for workers although they too will have access to the broader project GM. More details of the GRM are presented in the SEP.

Inclusion Plan. This ESMF has prepared an Inclusion Plan (additionally included in SEP), which aims to address the risk of exclusion of disadvantaged and vulnerable people in the intervention areas. These groups include: minority castes and groups; Internally Displaced People (IDPs); people who live in remote rural areas or areas characterized by violence and conflict and are bereft of social services and amenities; nomadic pastoralist communities; people living with disabilities (PWDs); and female headed households including vulnerable orphans and unaccompanied minors. The project will also endeavor to involve men since they

are often left out in health projects, yet their commitment and influence are essential for women and children to access services, as well as the need for general community commitment to the project for successful implementation, and security and conflict management. Measures will be put in place to ensure that disadvantaged and vulnerable groups are engaged in project consultations in the sub-project design, development of the ESMPs, project implementation and monitoring.

INTRODUCTION AND PROJECT CONTEXT

PROJECT CONTEXT

1. Situated in the Horn of Africa, Somalia is bordered by Ethiopia to the west, Djibouti to the northwest, the Gulf of Aden to the north, the Guardafui Channel and Somali Sea to the east, and Kenya to the southwest. With a total land area of 637,657 km² and situated between 2°S and 12°N latitudes and 41° and 52°E longitudes, Somalia has the longest coastline on Africa's mainland. The country's terrain consists mainly of plateaus, plains and highlands. Climatically, hot conditions prevail year-round, with periodic monsoon winds and irregular rainfall.

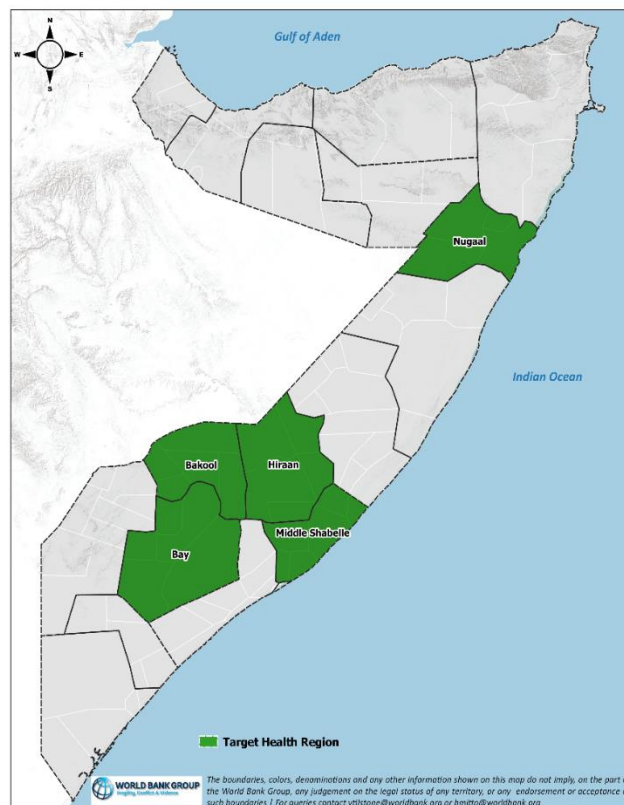


Figure 2: Map of Somalia, showing possible Project beneficiary regions

2. Somalia is faced with two critical challenges of creating sustainable internal peace and constructing a path for shared economic growth and prosperity. Among the most critical sectors for the emerging state is the health sector. Somalia has the very high prevalence of communicable and non-communicable illness, and some of the lowest health indicators in the world, according to the World Health Organization.

3. After a prolonged civil war and follow-on civil strife, the health of the Somali people has suffered greatly. Armed conflict has destroyed the little health infrastructure that was there, resulting in poor access

to essential health services for majority of the population. Largely in the hands of the private sector, Somalia’s health sector is generally described as a dysfunctional health system. It is mostly characterized by poor infrastructure, inability on the part of the different governmental authorities to deliver services, and an absence of equity.

4. The private sector is an important health service provider. At least 60 percent of health services and 70 percent of the country’s medicines are estimated to be delivered by the private sector, primarily in urban areas. However, as a result of limited regulatory capacity, the private sector is largely unregulated. Due to Somalia’s nascent health sector regulatory capacity, there are no quality standards nor functional regulatory bodies for health services or pharmaceutical products. As a result, providers can operate without any oversight and provide services and products of unknown quality. This limits the full potential of the private sector, as formal private sector investment requires functional regulations to be effective.

5. Government expenditure on health has been generally insignificant, hovering at 4 percent of total government expenditures annually since 1997 (WHO, 2004).¹⁹ As a result, most financing to the health sector comes from aid financing, which, according to a World Bank study reached up to US\$10 per capita in 2006 (World Bank, 2008), which, while a considerable amount compared to other fragile states, is still insufficient “to address the population’s needs and to meet the high operational costs of working in such a logistically challenging environment.”²⁰ In all this, an important point to note that is that policies in the health sector are either absent or, where they exist, incoherent. There is also a scarcity of actionable health information.

6. Health service delivery data indicates weak health systems in the Country. Service delivery indicators are low nationwide as shown above, due to a combination of health service supply and demand challenges. For instance, only 32 percent of births are attended by skilled personnel and 21 percent of births occur in health facilities nationwide. Thirty-one percent of women receive at least one antenatal care (ANC) visit nationwide while only 11 percent of children are fully immunized. There are similar gaps in treatment of childhood illnesses, for example, only 17 percent of children with an acute respiratory infection (ARI) in the two weeks before the Somali Health and Demographic Survey (SHDS) received antibiotics.

7. Service delivery challenges are underpinned by very limited financing for health in Somalia. Real per capita expenditure on health is approximately US\$13 per person per year (2019), far below Sub-Saharan Africa’s average of US\$204 (2019). Government expenditure on health as a percentage of per capita health expenditure is 15 percent (2019). Donor financing is an important source of health expenditure, comprising 38 percent of per capita expenditure (2019) and much of this is off-treasury. The high proportion of off-treasury donor resources has limited the Government’s involvement in many aspects of health sector

¹⁹ World Health Organisation, 2004. World Health Report – Somalia. Accessed on June 14, 2020, at <https://www.who.int/whr/2004/annex/country/som/en/>

²⁰ World Bank, 2008. A Review of the Health Sector Aid Financing to Somalia. World Bank Working Paper no. 142. Accessed on June 1, 2020, at <http://documents.worldbank.org/curated/en/457601468103478205/pdf/439750PUB0Box310only109780821375174.pdf>

programming, constraining the ability to increase efficiency in spending and Government leadership in the sector.

8. Out-of-pocket payments (OOP), as a percentage of per capita health expenditure in Somalia, are high at 46 percent. Average annual household OOP on health is estimated at US\$6 per capita out of a total of US\$13 and varies substantially between the richest quintile and the poorest quintile, indicating that households are accessing healthcare services based on the ability to pay instead of their healthcare needs, resulting in health inequities. The 2020 SHDS survey established that 48 percent of households used their income to pay for health expenditures while another 25 percent used resources from relatives or friends. Remittances are likely an important source of OOP for health, but there is little data on the extent of their contribution. There are almost no formal risk-protection mechanisms in the country: health insurance is limited to private plans for international companies and NGOs and estimated to account for 1 percent of total health expenditures.

9. As a result, health indicators in Somalia are among the lowest in the world, and lag behind even by sub-Saharan Africa standards. For example, the immunization coverage rate for measles is 46 percent countrywide and even lower in hard-to-reach areas (WHO, 2015)²¹. Only one in three Somalis has access to safe water; one in every nine Somali children dies before their first birthday; and the maternal mortality ratio is 850 deaths per 100,000 live births.²²

10. Somalia's lagging health outcomes reflect the country's insecurity, vulnerability, and deep-rooted poverty, limiting opportunities for people to access basic social services, including education and health. As seen in Table 2, Somalia's health indicators remain among the worst in the world, with an average life expectancy of 56 years. Other indicators lag behind those in the World Health Organization (WHO) Regional Office for Africa (AFRO) region as well as most indicators in select, comparable Fragility, Conflict, and Violence (FCV) impacted countries in WHO's Regional Office for the Eastern Mediterranean (EMRO) region, of which Somalia is a part.²³ While most health outcomes in Somalia improved from 2006 to 2019, some indicators such as fertility and stunting have declined since 2016.

²¹ World Health Organisation, 2015. Humanitarian Response Plans Somalia in 2015. Accessed on May 10, 2020, at <http://origin.who.int/hac/donorinfo/somalia.pdf>

²² *Ibid*

²³ Although Somalia belongs to the WHO EMRO region, geographically and culturally, it is part of sub-Saharan Africa. As a result, AFRO region data are more applicable and are used here.

Table 1: Somalia's Key Health Indicators

Indicator	2006²⁴	2016²⁵	2019²⁶	WHO AFRO Regional Average (2016)²⁷
Maternal Mortality Ratio (per 100,000 live births)	1040	865	692	536 (2017)
Neonatal Mortality Rate (per 1,000 live births)	45.1	39	N/A	26
Infant Mortality Rate (per 1,000 live births)	103.3	80.4	N/A	51
Under-five Mortality Rate (per 1,000 live births)	170.5	128.4	N/A	80.5
Total Fertility Rate (no. of births per woman)	7.2	6.3	6.9	N/A
Adolescent Fertility Rate (births per 1,000 women; 15-19 years)	127.17	102.14	140	102.1 (2015-2020)
Stunting (age-for-height among children under five years of age)	N/A	25.3% (2009)	28%	29%

11. In addition, the country has one of the lowest life expectancies in the world, estimated at 53 and 56 years for males and females, respectively. This is compounded by severe poverty. About 77 percent of Somalis live on just US\$1.9 per day, according to the World Bank’s Somalia High Frequency Survey, published in 2019.²⁸ Yet households spend disproportionately significant amounts of their incomes annually on healthcare.

12. This has exposed an already vulnerable population to high disease burden (both communicable and non-communicable) and malnutrition. The country is therefore off-track in reaching the Sustainable Development Goals by a wide margin (Warsame et al., 2015).²⁹ According to Warsame et al., as of 2015, there were 46 major health facilities in Somalia including seven referral hospitals, 27 district hospitals, 248 maternal and child health clinics and 544 dispensaries. In 2006, only 9 percent of births were attended by

²⁴The World Bank: <http://data.worldbank.org>

²⁵The World Bank: <http://data.worldbank.org>

²⁶The 2020 SHDS included no child mortality data including neonatal, infant, and under five mortality. This is a major gap in the results and discussions are currently under way with partners and UNFPA (which conducted the survey) on whether raw data exist to rectify this and other data gaps in the survey, including the absence of geographically disaggregated data.

²⁷Although Somalia belongs to the WHO EMRO region, geographically and culturally, it is part of sub-Saharan Africa. As a result, AFRO region data are more applicable and are used here.

²⁸ World Bank, 2019. Somalia Poverty and Vulnerability Assessment: Findings from Wave 2 of the Somali High Frequency Survey. Accessed on June 6, 2020, at <https://openknowledge.worldbank.org/handle/10986/32323>

²⁹ Warsame, A., Handuleh, J., and Patel, P. 2015. Prioritization in Somali health system strengthening: a qualitative study. In International Health, 8(3):ihv060

skilled health personnel (Global Health Observatory, 2020):³⁰ this has now improved to 32 percent as of 2019 (Somalia Health and Demographic Survey, 2019).³¹

13. The Somali government has acknowledged the poor state of the health sector and is engaging development partners in an effort to improve health outcomes for its people. In 2013, for the first time, the Ministry of Health (MoH) developed zone-specific Health Sector Strategic Plans (HSSP, 2013-2016) for Somaliland, Puntland and South-Central Somalia. This was an important step in building the government's capacity to improve access to health services for the people of Somalia (Federal Government of Somalia, 2016).³²

14. **Improving Somalia's health sector.** Much of the country's healthcare facilities are beset by systemic problems, including poor staffing, lack of appropriate equipment, and inequity in geographical distribution, with a disproportionate focus on urban centers. Generally, the national public health system has been poor for over three decades now, with only non-state actors bridging the yawning gaps in healthcare services in a sector that is almost entirely private (Warsame *et al.*, 2015). All these have had huge implications for the lives and livelihoods of Somalis.

15. Somalia's Ninth National Development Plan sets key priorities for improving health access and outcomes. These include

- institutional oversight and strengthening, which includes setting the legal and oversight frameworks at the Ministry of Health, and at the level of state and municipal government health bodies.
- focusing on most pressing health challenges, including maternal and early childhood health, reducing malnutrition and childhood stunting, and greater access to clean water and sanitation (in homes as well as in health facilities).
- focusing on the most vulnerable, especially rural citizens along with Internally Displaced Persons (IDPs), and those in newly liberated areas, who have the least access to health care.
- partnering with appropriate organizations to guarantee that the most vulnerable people are identified, including those living in IDPs. Ensure that assessment of protection-related health needs (e.g., exposure to violence or abuse) is undertaken only by staff who are trained in protection monitoring and assessment (including confidentiality, safe recording and handling of information, and reporting and referral procedures); and
- recognizing the importance of a common result framework, for example, in nutrition that has existed for some time (however, this has not been converted into a standard approach and enshrined in the national system of nutrition/health coordination).

³⁰ See <https://www.uhpartnership.net/country-profile/somalia/> for more details

³¹ Federal Government of Somalia, 2019. The Somali Health and Demographic Survey. Accessed on June 14, 2020, at https://somalia.unfpa.org/sites/default/files/pub-pdf/FINAL%20SHDS%20Report%202020_V7_0.pdf

³² Federal Government of Somalia, 2016. Comprehensive Multi Year Plan for Immunization System. Available at https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/somalia/national_cmyp_somalia.pdf

16. The plan calls on Somalia to coordinate with development partners to ensure better health services coverage. Specifically, the NDP pledges that the government will partner with non-state providers to rehabilitate or construct health clinics, and to increase distribution of Essential Package of Health Services (EPHS). Towards this, in 2019, Somalia became a Global Financing Facility (GFF) country, which will go a long way in reducing health sector fragmentation and strengthening the government’s stewardship role.

17. Basing his recommendations on the 2013 Somali Joint Health and Nutrition Programme,³³ overseen by UNICEF and the Health Consortium for Somali People, Warsame (2014), in his seminal study on “opportunity for health systems strengthening in Somalia”, calls for interventions in six distinct areas. These are (1) strengthening leadership and governance; (2) increasing health workforce quality and quantity; (3) delivering equitable health services through functioning health facilities; (4) developing a nationally financed and locally prioritized health financing system; (5) ensuring provision of appropriate and sufficient health products; and (6) establishing a comprehensive monitoring and evaluation system.³⁴

IMPROVING HEALTHCARE SERVICES IN SOMALIA PROJECT

18. The 'Improving Healthcare Services in Somalia Project', also known as “*Damal Caafimaad*” in Somali language,³⁵ is expected to run from 29 June 2021 to 30 June 2026 in selected geographical areas in Somalia. The project (incl. Additionally Financed components) seeks to improve coverage of essential health and nutrition services for underserved populations³⁶ in project areas and to develop capacity of the Ministry of Health to manage health and nutrition services. The project will support EPHS delivery in select regions and will coordinate with other partners who will support EPHS delivery in complementary regions.

19. In addition, the project will support capacity building for Ministries of Health across the country. A robust primary health system is essential for detecting and responding to outbreaks. The EPHS includes outbreak detection and response within the package. In addition, primary and secondary care facilities are critical for the referral chain to tertiary services including COVID-19 critical care centers, which are supported by the Somali Crisis Recovery Project.

20. The Project, including AF interventions and activities, will be implemented by the Ministry of Health, Somalia. The mission of the ministry is to “ensure the provision of quality essential health and nutrition services for all people in Somalia, with a focus on women, children, and other vulnerable groups.” The ministry also seeks to “strengthen the national and local capacity to deliver evidence-based and cost-

³³ For more details on this programme, please see http://www.unicef.org/somalia/reallives_13941.html

³⁴ Warsame, A. 2014. Opportunity for health systems strengthening in Somalia. The Lancet, Vol. 2, Issue 4. Available at [https://doi.org/10.1016/S2214-109X\(14\)70010-5](https://doi.org/10.1016/S2214-109X(14)70010-5)

³⁵ *Damal* is a Somali word that refers to *Acacia stenocarpa*, sometimes also known as *Vachellia seyal*, which grows in Somalia. *Caafimaad* in Somali means “health.”

³⁶ Underserved populations in this context means “women and children and persons living in project target areas, including hard-to-reach and difficult environments, i.e., IDPs and nomads” (reference from project’s Project Appraisal Document)

effective services based on the EPHS and Primary Health Care approach.”³⁷ The ministry adopted the EPHS framework in 2009 and has tried to implement it in the country with the support of the Joint Health and Nutrition Programme, supported by multiple donors and UN organizations.

21. The proposed project is in line with the Somalia National Development Plan’s Pillar 4 (“Social Development”), which calls for investments to achieve outcomes related to “improved health”, “improved social protection,” and “governance strengthening.” In the long-term, the project will also help in the achievement of peace and stability, as the interventions will help develop confidence in national institutions (including the Ministry of Health) and its enhanced capacity to deliver primary healthcare outcomes for the population in Somalia. The project will be implemented by way of four components, described in the next section.

PROJECT DEVELOPMENT OBJECTIVE AND COMPONENTS

22. **Project’s development objective.** The Project’s overall Development Objective (PDO) is to “improve the coverage of essential health and nutrition services in project areas and strengthen stewardship capacity of Ministries of Health.” The parent project has the following four components:

- **Component 1:** *Expanding the coverage of high impact health and nutrition services in select geographic areas: This component will finance delivery of essential health and nutrition services to enhance service coverage and quality.* Somalia’s EPHS will focus on the provision of:
 - child health services (routine immunization, micronutrient supplementation, promotion of infant and child feeding and nutrition referral);
 - maternal and neonatal health services, including testing and interventions during ANC visits, basic and comprehensive emergency obstetric and new-born care (BEmONC and CEmONC), and family planning;
 - Gender-based violence (SGBV) services (awareness raising, case management and counselling,);
 - disease surveillance (strengthening and maintaining disease surveillance and response as well as preparedness and response to disease outbreaks);
 - This component will be implemented in Nugaal (Puntland State), Bakool and Bay (South-West State, or SWS), and Hiraan (Hirshabelle State); and
 - Three delivery platforms are envisaged for extension of EPHS to Somalis, including:
 - *Contracting service delivery to non-state actors:* Considering limited-service delivery capacity in the public sector, the Government has agreed that the main health service delivery modality under the proposed Project will be Government contracting of health services in public facilities, to be implemented by NGOs. This is likely in the South-west State, Hirshabelle, and Puntland, and will involve contracting experienced partners, especially where there is lacuna in services by the government.

³⁷ More details on the Ministry of Health available on <https://moh.nomadilab.org/ministry/> -

- *Strengthening government service delivery system to expand service coverage:* this is likely in selected regions of Puntland, where there is existing government service delivery capacity.
 - *In urban areas, the Project may support Government contracting of private sector networks as a pilot.* This modality aims to facilitate effective Government engagement with private sector service providers to enhance delivery of high-impact health and nutrition services in select geographic areas.
 - **Sub-component 1.1: Family Planning Services:** FP is supported through a GFF trust fund allocation of approximately US\$5.5 million, with a focus on service access, quality, and social risk mitigation. Therefore, the proposed AF2 will support Component One in expanding the coverage of high-impact health and nutrition services in specific geographic areas (US\$90.25M total: US\$62.5M IDA (including US\$5.5M for Somaliland), US\$18.50M GFF, US\$4.25M GCF and US\$5.0 GFF Challenge Fund AF). The government will amend the ongoing contract with PSI to include the provision of FP services through the private sector in Mogadishu (Banadir region), Hargeisa (Somaliland), Kismayo (Jubaland), and Garowe (Puntland) using the USD 5.0 million AF from GFF Challenge Fund. These urban areas, characterized by high population density, underserved family planning needs, and a growing network of private sector providers, will benefit from this initiative. Building on the parent project, the AF aims to reduce intervention costs, expand services, increase information dissemination, and enhance long-term sustainability. PSI will collaborate with existing private sector networks to: Expand access to contraceptives, both financially and physically, Increase the variety of contraceptives available in the private sector, Create synergies with other ongoing health projects, Leverage learnings from previous projects to integrate FP services into existing maternal and sexual and reproductive health (SRH) services, such as antenatal care (ANC), post-abortion care (PAC), and postnatal services
 - **Component 2: Strengthening Government's stewardship to enhance service delivery:** through this component, the project will support the development of government stewardship capacities at both the Federal and FMS levels to enhance quality service delivery. The activities will be implemented under four sub-components:
 - *Sub-component 2.1: Health Information and Management Systems (HMIS) and Data Use for Decision Making:* The HMIS and data use subcomponent aims to improve data timeliness, quality, and use of DHIS2 to contribute to the long-term goal of ensuring a high-functioning health information system producing regular, quality, reliable data that are used for routine decision making.
 - *Sub-component 2.2: Public Financial Management (PFM), Contract Management, and Health Financing:* The PFM, contract management and health financing subcomponent will build Government contracting capacity and strengthen efficient resource use and accountability to mitigate fiduciary risks. PFM and contract management support will build off interim support financed by the World Bank during project preparation to address immediate PFM needs in the FMOH and develop initial contracting systems to accelerate project implementation.
 - *Sub-component 2.3: Private Sector Development and Regulatory Reforms:* The private sector development and regulatory reform subcomponent will improve quality of health services delivered by the private sector through private sector networks, setting up basic regulatory and
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accreditation systems with a focus on the health workforce as well as health products and devices to improve quality of care. At the FGS level, the focus will be on the development of national regulatory bodies and regulations, and at the FMS level, the focus will be on development of registration and compliance units.

- *Sub-component 2.4: Organizational Development:* The organizational development subcomponent will support development of systems and process for decision making, internal information sharing, internal communication, external communication, and information storage/record keeping; and enhancing capacity for planning, learning and review including development and implementation of systems and processes for regular review and learning.
- **Component 3:** *Project Management, Knowledge Management and Learning;* will support day-to-day project management including coordination, administration, communication, management, procurement, M&E, and dissemination of project activities at both FGS and FMS levels. To this end, the component will finance the following activities: (i) supervising, coordinating, and providing oversight for project implementation facilitating, and (ii) learning and knowledge sharing across and within FGS and FMS. The component will also support the cost of specialists necessary for project management.
- **Component 4:** *Contingency Emergency Response Component (CERC)* – This component is a zero cost component known as a Contingency Emergency Component (CERC), will provide immediate surge funding in the event of a public health emergency, such as a disease outbreak, is included if the need to reallocate funds arises. This component will only be triggered in the case of a public health emergency and when certain actions, as agreed by the Government and Bank teams, are met.

23. The proposed Additional Financing (AF) will retain the original four components: (1) Expanding the coverage of high-impact health and nutrition services in select geographic areas; (2) Strengthening Government’s stewardship to enhance service delivery; (3) Project Management and Knowledge Management and Learning; and (4) a Contingency Emergency Response Component (CERC).

24. In addition, the proposed Additional Financing (AF) from the Green Climate Fund Cooling Facility of US\$4.25 million to the Damal Caafimaad project will promote the adoption and use of climate friendly cooling equipment and appliances in the health sector and strengthen cold chain capacity necessary for expanding the delivery of maternal and child health services, especially immunization. In particular, the proposed AF will finance the following:

25. Under component 1, the proposed AF will provide additional US\$4.00 million increasing the component cost from US\$75.50 million to US\$79.50 million. The AF will finance investments in climate friendly cold chain equipment, specifically purchases of Solar Direct Drive (SDD) refrigerators along with equipment for solar power generation and cooling for selected PHUs and health centers. Based on initial assessment, the AF will procure SDD refrigerators for 200 health facilities in six regions including Primary Health Units which the government intends to upgrade to provide immunization services. No air conditioners will be purchased by the project as part of the AF.

26. Under component 3, the proposed AF will provide additional US\$0.25 million increasing the component cost from US\$6.00 million to US\$6.25 million. The AF will finance technical assistance to improve the policy environment for climate friendly cold chain and power. Specifically, the support will

focus on the development of policies and mechanisms to dispose of obsolete cold chain equipment, such as kerosene powered cold chain equipment, and systems to ensure continuous maintenance and security for SDDs and solar power systems.

27. The Project will also retain a proportion of the project funds to contribute to the achievement of the Project's PDO in Somaliland. The disbursement of the funds for Somaliland will be contingent on: (i) the pending resolution of the implementation modalities for Somaliland including clarity on flow of funds; (ii) agreement on the specific project activities; and (iii) completion of relevant fiduciary requirements, including disclosure of necessary ESF documents. If an agreement on the disbursement of the funds will not have been attained by the time of the Project's Mid-Term Review (MTR), the allocated funds will be cancelled from the total project cost or reallocated based on the agreement reached at that point.

28. Both the POM and the Emergency Response Operations Manual will detail the SRM measures for all aspects of the project. Revised environment and social (E&S) instruments will be required for the CERC as a condition of disbursement.

PROJECT BENEFICIARIES

29. The project envisages both direct and indirect beneficiaries. In general, the project beneficiaries will be mothers, children, women of reproductive age and persons living in project target areas, specifically the residents of the FMS where the project activities will be implemented, including hard-to-reach populations like IDPs and nomads, who will be covered by the delivery of EPHS. There will also be concerted effort to engage men who are often side-lined in health interventions and buy-in is critical for project success and social risk management. Other beneficiaries include the Ministries of Health officials in both FGS and FMS, who will receive capacity building and technical assistance, as well as the formation of proposed new parastatals as part of the reform process in the Somali health sector.

30. Direct beneficiaries: rural poor, children, mothers, health centres, health personnel, community institutions, among others. The indirect beneficiaries include traders importing medicines, among others.

31. The following have been identified as likely project regions: South West State: Bay and Bakool; Puntland state: Nugaal region; Hirshabelle state: Hiiraan and possibly others (see figure 2 above). Other beneficiaries of project will include government institutions at both the levels of the federation, specifically the FGS MoH and FMS MoH will benefit from the capacity building component of the project. Consultants who are employed under the project to assist the MoH in the project implementation and NGOs to be contracted to deliver health services in the project locations will also benefit from the project.

THE PROJECT EXPECTED RESULTS

32. The expected key results of the project include:

- a. Improvement of coverage of essential health and nutrition services in project locations;
- b. Strengthened stewardship, governance, and accountability of FGS and FMS MoH;

- c. Expansion of the coverage of essential health and nutrition services to underserved populations in the project locations;
- d. Enhanced delivery of quality health services by FGS and FMS MoH; and
- e. Provision of emergency fund to FGS and FMS MoH in case of epidemics and outbreaks during the project implementation period.

SCOPE AND METHODOLOGY OF THE ESMF

PURPOSE AND SCOPE OF THE ESMF

33. The purpose of the ESMF is to ensure that the activities executed under the Improving Healthcare Services in Somalia project, including Additionally Financed interventions and activities (also identified throughout this ESMF as “the project”) address and identify measures to avoid and minimize environmental impacts, as much as possible. Where these cannot be avoided, the impacts are adequately identified, assessed and necessary mitigation measures designed and implemented. Measures will follow relevant, existing Somali environmental legislation and the World Bank’s Environmental and Social Standards, as well as WB’s Environmental, Health and Safety Guidelines (EHSGs) that include Good International Industrial Practices (GIIP). As a rule of thumb, the most stringent framework(s) will be adopted and applied for the Project.

34. The Ministry of Health is expected to prepare, validate, and disclose this ESMF in all the participating FMS capitals as well as in Mogadishu, in order to obtain valuable input from Somalis and to enrich the entire process of E&S safeguarding.

ESMF JUSTIFICATION

35. The Environmental and Social Management Framework (ESMF) clarifies appropriate environmental and social standards, processes, and mitigation principles, organizational arrangements and design criteria to be applied to subprojects, which are likely to be financed under the overall *Damal Caafiga* project, including intended interventions and activities under AF. These standards, principles, instruments and other documents are to be applied during project implementation by the PCIU, the MoH, and state administrations in the project-supported localities in Somalia and any private sector companies, such as health centre operators, who will be supporting and participating in the project.

36. The project PCIU, based at the Federal Ministry of Health, and the PMTs at the FMS level, will use and refer to this ESMF during implementation of the project. Where appropriate, Environmental and Social Management Plans (ESMPs) will be prepared during project implementation following guidelines that are made clear in this ESMF. It remains the responsibility of the Safeguards focal person with the PCIU managing this project, and their counterparts at the PMTs, to ensure that the necessary mitigation plans are developed and adhered to by the project actors. The specific objectives of this ESMF are:

- To ensure that the implementation of the project will be carried out in an environmentally and socially sustainable manner.
- To provide information about scope of adverse environmental and social risks and impacts expected during activities planning and operation;
- To describe the approach to mitigation and monitoring actions to be taken, and their cost implications.

- To clarify the roles and responsibilities of the MoH, the project PCIU and respective PMTs at the FMS level and participating private sector companies and other stakeholders with regard to E&S due diligence, management of risks and impacts, and monitoring.
- To provide the project implementation team with an E&S screening process and risk management procedures that will enable them to identify, assess and mitigate potential environmental and social risks and impacts of parent project activities and interventions and activities of the AF, including through the preparation of a site-specific Environmental and Social Management Plans (ESMPs), and site-specific Environmental and Social Impact Assessments (ESIA), where applicable.

ESMF PRINCIPLE

37. This ESMF will guide the PCIU at the Federal Ministry of Health in the Somali Republic in implementing the project in line with World Bank’s overall Environmental and Social Framework and the Somalia government’s environmental and social management standards, including, inter alia, the provisional Constitution of Federal Republic of Somalia, the Labor Code, and the newly developed National Environmental Policy.

METHODOLOGY

38. **Literature review.** The ESMF was prepared through extensive literature review. A number of publications on the health sector in Somalia were consulted, most of which are cited in the ESMF. Details of the publications, including full citations, are provided by way of footnotes.

39. **Desktop review of policy environment.** In close coordination with the World Bank, the project preparation team in Mogadishu undertook a review of relevant national legislation, policies, and guidelines on the health sector in Somalia. In addition, relevant national policies, regulations and legislation regarding SRM and the World Bank’s ESF were also reviewed.

40. **Consultations with stakeholders.** Consultations were conducted virtually from March 2020 to April 2020. Additionally, in February 2021, a series of virtual individual consultations and a stakeholder workshop were held with a range of stakeholders including government staff, civil society and NGOs working in the health sector. The aim of these consultations was to solicit insights on the potential environmental and social risks and mitigation measures related to the implementation of the ‘Damal Caafimaad’ project, which has informed the preparation of the parent Project’s ESMF, and consequently, cleared by the Bank. The stakeholder consultation workshops engaged 39 individuals, 6 of whom were women. A list of participants and summaries of these consultations are presented in Annex 8 and 9. Due to the COVID 19 pandemic, these engagements were done virtually with stakeholders in the project target locations. Further consultations will be held at FMS and community level to inform SecMPs for implementing partners for each region and contractors and MoH.

41. For the purpose of AF components, another consultation with key stakeholders and representatives of the community was held on 27th of June 2023, to validate E&S instruments for the new proposed interventions and activities under AF. The Participants had the opportunity to express their views and

concerns around the possible E&S risks and impacts of the AF interventions and activities, see Annex 10 for details. Accordingly, this ESMF has been updated, as well as other instruments, including SEP, GBV Action Plan, Security Management Framework, and the LMP. Summary deliberations of the consultations are described in the Table 2 below:

Table 2: Deliberations undertaken in the preparation of this ESMF

Location & Time interval	Nature of consultations undertaken	Participants met (number, description)	Summary of the deliberations and agreements
Mogadishu 17 & 18 June, 2025	Stakeholder Engagement on E&S aspects of the newly introduced AF2 interventions and activities.	65 participants including private clinics representations, experts in FP outreach, FMOH, MoH, PCIU, and FMS PMTs, and project E&S specialist in Somalia.	Discussed community awareness, misinformation, lack of internal GRMs, absence of CoC and coordination with PCIU, PMTs, and PSI and agreed to provide refresher training and supportive supervision, promote safe working environments, and integrate internal GRM for staff, also to ensure private facilities implement appropriate waste segregation and disposal systems. See Annex 10 and 11 for more details.
Mogadishu: 27 June 2023	Collecting views and concerns on E&S aspects of the newly introduced AF interventions and activities.	A total of 34 participants. Included FMOH representatives, project management, E&S specialists, academia, and NGOs	Discussions included issues related to labors, labor rights, OHS, complaints by beneficiaries and project workers, inclusion of minorities, disadvantaged, and vulnerable groups, as well as impacts on environment and communities, such as improper waste disposal (incl. solar power equipment waste), among others. Agreed to reduce, reuse, recycle waste where applicable. See Annex 9 and 10 for more details.

<p>Mogadishu: March 2020 – April 2021</p>	<p>Health sector reforms</p>	<p>The Ministry of Health has conducted a number of consultation meetings at FGS level.</p>	<p>Consultative meetings have been held for the purpose of preparing this ESMF. The stakeholder meetings were conducted virtually on diverse dates, including December 14, 2020, January 21, 2021, February 3, 2021, and finally on March 24, 2021. The meetings were attended by stakeholders in the health sector in Somalia. Input was received from International Non-Governmental Organizations (INGOs) operating in the health sector in the country, especially on medical waste management and placement of placenta pits.</p>
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POLICY, LEGISLATIVE AND INSTITUTIONAL FRAMEWORKS

OVERVIEW

42. This section describes the existing policy, legislative and institutional framework that will be important for consideration in the design, implementation, monitoring and evaluation of the Improving Healthcare Services for Somalia project (including AF). The section begins with the existing framework in the Federal Government of Somalia, before focusing on the respective systems in Puntland, South-West State, Galmudug, Hirshabelle, and Jubbaland states and the Benadir Regional Administration.³⁸

43. It is important to note that at the time of the development of this ESMF that South-West State, Hirshabelle, Galmudug and Jubbaland did not have any significant legislative frameworks governing the management of the environment and natural resources sector. It was therefore difficult to include the respective policy, legislative and institutional frameworks for these states in this ESMF. The World Bank has undertaken a systemic study in South-West State and Jubbaland that has identified existing gaps in environmental and social regulations, policies and legislation, with a view of capacity enhancement for the two states.

44. The project will be implemented by the Ministry of Health at the FGS level. The mission of this ministry is to “ensure the provision of quality essential health and nutrition services for all people in Somalia, with a focus on women, children, and other vulnerable groups, and strengthen the national and local capacity to deliver evidence-based and cost-effective services based on the EPHS and Primary Health Care Approach.”³⁹

SOMALIA NATIONAL LAWS, POLICIES AND LEGISLATIONS

45. **Constitution of the Republic of Somalia.** The key legal instrument for management of environmental and social affairs in Somalia is the Constitution, especially Article 10 (“Human Dignity”), Article 11 (“Equity”), Article 24 (“Labour Relations”), Article 25 (“Environment”), Article 27 (“Economic and Social Rights”), Article 29 (“Children”), Article 31 (“Language and Culture”), Article 32 (“Right of Access to Information”), Article 43 (“Land”), Article 44 (“Natural Resources”), Article 45 (“Environment”), Article 50 (“Principles of Federalism in the Federal Republic of Somalia”), Article 52 (“Cooperative Relationships Between the Various Federal Member State Governments”), Article 111J (“The Office of the Ombudsman”), and Article 111H (“National Security Commission”).

46. Article 11 of the Constitution stipulates the following: (1) All citizens, regardless of sex, religion, social or economic status, political opinion, clan, disability, occupation, birth or dialect shall have equal

³⁸ This EMF covers all these FMSs, although at present the drafter did not have an indication of the actual participating states. This EMF therefore adopts the precautionary principle and attempts to cover as many states as possible, despite the obvious difficulties with getting information on the policies and legislation.

³⁹ See the ministry’s website for more details: <https://moh.nomadilab.org/ministry/>

rights and duties before the law; (2) Discrimination is deemed to occur if the effect of an action impairs or restricts a person’s rights, even if the actor did not intend this effect; (3) The State must not discriminate against any person on the basis of age, race, colour, tribe, ethnicity, culture, dialect, gender, birth, disability, religion, political opinion, occupation, or wealth; (4) All State programs, such as laws, or political and administrative actions that are designed to achieve full equality for individuals or groups who are disadvantaged, or who have suffered from discrimination in the past, shall be deemed to be not discriminatory.

47. Article 24 stipulates the following principles of labour relations: (1) Every person has the right to fair labour relations; (2) Every worker has the right to form and join a trade union and to participate in the activities of a trade union; (3) Every worker has the right to strike; (4) Every trade union or employer’s organization or employer has the right to engage in collective bargaining regarding labour-related issues; and (5) All workers, particularly women, have a special right of protection from sexual abuse, segregation and discrimination in the workplace. Every labour law and practice shall comply with gender equality in the workplace.

48. Article 31 on Language and Culture states the following provisions: (1) The state shall promote the positive traditions and cultural practices of the Somali people, whilst striving to eliminate from the community customs and emerging practices which negatively impact the unity, civilization and wellbeing of society; (2) The state shall collect, protect and preserve the country’s historic objects and sites, whilst developing the know-how and technology that shall enable the fulfilment of such an obligation; (3) The state shall promote the cultural practices and local dialects of minorities; and (4) The rights mentioned in this Article shall be implemented in accordance with the fundamental rights recognized in this Constitution.

49. Article 32 on Right of Access to Information states that: (1) Every person has the right of access to information held by the state; (2) Every person has the right of access to any information that is held by another person which is required for the exercise or protection of any other just right; and (3) Federal Parliament shall enact a law to ensure the right of access to information.

50. Article 50 on Principles of Federalism in the Federal Republic of Somalia states the following: The various levels of government, in all interactions between themselves and in the exercise of their legislative functions and other powers, shall observe the principles of federalism, which are: (a) Every level of government shall enjoy the confidence and support of the people; (b) Power is given to the level of government where it is likely to be most effectively exercised; (c) The existence and sustainability of a relationship of mutual cooperation and support between the governments of the Federal Member States, and between the governments of the Federal Member States and the Federal Government, in the spirit of national unity; (d) Every part of the Federal Republic of Somalia shall enjoy similar levels of services and a similar level of support from the Federal Government; (e) Fair distribution of resources; (g) The resolution of disputes through dialogue and reconciliation.

51. Article 52 of the Constitution lays the framework for cooperation between the centre (the FGS) and the fringes (the FMSs), and makes it clear that the health sector is a matter for mutual cooperation. Article 27 of the Provisional Somali Constitution states that “every [Somali] has the right to healthcare, and no one

may be denied emergency healthcare for any reason, including lack of economic capability” (Article 27, clause 2).

52. Article 25 of the Constitution states that “[every Somali] has the right to an environment that is not harmful to their health and well-being, and to be protected from pollution and harmful materials.” The article proceeds to declare that “[every Somali] has the right to have a share of the natural resources of the country, whilst being protected from excessive and damaging exploitation of these natural resources.”

53. Article 45 (in Chapter 3 – “Land, Property and Environment”) exhorts “all people in ... Somalia” to “participate in the development, execution, management, conservation and protection of the natural resources and environment.”

54. Article 43, on its part, provides guidelines on environmental and social safeguards that can be observed. However, there are no standing environmental and/or social safeguards in terms of legislated and or drafted regulations. The Article also affirms that the federal government shall give priority to the protection, conservation, and preservation of the environment against anything that may cause harm to natural biodiversity and the ecosystem.

55. Article 111 on the Office of the Ombudsman stipulates the following: (a) A member of the Council of Ministers, the Federal Parliament or any other person shall not interfere with the work of the office of the Ombudsman. (b) Each department of the Government shall co-operate with the office of the Ombudsman regarding the need to maintain its independence, integrity and effective service delivery. The Ombudsman shall: (a) Investigate complaints regarding allegations or outright violations against basic rights and freedoms, abuse of power, unfair behaviour, mercilessness, lack of clemency, indiscipline or disrespect towards a person that lives in Somalia by an officer who works at the various levels of government, an apparently unfair behaviour, or act in a corrupt manner, or a behaviour by an officer deemed as illegal by a democratic society or regarded as mischief or injustice. (b) Investigate complaints in relation to the activities of the Public Service Commission of the government, administrative institutions of the government, and the defence and police forces whoever such complaints relate to, failure to equally align those services or fair recruitment among all people in those services or to administer those services fairly. (c) Take appropriate steps that the public calls for, to rectify or change items mentioned in earlier clauses through a fair, and appropriate process, which include, but are not limited to: (i) Consultations and sacrifices among the people concerned; (ii) Reporting on the complaints and matters presented to the Ombudsman, and submit to the head of the offender; (iii) To forward the matter to the Attorney General; (iv) To bring the matter before a court that forbids improper conducts by an officer.

56. Article 111H on National Security Commission states that: (1) A National Security Commission shall be established by federal law. The National Security Commission shall be independent and shall comprise security experts from all sectors. (2) The mandate of the National Security Commission shall be to: (a) Study and develop an integrated security framework to address the present and future needs of Somalia for review and adoption by the Federal Parliament; (b) Present proposals to ensure that human security is prioritized and incorporated into the national security framework; (c) Develop a framework

through which the public may provide oversight and monitor security related expenditure; and (d) Seek redress from abuses by security personnel.

57. **Policy, Legal and Institutional Frameworks.** The project is required to meet the health sector laws of Somalia, as well as environmental management systems in place in the country, including the National Environment Policy (recently published by the Office of the Prime Minister) and the newly developed Environmental and Social Impact Assessment Regulations of 2021. The Federal Government of Somalia developed the Ninth National Development Plan (NDP) covering the period from 2020-2024. Chapter 8.3 is dedicated to the health and nutrition sector, with a vision clearly enunciated that all people in Somalia should get access to improved health services. The policy identified eight targets for the health sector.

58. **Somalia Health Sector Strategic Plan.** The Somalia National Health Policy was approved in 2014. The FGS then developed the second version of the National Health Sector Strategic Plan (HSSP-II 2017-2021) with chapters on each of the FMS having similar strategic priorities. The Strategy is based on nine building blocks of the health system. It prioritizes governance and leadership, followed by human resources, services delivery, health financing, pharmaceuticals and medical technology, health intelligence and information system, social determinants of health, emergency preparedness and response and health infrastructure.

59. The HSSP II takes a pragmatic approach to the provision of essential package of health services (EPHS) including community-based health services across the Federal Member States and Regions of Somalia but the EPHS implementation is limited to some regions due to funding limitations and insecurity. The EPHS is largely implemented by NGOs with emergency support coming from humanitarian partners. The FGS is currently updating the EPHS framework with the aim of guiding all development and humanitarian partners to support the EPHS framework. The priority is to consolidate and scale-up of essential health services in all areas where access and security permits.

60. The HSSP-II responds to the most urgent health systems development challenges. It is the second post-conflict Plan that seeks to build effective health sector institutions as well as core planning and financing systems in Somalia. The plan provides a framework for future health programs to work within, expanding access to quality services, encouraging better targeting of disease specific programs, better coordination of this work with government strategic priorities, and more effective use of external support. The Plan also acts as an overarching framework for the numerous sub-sector strategies and plans that have been, or are in the process of being developed.

61. The HSSP-II has set a target of developing and/or adopting the following health sector policy and legal frameworks by 2021:

- Public Health Act;
- Drug Policy – already developed and endorsed;
- Drug Act – the draft bill has been submitted to the parliament – pending for approval;

- Health Policy – the last one developed was 2014;
- Health Regulatory Framework: National Health Professional Act was developed and signed by the President – it is currently in force;
- WATSAN and Environmental Health Policy and Strategy – this has been developed and endorsed; and
- Community Health Strategy was developed in 2015.

62. The project is also structured to meet the requirements of the Somalia-WHO Country Cooperation Strategy.⁴⁰ In particular, the project interventions will contribute to the achievement of:

- Strategic Priority 1 (“Communicable Diseases”): through implementing activities that will reduce the burden of communicable diseases, and by way of child health services (routine immunization; micronutrient supplementation) that are planned in the project.
- Strategic Priority 2 (“Non-Communicable Diseases”): this will be achieved through planned investments in primary health care, knowledge and documentation activities, and strengthening the capacity of Somali authorities to prevent and manage NCDs and their risk factors.
- Strategic Priority 3 (“Health through the Life Course”): the proposed project has significant focus on maternal, new-born, and child health; the project also proposed to strengthen coordination between participating FMSs and development partners on maternal, neonatal, and child health.
- Strategic Priority 4 (“Health System and People-Centred Healthcare Services”): The proposed project has a focus on strengthening the existing weak health systems by infusing both technical (personnel) as well as policy and regulatory frameworks in order to ensure greater well-being of the people of Somalia.

63. **Somalia National Development Plans.** The National Development Plan (NDP) 2017-2019 included a health policy focusing on the provision of essential healthcare services. The plan also called for investment in improved capacity building and regulation of the health workforce, as well as implementation of the long-term Medicine and Supply Plan to secure delivery of essential health supplies. The plan also focused on strengthening institutional and management capacity at all levels through a ‘Health in all Policies’ approach. All these interventions were aimed at creating a sustainable health financing system and an effective health management information system.

64. The NDP 2017-2019 has been succeeded by the ninth NDP, which covers the period 2020-2024. The Plan sets three main priorities for improving health access and outcomes. These are:

- (a) institutional oversight and strengthening, which includes setting the legal and oversight frameworks at the Ministry of Health, and at the level of state and municipal government health bodies.

⁴⁰ More details are available at https://apps.who.int/iris/bitstream/handle/10665/136871/ccsbrief_som_en.pdf;jsessionid=220403634A9968509EB6382FE6BD779C?sequence=1

- (b) focusing on most pressing health challenges, including maternal and early childhood health, reducing malnutrition and childhood stunting, and greater access to clean water and sanitation (in homes as well as in health facilities).
- (c) focusing on the most vulnerable, especially rural citizens along with Internally Displaced Persons (IDPs), and those in newly liberated areas, who have the least access to health care.

65. Somalia’s National Transformation Plan (NTP) 2025-2029 sets out four overarching priorities for the country’s development trajectory:. These include

- (a) strengthening institutional oversight and governance frameworks at the national, state and municipal levels.
- (b) enhancing sustainable economic transformation and social and human capital development, including improved access to healthcare and education, with special attention to maternal and early childhood health, nutrition, water, sanitation and hygiene.
- Persons (IDPs), and those in newly liberated areas, who have the least access to health care.
- (d) building environmental and climate resilience, promoting sustainable resource management and disaster risk reduction.

The Plan calls on the government to coordinate more closely with development partners and non-state providers to rehabilitate and expand health infrastructure, scale up essential health services and strengthen health system stewardship under the Ministry of Health.

66. **Legislation and Policies on The Civil Service.** The Provisional Constitution provides the legislative framework for labour issues. It provides that “all workers, particularly women, have a special right of protection from sexual abuse, segregation and discrimination in the workplace. Every Labour law and practice shall comply with gender equality in the work place” (Article 24-5). Labour Code of Somalia (Law 1 Number 65, adopted in 1972) is the specific labour law governing all aspects of labour and working conditions, which covers the contract of employment, terms and conditions, remuneration, and OHS, trade unions and labour authorities. The provisions of the Labour Code apply to all employers and employees in all project areas. The Labour Code is applicable to all project workers. The Code is broadly consistent with the ESS2, while there is a significant gap in the enforcement aspect of the legislation (see Section VIII on the institutional framework). The public service and institutions are governed by the Civil Service Law (Law Number 11).

67. The Federal Ministry of Labour and Social Affairs (MOLSA) is responsible for labour policy and regulatory frameworks. The Labour Ministry in each State is in charge of implementing the labour code, including labour inspection. While five States have labour ministries, only Puntland has three Labour Inspectors under the Minister. Others have no functioning labour inspection. The Revised Draft Somalia Labour Code (which is awaiting cabinet approval) has more emphasis on OHS requirements. It makes the Director of Occupational Safety and Health (DOSHS) responsible for the registration of hazards and risks, regulation and supervision of all workplaces and monitoring or enforcing compliance with Labour Code and any other Labour law to the extent that they regulate safety, health and welfare in the workplaces. Part VI of the Revised Draft Labour Code covers the administration of occupational accidents, injury and disease

provisions at workplace, employer's general duties towards to OHS, insurance requirements, employees' general duties, medical support, compensations, offenses and penalties, etc. The Labour Code covers protection against risks to the workers, notification procedures in occupational accidents, medical requirements at site and conveyance of injured workers to the hospitals, among others.

68. **Somalia National Environment Policy.** The Somali Cabinet, on February 13, 2020, approved the National Environmental Policy. The stated goal of environmental policy is to improve the health and quality of life of the Somali people. The development of this policy was backstopped by the Global Environment Facility (GEF) and the United Nations Development Program (UNDP). This is the first time that an environmental policy has been developed and taken to Cabinet level for approval, since the collapse of the previous central administration in 1991.

69. **Somalia Solid Waste Management Framework.** In Mogadishu, the local government or Benadir Administration collects transports and disposes waste materials from the city. Waste management differs in the urban areas from that of the rural area, as there are more people in the rural area in comparison to the city. This is done in order to minimize harm to individual's health as well as the environment. In Somalia there is no distinction of the nature of waste; whether solid, liquid or any other form; waste will be considered as waste and dumped in the dumping sites.

70. In Mogadishu, apart from the local government, there are entities in the environment sector that ideally have to have a say in the identification of the dumping locations, including the Directorate of Environment. There are two big dumping locations in Mogadishu one situated in Medina district while the other one is located in Karan district. These two dumping places are the official places to dump the wastes that are collected from the different districts of Mogadishu. The names of the two dumping sites are: Qashinweyne in Karan, and Kaawo in Madina.

71. For the last two years the Turkish Government has been assisting the Banadir administration with waste collection. The Turkish government is accountable for the entire process. Recycling: No recycling is practiced in Mogadishu. There are cleaning companies that operate in certain compounds. They clean regular trash from compounds.

LAWS AND REGULATIONS IN FEDERAL MEMBER STATES OF SOMALIA

72. It is important to note that as at the time of preparing this ESMF, there are no environmental laws or regulations in place to manage environmental risks and impacts for either South-West State or Hirshabelle State.

73. **Puntland.** The National Environmental Policy (2015) provides the overall guiding policies relating to the management of the environment and natural resources. This policy allows a rationalisation of administrative regulations and policies to eliminate deficiencies or inconsistencies with other previous policies. The policy promotes the use of appropriate environmental assessment instruments such as the EIA and Strategic Environmental Assessment.

74. The legislative and policy environment in Puntland is still adjudged as weak, although there has been much greater progress here as compared to Somalia. Puntland’s Constitution envisages, in Article 96, the importance and protection of the environment. Among the key features include combating deforestation, soil erosion and pollution.

75. The existing policies, laws and regulations in Puntland relevant to the Somalia health project implementation include the following:

- Environmental Policy (2014) approved by the Cabinet and Parliament.
- Environmental Management Act (2016) approved by the Cabinet.
- Puntland Waste Management Policy (2016).
- EIA Act and Regulation (2016) approved by Cabinet and Parliament.
- Ministry of Environment and Climate Change Strategic Plan (2016-2020).

76. The environmental licensing process in Puntland is relatively straightforward. Ministries control the licensing procedures.

- The Ministry of Environment and Climate Change (Puntland) has the powers to grant any of the licenses sought.
- Every license shall be subject to such conditions as may be specified therein during the issuance stage.
- The minister (or any person authorized by him or her) may at any time cancel or suspend any license granted by or on behalf of the minister.
- Grounds for cancellation include suspicions of infringement of any of the conditions upon which said license has been granted.
- The minister may, at any time, also vary the conditions of any such license.
- Any person aggrieved by any order under this clause may appeal to the minister, whose decision shall be final.

INSTITUTIONAL CAPACITY FOR ENVIRONMENTAL MANAGEMENT

77. **Somalia Federal Government.** The Somali government has introduced changes in the institutional set-up dealing with environmental issues in the country. A Directorate of the Environment and Climate Change (“DoECC”) has been formed within the Office of the Prime Minister. The Directorate is mandated to draft the national environmental policies, regulations and legislations including establishing of the Environmental Quality Standards, Sectoral Environmental Assessments (SEAs), Environment Impact Assessments (EIAs) and Environmental Audits (EAs), among others. However, necessary laws or legislations have not yet been formulated, and no commissions or authorities have been established as of March 2020.

78. The DoE, part of the Office of the Prime Minister (OPM), takes the lead in the formulation of environmental policies and laws, coordinates stakeholder consultation and partnerships with state agencies,

local councils, civil society and private sector entities (Somalia State of the Environment Report, 2019). The Directorate is also the operational focal point for multilateral environmental agreements and funds, such as the Global Environment Facility (GEF), Green Climate Fund (GCF) etc. It is also tasked with conducting Sectoral Environmental Assessments (SEAs), Environment Impact Assessments (EIAs) and Environmental Audits (EAs).

79. The Somalia National Environment Policy was approved at Cabinet level on February 13, 2020. This policy which will be the foundation for sustainable management of natural resources both at the Federal and member state levels. The National Environment Management Bill of 2020 was passed by a Cabinet resolution on November 26, 2020. The Bill, based on 25 and Article 45 of the Provisional Constitution, will be moved to the two houses of parliament for approval. The Bill has 18 sections and has clauses relevant to this project.

80. In addition, the Directorate of Environment and Climate Change has also published draft Environmental and Social Impact Assessment (ESIA) regulations. These regulations prescribe the procedures for conducting environmental assessments of the nature envisaged by this ESMF. They also outline the projects for which an ESIA will be required – under the First Schedule of the regulations. The regulations state that no proponent (in this case, the Ministry of Health) shall implement a project for which approval is required under the Environmental Management Act and under these regulations unless the environmental and social impact assessment has been concluded in accordance with these regulations.

81. **South-West State.** South-West State has within the government echelons the Ministry of Environment and Tourism (MoE&T), which manage environmental related issues within the state. The MoE&T has developed and passed environmental and social impact assessment (ESIA) regulations, which are meant to govern environmental matters, including licensing of landfills, waste pits and medical waste incinerators, in addition to oversight over environmental governance.

82. State ministries in charge of environment and tourism are the principal institutions to be consulted before, during and after the implementation of all interventions under the Somalia health project, in so far as they relate to possible environmental and social risks and impact. These ministries are mandated to supervise, and co-ordinate all matters relating to the environment.

83. **Puntland.** The Ministry of Environment, Agriculture and Climate Change (MoEACC) deals with management of environment and natural resources in Puntland. The ministry collaborates with the Humanitarian Affairs and Disaster Management Agency (HADMA) in the development of climate change, early warning and drought resilience strategies. It also collaborates in the identification and mapping of Puntland disaster prone zones.

84. The MoAECC has responsibility for climate change mitigation and adaptation strategies and has a five-year plan (2017-2021). Puntland's disaster management authority, HADMA, is not directly involved in environment-related activities, but has a key role in disaster preparedness, management and mitigation. The Ministry of Planning and International Cooperation (MoPIC) has a three-year development plan (2017-

2019) covering livestock, agriculture, social services and the environment. The plan was approved in 2016 by the Puntland Cabinet and is being supported by the UNDP Somali Project Watch Brief.

85. **Benadir Regional Administration (BRA).** BRA is a local government entity, established in law and enshrined in clause 1(b) of article 48 of the Constitution of the Federal Republic of Somalia, which relates to the structure of the state. Benadir is one of the 18 administrative divisions of Somalia established at independence in 1960. Benadir itself is comprised of 17 administrative districts that make up the city of Mogadishu, which is also capital of the federal republic. The BRA bears the dual responsibility of managing the affairs of the region as well as the municipality of Mogadishu. Thus, its administrative head is also the governor of the region as well as mayor of the city. Law Number 6 relates to local government and its older version, Law 19, clearly defines the mandates to provide basic services to the city of Mogadishu, including health services. The BRA will likely be a key partner of the Somalia health project, especially in the capital city.

INTERNATIONAL CONVENTIONS AND AGREEMENTS SIGNED OR RATIFIED BY SOMALIA

86. There are a number of international treaties, agreements and conventions that had been signed or ratified by Somalia. These conventions and agreements are aimed at halting environmental degradation and improving the sustainable use of natural resources, and may be of limited relevance for the Somalia health project. Among the important international conventions related to natural resource use and management that Somalia is a signatory to, include:

- Convention on International Trade in Endangered Species of Wild Fauna and Flora.
- Convention on the Conservation of Migratory Species of Wild Animals.
- Regional Convention for the Conservation of the Red Sea and the Gulf of Aden Environment.
- Protocol concerning Regional cooperation in Combating Pollution by Oil and other Harmful Substances in Cases of Emergency.
- UN Convention on the Law of the Sea.
- Protocol concerning Co-operation on Combating Marine Pollution in cases of Emergency in the Eastern African region.
- Convention for the protection, Management and Development of the Marine and Coastal Environment of the Eastern African Region (Nairobi Convention).

87. Somalia has been a member of the International Labour Organization (ILO) since 1960. The country has ratified 6 out of 8 fundamental conventions of the International Labour Organization (ILO), including the following: Forced Labour Convention (No.29) (ratified in 1960); Freedom of Association and Protection of the Right of Organize Convention (No. 87) (ratified in 2014); Right to Organize and Collective Bargaining Convention (No.98) (ratified in 2014); Abolition of Forced Labour Conventions (No. 105) (ratified in 2014); Discrimination (Employment and Occupation) Convention (No. 111) (ratified in 1961); and Worst Forms of Child Labour Convention (No. 182) (ratified in 2014).

88. The following were ratified in April 2021: Violence and Harassment Convention, 2019 (No. 190); International Labour Standards Convention, 1976 (No. 144); the Occupational Safety and Health Convention, 1981 (No. 155); the Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187); the Migration for Employment (Revised) Convention, 1949 (No. 97); the Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143); and the Private Employment Agencies Convention, 1997 (No. 181).

WORLD BANK ENVIRONMENT AND SOCIAL STANDARDS

89. **Relevant Environmental Standards.** The World Bank’s Environmental and Social Standards seeks to avoid, minimize, else mitigate the adverse effects of development projects it is financing through the Investment Project Financing (IPF) modality. The compliance with these Standards is required among others, to assure that the project is eligible for World Bank support. Due to the dearth of applicable national- and FMS-level environmental and social laws and regulations, the project will apply the World Bank Environment and Social Framework. Seven ESSs will be relevant to the *Damal Caafimaad* project:

- ESS1 (“Assessment and Management of Environmental and Social Risks and Impacts”)
- ESS2 (“Labour and Working Conditions”)
- ESS3 (“Resource Efficiency and Pollution Prevention and Management”)
- ESS4 (“Community Health and Safety”)
- ESS6 (“Biodiversity Conservation and Sustainable Management of Living Natural Resources”)
- ESS8 (“Cultural Heritage”)
- ESS10 (“Stakeholder Engagement and Information Disclosure”)

90. More details on the ESSs and how they apply to the project are enumerated in Table 3 below.

Table 3: Summary of applicable World Bank Environment and Social Standards (ESSs)⁴¹

Standard	Relevant?	Explanation on application
<p><i>ESS 1 Assessment and Management of Environmental and Social Risks and Impacts</i></p>	<p>Yes</p>	<p>This Standard sets out the Ministry of Health’s (Somalia) responsibilities for assessing, managing and monitoring environmental and social risks and impacts associated with each stage the project in order to achieve environmental outcomes consistent with the Environmental and Social Standards (ESSs).</p> <p>The project envisages small-scale construction works, which may entail the refurbishment of existing health facilities, installation of equipment including x-ray facilities, installation of solar power equipment and Solar Direct Drive Refrigerators as part of the AF, as well as the development of sanitary facilities, and development and operation of medical waste management facilities, such as waste pits, which may adversely affect the health of ecosystems and people through air pollution, generation of leachate, and contamination of land and groundwater.</p> <p>During the construction phase, there may be significant quantities of construction waste generated, including possible electronic waste, in addition to dust, noise and air pollution. During the operational phase of the project, there will likely be generation of moderate quantities of medical and other waste that is generally expected, for the most part, to be non-toxic and non-hazardous.</p> <p>The composition of waste produced may be in the form of sharp objects (including needles, syringes, disposable scalpels and blades), waste contaminated with blood and other bodily fluids (e.g., from discarded diagnostic samples), cultures and stocks of infectious agents from laboratory work or waste from patients with infections (e.g. swabs, bandages and disposable medical devices).</p> <p>Other wastes may include chemical wastes, such as solvents and reagents used for laboratory preparations, disinfectants, sterilant and heavy metals contained in medical devices (e.g., mercury in broken thermometers) and batteries, electronic waste from discarding unused/dead parts of solar generation equipment, as well as pharmaceutical wastes (including expired, unused and contaminated drugs and vaccines), and old medical equipment such as X-ray machines and laboratory testing equipment.</p> <p>As a result, this ESMF has been prepared, in conjunction with other, appropriate safeguards documentation, including:</p> <ul style="list-style-type: none"> ■ Infection control and waste management plan (ICWMP) – see Annex 7

⁴¹ More details at <http://www.worldbank.org/en/projects-operations/environmental-and-social-framework/brief/environmental-and-social-framework-resources>

Standard	Relevant?	Explanation on application
		<ul style="list-style-type: none"> ■ Labour Management Procedures ■ Stakeholder Engagement Framework ■ Security Management Framework ■ Environmental and Social Commitment Plan <p>On another hand, substantial social risks are expected from the project. The risks will be mitigated according to the measures outlined in the ESF. The project-wide GBV action plan also identifies actions to prevent GBV among staff and patients and ensure separate, survivor-centric and confidential procedures for dealing with grievances and provision of services for survivors.</p> <p>The social risks and impacts are various and will depend on locations and may vary over time. These include:</p> <ol style="list-style-type: none"> a. The risk of project benefits not reaching disadvantaged and vulnerable groups including: nomads, IDPs, minority groups, men, people with disabilities, women who have experienced GBV, people who live in remote areas both in terms of siting of services and accessibility, and how services are provided including the attitude and make up of health work force and social cultural and religious considerations; b. The risk of diversion of project benefits in hard-to-reach areas such as those controlled by armed groups; c. Ensuring health services are acceptable and accessible to women particularly when delivered by men and the potential risks of SEAH in delivery or uptake of health services (including of midwives or female mobile health outreach workers); d. Potential risks of increased social tension in the community for example, around the types of services delivered (e.g. child spacing, vaccination, maternal health, female genital mutilation/cutting (FGM/C) or survivor centric GBV services), particularly when in competition with traditional provision, social cultural practices or against the recommendations of religious leaders or others and how services are provided (by whom or how discretely due to the taboo around GBV/SEAH), or siting of services; e. Labour risks including OHS risks, child and forced labour linked to supply and installation of solar power equipment, in particular, security risks to staff, SEAH, and other forms of GBV that may occur in recruitment or retention of skilled female health workers (see also ESS2 and ESS4 sections below). Risks also exist around delayed payments and conditions (hours of work) and access or use of a GM (due to lack of trust and confidentiality in complaints handling);

Standard	Relevant?	Explanation on application
		<p>f. Exclusion and selection bias: recruitment of health professionals and consultants may be influenced by nepotism, clannism and gender whereby people from minority groups, IDPs, women and PWDs are excluded;</p> <p>g. Elite capture of project benefits, especially recruitment and contracting of implementing partners, private healthcare providers and suppliers, may limit project quality and reinforce exclusion;</p> <p>h. Contextual risks of operating in a conflict zone where effective and inclusive community consultations, stakeholder engagement, and community participation and safety of staff is challenging;</p> <p>i. Challenges in developing effective GM due to difficulty in accessing rural areas, and the collective nature of traditional complaints handling and the difficulty of disadvantaged and vulnerable groups raising complaints;</p> <p>j. For component 2, HMIS and Information Management will include data privacy and confidentiality requirements as outlined in the SocMF and Labour Management Procedures; and</p> <p>Policy developments will need to be in line with the requirements of the ESF including effective stakeholder consultations.</p>
<p><i>ESS2 Labour and Working Conditions</i></p>	<p>Relevant</p>	<p>Labour Management Procedures (LMP) will be developed to ensure non-discrimination, equal opportunity, protection, fair treatment and accessible complaints mechanisms for direct workers: i.e., staff employed by the project and contractors, as well ensuring safety and healthy working conditions for all workers. It will also proscribe against child labour and forced labour for all contractor workers and primary suppliers, especially forced labour related to transport and installation of solar power equipment and SDD refrigerators.</p> <p>The following are the labour-related risks expected during the implementation of the project:</p> <p>For direct workers:</p> <ul style="list-style-type: none"> ■ Discrimination and exclusion: Direct workers from disadvantaged and vulnerable groups may be deliberately excluded from employment opportunities under the project due to clannism, nepotism and gender considerations. People in senior positions at the MoH and relevant government agencies may set higher employment qualifications which may exclude disadvantaged and vulnerable groups including women, minority groups, IDPs, and PWDs; ■ Labour disputes over terms and conditions of employment: Like any other project, labour-related disputes are likely to occur in the “Damal Caafimaad” project. Labour-related disputes might emerge between health professionals (and consultants) and the MoH (or contracted agencies) over labour wages

Standard	Relevant?	Explanation on application
		<p>rates, working hours, payment delays, health and safety concerns in the work environment and deplorable working conditions. In turn, there is also a risk that employers may retaliate against workers for demanding legitimate working conditions, or raising concerns regarding unsafe or unhealthy work situations, or any grievances raised, and such situations could lead to labour unrest.</p> <p>For all workers:</p> <ul style="list-style-type: none"> ■ OHS risks: The primary risk to worker safety is due to the potential exposure to infectious diseases such as Covid-19 and other communicable diseases. Lack of personal protective equipment (PPE) and safe workplace practices may put the workers at risk. In addition, physical structures from which workers provide services to the community may not cater for female workers, which may limit their functionality and thus accessibility of services for women. There is also a risk of child/ forced labour during installation of solar power equipment and SDD refrigerators, as well as risk of HIV/AIDS due to labour influx that will be occasioned with the recruitment of staff for the various facilities. ■ SEAH: this will mainly affect female workers during recruitment or retention process given men dominate the hiring management in most government offices and NGOs. ■ Insecurity: Communal conflict and threats by Al Shabab remain a persistent challenge in Somalia and have, in the past, impeded delivery of services in many locations. Ensuring security for project operations, including project workers at the regional and district-level health workers and the potential for increased conflict due to the drought or floods, will remain a challenge. Health workers and health centres at regional and district-level may be targeted by the Al-Shabab armed group due to their affiliation with government or NGOs.
<p><i>ESS3 Resource Efficiency and Pollution Prevention and Management</i></p>	<p>Yes</p>	<p>There are environmental impacts of health systems supported under this project associated with the possible heavy consumption of energy and water resources in support of health centre operations. It is also envisaged that there are possible greenhouse gas emissions from both medical activities and operation of cold chain equipment, use and disposal of toxic chemicals, and production of waste and wastewater and their disposal. The generation of some solid and liquid wastes in the health centres to be supported under this project will require well-prepared disposal facilities.</p> <p>The waste disposal options open to the project include waste pits located within health centre footprints. It is also possible that health centre waste may be routed to uncategorized landfills (some form of open dumping or lightly managed dumps). Installation and decommissioning of solar power and cold chain equipment, which is financed under AF, will also pose additional risk of hazardous waste mismanagement and improper disposal.</p>

Standard	Relevant?	Explanation on application
		<p>This ESMF covers management of both onsite waste pits as well as transportation to and management of medical and hazardous waste into nearby uncategorized landfills (<i>see ICWMP in Annex 7</i>).</p> <p>The project will screen activities in order to ensure efficiency of resource use and minimize pollution and build local capacity to manage resource use efficiency during implementation. Care will be taken to ensure that the medical and other waste disposal system selected will be context-appropriate, given the low-capacity levels existing in Somalia.</p> <p>In addition, the World Bank’s EHS Guidelines including the General, Healthcare Facilities, Healthcare Facilities will be applicable and used for screening and ES assessment of these disposal facilities. The project team will be trained in life-cycle infection control, with a focus on segregation, packaging, disinfection of infectious or dangerous healthcare waste.</p> <p>Waste pits sited within the health centre footprint will be the first point for consideration in waste disposal for the project-supported health centres. The incineration of waste may also occur as a step prior to medical waste disposal. Incineration may involve the generation of climate-relevant emissions, which are mainly CO₂ (carbon dioxide) as well as N₂O (nitrous oxide), NO_x (oxides of nitrogen), NH₃ (ammonia) and organic C, measured as total carbon. Risk of harmful releases will also be applicable to the newly introduced climate friendly cold chain equipment if accidental release of refrigerants occurs.</p> <p>CO₂ constitutes the chief climate-relevant emission of waste incineration. However, the generation of greenhouse gas emissions is limited in the context of the proposed project: the incineration of 1 Mg of waste in incinerators is associated with the production and release of about 0.7 to 1.2 Mg of carbon dioxide (CO₂ output). The climate-relevant CO₂ emissions from waste incineration are determined by the proportion of waste whose carbon compounds are assumed to be of fossil origin: in the project context, again this is likely to be limited.</p> <p>On the other hand, inadequate incineration or the incineration of unsuitable materials may result in the release of pollutants into the air and in the generation of ash residue. Incineration of heavy metals or materials with high metal content (in particular lead, mercury and cadmium) can lead to the spread of toxic metals in the environment.</p> <p>To mitigate this, the project will prepare a Medical Waste Management Plan to address aspects such as regulatory framework, planning issues, waste minimization and recycling, handling, storage and transportation, treatment and disposal options, and training. In the preponderance of health centres, locally sourced, non-commercial incinerators can provide sufficient heat to incinerate properly, with the caveat the medical waste has been sorted adequately prior to incineration. However, a final determination of the final incinerator type to be used will be made during the environmental assessment process of the project.</p>

Standard	Relevant?	Explanation on application
		<p>In addition, subject to the findings of the environmental assessment undertaken, the project will explore the use of alternatives to incineration such as autoclaving, microwaving, steam treatment integrated with internal mixing, which minimize the formation and release of chemicals or hazardous emissions. These should be given consideration in localities where there are sufficient resources to operate and maintain such systems and dispose of the treated waste.</p>
<p>ESS4 Community Health and Safety</p>	<p>Yes</p>	<p>The disposal of untreated health care wastes in waste pits or uncategorized landfills can lead to the contamination of drinking, surface, and ground waters if not properly constructed, posing danger to human health and community wellbeing. Communities are also likely to be exposed to health problems arising from ineffective infection control and inappropriate healthcare waste management, as well as inappropriate sanitation facilities.</p> <p>To mitigate this, the project will strive to achieve universal access, ensuring that the rehabilitation of healthcare facilities will provide unimpeded access for people of all ages and abilities in different situations and under various circumstances. An awareness raising campaign will be undertaken to sensitize local communities against the reuse of needles, medicine bottles, and other used or expired medical supplies. In addition, rehabilitation and/or refurbishment of health facilities may pose a danger to construction crews.</p> <p>Where the project interventions include civil works, there are community health and safety challenges that can arise. Therefore, the project team will prioritise training of the contractors and their workers on structural safety issues. Due care will be taken to minimise exposure of the beneficiary communities arising from poor infection control through investing in emergency preparedness and response mechanisms: this will address incidents associated with infection control as well as environmental and health incidents arising from medical waste management facilities.</p> <p>The PMT will conduct a full EHS audit of each existing HCF facility under their jurisdiction and supply the results of the audit to prospective contractors. This will be important for the bidders and prospective contractors to properly understand the existing HCF conditions (including all existing EHS liabilities). With the benefit of this audit and their own understanding, bidders can properly and adequately include in their bids (both technical measures and their implementation costs) all needed EHS measures (including medical waste management, water supply, wastewater management, indoor air quality, hazardous materials management, waste management, requirements related ESS4 and healthcare infrastructure and equipment design and safety of services). This EHS audits will cover both construction but more importantly the HCFs’ operational phase.</p> <p>In addition, the Ministry of Health and the PMT will design, construct, operate, and decommission the structural elements of the healthcare centres in accordance with the requirements established in the Bank’s EHSGs and other GIIP, taking into consideration safety risks to third parties and affected communities. The health facilities’</p>

Standard	Relevant?	Explanation on application
		<p>structural elements will be designed and constructed by competent professionals. Structural design will take into account climate change considerations, as appropriate. The PMT will ensure that in the usage of the health facilities, the concept of “universal access” is implemented, meaning that all persons, irrespective of background and age, will be given unimpeded access to the facilities.</p> <p>Security challenges will be addressed by the Security Management Framework, which has been prepared for this project</p>
<i>ESS6 Biodiversity Conservation and Sustainable Management of Living Natural Resources</i>	Yes	<ul style="list-style-type: none"> ■ While a few locations in a few municipalities may contain some land with inherent environmental sensitivity relevant to ESS6, the subproject screening process in the ESMF will exclude such sensitive areas. ■ The ESMF includes specific measures to avoid or minimize negative impact on critical or protected areas if the sub-project screening process does not otherwise exclude these areas.
<i>ESS8 Cultural Heritage</i>	Yes	<ul style="list-style-type: none"> ■ There is the potential for chance find of cultural or archaeological significance during construction or rehabilitation of healthcare facilities, and the existence of some historic buildings in the neighborhood of the HCFs that could potentially be impacted from the construction. ■ The ESMF has been updated to comply with ESS8, and the subproject specific ESMPs will address these issues through the inclusion of chance find procedures.
<i>ESS10 Stakeholder Engagement and Information Disclosure</i>	Yes	<p>A Stakeholder Engagement Framework (SEF) has been prepared prior to appraisal as part of the Social Management Framework, and outlines how appropriate representation and participation of various groups of stakeholders will be carried out, including their viewpoints and suggestions in improving project documentation, including this ESMF. Once project sites are known, specific and costed stakeholder engagement plans will be prepared by the different implementing agencies and, approved, implemented and monitored by the MoH throughout the different phases of the project cycle.</p> <p>As part of the information disclosure arrangement, the main environmental and social instrument (this ESMF) will be disclosed publicly on the MoH website. Meaningful and inclusive consultations with relevant stakeholders will be conducted before the appraisal stage, and its results adequately recorded and disclosed.</p>

91. The project will comply with the ESSs, where potential E&S risks and impacts are anticipated. Where possible, the project will put premium on implementing alternative measures to avoid, minimize, mitigate, manage or compensate adverse environmental impacts. Avoidance measures will be prioritized over mitigatory or compensatory measures consistent with the mitigation hierarchy. Additionally, the project will enhance positive impacts in project selection, location, planning, design, implementation and management

WORLD BANK GROUP EHS GUIDELINES

92. WBG has guidelines for Environment, Health and Safety (EHS) that serve as useful references for general issues as well as sector-specific activities. Projects financed by the World Bank Group are expected to comply with this guideline as required by the policies and the standards. The EHS guidelines are mainly on occupational health and safety, community health and safety as well as on construction and decommissioning. It contains guidelines cross cutting on environmental (waste management, ambient air quality, noise and water pollution), occupational health and safety issues among others, applicable to all the industry sectors. This Project will comply with the World Bank's General EHS Guidelines and Healthcare Facilities EHS Guideline. Other Good Practice Notes of the World Bank relevant to the Project include:

93. Good Practice Note Addressing Sexual Exploitation and Abuse and Sexual Harassment. The WBG Good Practice Note on Addressing Sexual Exploitation and Abuse and Sexual Harassment (SEAH) addresses key risks of varying forms of gender-based violence, and in particular risks of SEAH that may arise or be exacerbated by World Bank-financed project. This Good Practice Note outlines in particular the identification and mitigation of these risks and impacts through project preparation and implementation, through key instruments such as the SEP, GM and LMP. The GBV note includes definitions of SEAH and how to manage and mitigate against those risks in Bank-financed projects; updated language changing Gender Based Violence (GBV) to SEAH where relevant; and additional information on third-party monitoring of SEAH. It provides guidance on identifying risks of SEAH and how to best manage such risks.

94. World Bank Guideline on Non-discrimination and disability. The ESF strengthens the Bank's commitment to identify disadvantaged and vulnerable individuals and groups, including PWDs, and assessing and preventing potential risks and negative impacts that could affect them disproportionately, as well as barriers to accessing project benefits. The World Bank Directive states: addressing risks and impacts on disadvantaged or vulnerable Individuals or groups refers to those individuals or groups who, by virtue of, for example, their age, gender, race, ethnicity, religion, physical, mental or other disability, social, civic or health status, sexual orientation, gender identity, economic disadvantages or indigenous status, and/or dependence on unique natural resources, may be more likely to be adversely affected by the project impacts and/or more limited than others in their ability to take advantage of a project's benefits. Such an individual/group is also more likely to be excluded from/unable to participate fully in the mainstream consultation process and as such may require specific measures and/or assistance to do so. This will take into account considerations relating to age, including the elderly and minors, and including in circumstances where they may be separated from their family, the community or other individuals upon whom they depend.

95. World Bank Good Practice Note on Assessing and Managing the Risks and Impacts of the Use of Security Personnel. The World Bank’s Good Practice Note on Assessing and Managing the Risks and Impacts of the Use of Security Personnel helps with guidance on identifying risks that could arise from the use or presence of security personnel that have been engaged to protect the project or related aspects. If it is decided that security personnel should be engaged, the potential risks and impacts stemming from such engagement in turn needs to be assessed and management measures identified in accordance with the mitigation hierarchy.

GAP ANALYSIS

96. The activities as proposed in parent project and AF, will need to comply with both existing Somali laws and regulations and World Bank Environment and Social Standards. This sub-section compares the national public sector environmental management rules, regulations and standards to World Bank’s Standards. The main objective of this assessment is to help implement this ESMF more effectively at the Federal and State levels in Somalia through an understanding of existing gaps.

97. Table 4 below summarizes a comparison focusing on the World Bank policies relevant to the project and gaps identified in existing Somali laws and regulations. All gap-filling measures proposed will be adopted for this Project.

Table 4: GAP analysis for ESSs

Scope	Bank Standard	Government of Somalia policies, regulations	Gaps identified	Gap-filling measures
<i>ESS1 (“Assessment and Management of Environmental and Social Risks and Impacts”)</i>				
Environmental and social risks and impacts assessment instruments and protocols	Range of instruments to satisfy the Bank include EIAs, regional or sectoral EIAs, ESMPs, etc.	Instruments for E&S assessment have not been delineated adequately at the FGS level, and are absent in the FMSs generally, except in one FMS (Puntland)	EIAs not incorporated into Federal laws, and are weakly captured at State level in only Puntland Missing in all the other FMS	ESMF and the instruments highlighted in the mitigation plan for the project to guide the borrower
Environmental and Social impact screening	E&S Screening procedures developed for projects involving sub-projects, as is likely to be the case in the <i>Damal Caafimaad</i> project	There are no clear procedures for E&S screening under the statutes of Somalia	E&S Screening procedures are absent in all the FMS save for Puntland.	ESMF to guide the borrower E&S assessment and management plans will be completed by contractors for sub-projects including E&S screening
Public consultations	The Bank requires the Borrower to initiate consultations with project-affected persons and other interested parties including CSOs	Procedures for public consultations not explicitly stated	Procedures for public consultations not explicitly stated	SEP to guide the borrower Stakeholder consultations have been carried out at FGS level, and more consultations will be conducted at FMS level and by the contractors on the ESMPs once drafted.

Scope	Bank Standard	Government of Somalia policies, regulations	Gaps identified	Gap-filling measures
Monitoring of environmental and social data	Bank requires regular monitoring of E&S data (including volumes of medical and other healthcare wastes generated, etc.) to evaluate the success of the mitigation plan and to foster corrective measures at the earliest possible juncture	There are no procedures provided in regulations in the country on the conduct of monitoring activities in the collection of E&S data	There are no procedures provided in regulations in the country on the conduct of monitoring activities in the collection of E&S data, especially volumes of solid waste likely to be generated in this project and the medical and other pathological wastes	ESMF, ESCP, and the accompanying ICWMP to guide the borrower The E&S specialists at FMS and FGS levels will monitor the E&S performance of the contracting partners and review quarterly reports.
Institutional arrangement	Requirement by the Bank for specific description of institutional arrangement and implementation schedule for monitoring and mitigation measures	Mandate of the MoH as the project implementing partner Ministry of Environment and Climate Change in the FGS, to be responsible for oversight of environmental matters	MoH has capacity for technical implementation of project interventions using it's PCIU E&S Safeguard consultant support Ministry of Environment and Climate Change is not at present directly responsible for coordinating institutional responses under this ESMF, and the institutional information is not available, and its remit is unknown, as is its technical capacities	MoH-based PCIU to work with the respective ministries and agencies responsible for management of E&S matters as the focal points for administration of this ESMF Contractors responsible for implementation of E&S risk management, overseen and supported by E&S specialists based at the MoH FMS and FGS levels.
ESS2 (“Labour and Working Conditions”)				

Scope	Bank Standard	Government of Somalia policies, regulations	Gaps identified	Gap-filling measures
Management of different types of project workers	The Bank puts emphasis on the identification and characterization of different types of workers (project workers, direct workers, contracted workers, community workers, primary supply workers) to manage different types of labor risks.	Labour Code of Somalia (Law Number 65, adopted in 1972) is the specific labor law governing all aspects of labor and working conditions, which covers the contract of employment, terms and condition, remuneration, and OHS, trade unions and labor authorities. The provisions of the Labour Code apply to all employers and employees in all project municipalities. The Labour Code is applicable to all project workers of the Somalia health project.	The Labour Code is broadly consistent with the ESS2, while there is a significant gap in the enforcement aspect of the legislation. More details are presented in the LMP.	ESMF and the Labour Management Procedures (LMP) to guide the borrower, including LMP prepared by the contractors.
Labour standards	Several provisions made under ESS2 to safeguard the healthcare workers and other project workers, promote safety at work and ensure that they have a viable means of communicating grievances and receiving redress.	Article 24(5) stipulates that all workers, particularly women, have a special right of protection from sexual abuse, segregation and discrimination in the workplace. The Puntland Sexual Offences Act 2016 prohibits sexual harassment.	The new labor code, amending the code from 1972, has not been passed yet. The implementation of the existing articles in practice may not be very strong.	The Project will fully comply with WB ESS 2. This is set out in the LMP. The Project will not allow any forced and child labor. It will hold all contractors liable to the implementation of the LMP. The PCIU will have overall responsibility to monitor the implementation of the

Scope	Bank Standard	Government of Somalia policies, regulations	Gaps identified	Gap-filling measures
		<p>Article 14 prohibits Human trafficking: A person may not be subjected to slavery, servitude, trafficking or force labor offences.</p> <p>Every labor law shall comply with gender equality.</p> <p>Provisional Constitution of the Federal Republic of Somalia Article 14 stipulates that a person may not be subjected to slavery, servitude, trafficking, or forced labor for any purpose.</p> <p>The Labour Code of 1972 stipulates that all contracts of employment must include: (a) the nature and duration of the contract; (b) the hours and place of work; (c) the remuneration payable to the worker; and (d) the procedure for suspension or termination of contract. Furthermore, all contracts must be submitted to the competent labor inspector for pre-approval.</p>		<p>LMP and will hold all contractors liable to the implementation of the LMP including subproject Labour Management Plans as part of the contractors ESMPs. The Project will fully comply with WB ESS 2, including setting up the workplace GMs.</p> <p>The PCIU will draw support from DOSH officers where they are in office.</p>

Scope	Bank Standard	Government of Somalia policies, regulations	Gaps identified	Gap-filling measures
<i>ESS3 (“Resource Efficiency and Pollution Prevention and Management”)</i>				
Pollution prevention and management	This ESS requires the Borrower to undertake a health and safety risk assessment of potential for pollution generation at supported health facilities, which may affect communities, workers and the environment	<p>No known national waste management standards</p> <p>No known designated landfills for medical wastes by municipalities</p> <p>No guidelines nationally known to support operation of incinerators</p> <p>No known national statutes in support of periodic environmental audits</p> <p>No national pollution standards known at the time of developing this ESMF</p>	There are no supporting legislative frameworks for pollution prevention and management	<p>ESMF to guide the Borrower on pollution prevention and management</p> <p>Separate ICWMP to guide the Borrower in managing medical waste</p> <p>Individual health centers to develop ESMPs for the assessment of the E&S impact of medical waste incinerators or any other framework used for management of medical waste</p>
Management of hazardous wastes	<p>The bank requires the Borrower to undertake specific measures to manage both hazardous and non-hazardous wastes.</p> <p>Specific emphasis is given in this ESS with respect to transportation and disposal, obtain chain of custody documentation to the final destination.</p>	No known national legislation or policies on management of hazardous wastes	There are no approved hazardous waste disposal sites in Somalia	ESMF and the ICWMP to guide the Borrower on the management of both hazardous and non-hazardous wastes, including pathological and medical wastes from the health centers

Scope	Bank Standard	Government of Somalia policies, regulations	Gaps identified	Gap-filling measures
	Approved disposal sites are required for this ESS.			
ESS4 (“Community Health and Safety”)				
Health of community members	The ESS envisages that the project will put measures in place to anticipate and avoid adverse impacts on the health and safety of project-affected communities during the project life-cycle from both routine and non-routine circumstances. Further, it provides for the avoidance or minimization of community exposure to project-related traffic and road safety risks, diseases and hazardous materials.	<ul style="list-style-type: none"> • The Somali Penal Code of 1962. The Code criminalizes rape and other forms of sexual violence as well as forced prostitution. • Articles 398-9 provide that ‘carnal intercourse’ and ‘acts of lust omitted with violence’ are punishable with 5-15 years and 1-5 years of imprisonment. Abduction for the purpose of lust or marriage is prohibited under Art 401. • Article 39(i) makes abuse of power in the commission of a crime an aggravating circumstance and Article 33 provides that when a superior officer orders the commission of an offence both the perpetrator and his superior will be liable. 	<p>The Somali Penal Code of 1962 fails to protect survivors and prosecute perpetrators for GBV/SEAH crimes.</p> <p>The crimes under Articles 398-9 are too narrowly defined to satisfy international law standards of protection from sexual and GBV/SEAH.</p> <p>Furthermore, in practice it has been documented that women complaining about a rape may find themselves trapped by the Article 426 prohibition against adultery that makes no exception for the case of rape.</p> <p>In practice provisions under Art 39(i) offer little more than theoretical protection.</p>	The LMP, SEP and the GBV Action Plan developed for this project will guide the prevention and mitigation of harm to communities by the project including addressing stigma, discriminatory laws (such as the laws on adultery) and GBV/SEAH.

Scope	Bank Standard	Government of Somalia policies, regulations	Gaps identified	Gap-filling measures
Security personnel	<p>This ESSs 1&4 postulates that when the Borrower retains security personnel to safeguard workers and property (including high-value medical assets), it will assess risks posed by these security arrangements to those within and outside the project site.</p> <p>The Borrower will not sanction any use of force by direct or contracted workers in providing security except when used for preventive and defensive purposes in proportion to the nature and extent of the threat.</p> <p>Borrowers must prepare Security Risk Assessments (SRA) and Security Management Plans (SMP) to identify and mitigate risks to project workers and assets as well as community</p>	<p>District police will likely provide security services in the implementation of the project. The civil servants in Somalia are governed by Provisional Constitutions and Civil Service Law (Law Number 11).</p> <p>However, there are no security protocols guiding their deployment, and there is possibility of violence meted out on civilians or workers or even the possibility of rent-seeking.</p>	<p>There are no security guidelines for MoH staff or contractors.</p> <p>While the security protocols guiding their deployment and use of force are broadly unknown, the project will coordinate with the law enforcement authorities in each municipality to manage associate risks.</p>	<p>The project to be guided by the ESMF and relevant provisions of ESS4 on the deployment of security personnel to support project activities.</p> <p>Further delineation of security operations to be provided in the Security Management Framework (SecMF) of the Project, and through site-specific Security Management Plans (SecMPs).</p>
Universal access	<p>The ESS4 is emphatic on the right to access to services, especially on the concept of “universal access.”</p>	<p>The service charter of the Ministry of Health is silent on the issue of “universal access.”</p>	<p>The concept of universal access is not widely acknowledged in the FGS policies</p>	<p>The Project will be guided by the provisions of ESS4 on unimpeded access for people of all ages and abilities in different situations and under</p>

Scope	Bank Standard	Government of Somalia policies, regulations	Gaps identified	Gap-filling measures
				various circumstances, as set out in GIIP.
<i>ESS6 (“Biodiversity Conservation and Sustainable Management of Living Natural Resources”)</i>				
Ecosystem restoration	In accordance with the mitigation hierarchy provided in ESS1 and with the requirements of this ESS, Borrower is required to ensure that biodiversity expertise is utilized to develop and implement a Biodiversity Management Plan.	Somalia has developed National Biodiversity Strategy and Action Plan (NBSAP), which calls for action to be taken to manage the 40+ identified biodiversity hotspots.	However, no draft management plan is provided in Somalia’s NBSAP.	The project to be guided by the ESMF and relevant provisions of ESS6 on biodiversity restoration where the project interfaces with biodiversity and other environmentally sensitive areas
<i>ESS10 (“Stakeholder engagement and information disclosure”)</i>				
Meaningful engagement of stakeholders in the project activities from planning to implementation levels	The World Bank anticipates that the project will establish a systematic approach to stakeholder engagement that will help Borrowers identify stakeholders and build and maintain a constructive relationship with them, in particular project-affected parties. Further, the project will promote and provide means for effective and inclusive engagement with project-affected parties throughout the project life-cycle on issues that could	The Provisional Constitution of the Federal Republic of Somalia, Article 32 stipulates that every person has the right of access to information held by the State. The Federal Parliament shall enact a law to ensure the right of access to information.	The law on the right of access to information currently only exists as a draft.	The Project will implement stakeholder consultations throughout the lifetime of the project, as per the SEP. The contractors will develop sub-project SEPs in line with the project SEP, which will be reviewed and cleared by the MoH and the World Bank. The PCIU will ensure that a GM for the project is in place, in accordance with ESS10 as early as possible in project development to

Scope	Bank Standard	Government of Somalia policies, regulations	Gaps identified	Gap-filling measures
	<p>potentially affect them. The project affected persons should be provided with accessible and inclusive means to raise issues and grievances, and allow Borrowers to respond to and manage such grievances.</p>			<p>address concerns from project affected persons.</p> <p>The contractors will outline their workplace GMs in their subproject SEPs including confidential channels for GBV/SEAH reporting.</p>

ACTION PLAN FOR CAPACITY ENHANCEMENT IN E&S RISK MANAGEMENT

1. The Damal Caafimaad project is projected to be implemented by the Ministry of Health, in the Federal Government of Somalia.
2. Based on a preliminary assessment of existing capacity at the Ministry of Health, the World Bank’s ESF team (both environment and social) have taken note of the low capacity for E&S risk management.
3. As a result of the aforementioned observation, the Bank’s E&S specialists assigned to the project have worked very closely with the Somali government counterparts from the Ministry of Health in the preparation of environmental and social instruments required for appraisal, in many cases participating in the drafting and updating of the instruments.
4. These documents include:
 - a. Environmental and Social Commitment Plan (ESCP)
 - b. Social Management Framework and Environmental Management Framework (merged in this document as Environmental and Social Management Framework (ESMF))
 - c. Security Management Framework (SecMF)
 - d. Labour Management Procedures (LMP)
5. The project’s coordination and implementation unit (PCIU) is required to undertake the following tasks on E&S risk management on implementation:

Table 5: E&S Capacity assessment per phase

Phase	Instrument, intervention	Capacity assessment
Preparation post-implementation	Environmental Health and Safety (EHS) audits	Very limited. The Bank has provided a simplified audit tool for administration to health centers to be supported. The audits will be conducted at the same time as part of the planned mapping of health facilities.
	Environmental and Social Assessments and Management Plans (ESMPs)	Very limited. The ESMPs have to be prepared by the implementing partners and reviewed and cleared by the Bank.
	Site-specific Infection Control and Waste Management Plan (ICWMP)	Very limited. The site-specific ICWMPs have to be prepared and reviewed by the Bank.
Implementation Monitoring	Environmental Management Framework	Limited. The Bank will work with the government counterparts to put in place a regime for monitoring the implementation of this ESMF.

6. Based on the assessment it is expected that the Ministry of Health team in the Somali government implementing the project will require substantive assistance in meeting the World Bank’s ESF requirements.

7. Longer-term, this action plan will be the first step in the MoH and the Somali government in establishing their own E&S risk management systems.
8. This E&S risk management capacity action plan has been prepared to directly aid the E&S specialists attached to the Ministry of Health and who will be responsible for supporting the Damal Caafimaad project (incl. AF), this will be updated once staff and implementing partners are on board as guided by the draft TOR for E&S capacity Assessment in Annex 17.
9. This draft plan has been discussed with the counterparts in the Ministry of Health, Somalia, who have had their input and accepted this plan as part of the overall project design for the Somalia health project.
10. Once staff and implementing partner are in place, a capacity assessment and development plan will be updated as per the TOR in Annex 17.
11. Before the bidding process, potential organizations will be oriented on the E&S requirements and reference documents. In their bids, contractors will be required to provide plans for E&S implementation including for E&S assessment and management plan and staffing plan as part of their bids which will be reviewed by WB safeguards staff and no objection provided. Once contracted, the contractors will develop the E&S assessment plan including a SEP, inclusion plan, GBV Action Plan, labour management plan and area specific SecMPs, which will be informed by stakeholder consultations in line with the E&S instruments. The plan will be reviewed by the MoH and will be submitted to the World Bank for clearance. Clearance will be obtained before implementation of activities.
12. The FMS and FGS E&S specialists will guide and monitor the implementation of plans and ensure remedial measures are taken including providing capacity building support to the implementing partners and contractors. Once the FGS and FMS E&S specialists and the implementing partners are on board, this capacity assessment and implementing plan will be updated. Given there are very few experienced E&S safeguards specialists in Somalia particularly at FMS level, it is likely that capacity will have to be developed from scratch. Thus, a training and capacity building plan will be developed to be facilitated by World Bank consultants and the RCRF E&S specialists and other government specialists and consultants. The capacity building plan may need to be developed and implemented by an independent SRM capacity building specialist and will include sessions on collaboration and synergy with other World Bank funded projects, e.g., RCRF and the SCRP, both of which have health components. The capacity building process will consist of practical virtual sessions as shown in Table 6 below.

Table 6: Capacity building plan

Session	Timeframe	For whom
E&S requirements for implementing partners/contractors	Once requests for proposals are issued	Potential implementing partners. All organizations working in health delivery in the targeted regions could be invited.
E&S requirements for MoH and action planning	Once FGS and FMS staff are in place.	PCIU and FMS PMT staff including E&S specialists, GBV advisor, security management specialist, communication specialists.

Session	Timeframe	For whom
GM	Month 1	All direct workers including E&S specialists, GBV advisor, security management specialist, communication specialists
GBV	Month 2	All direct workers including E&S specialists, GBV advisor, security management specialist, communication specialists
LMP and code of conduct	Month 3	All direct workers including E&S specialists, GBV advisor, security management specialist, communication specialists
Medical waste management	Month 4	All direct workers including E&S specialists, GBV advisor, security management specialist, communication specialists
Inclusion plan	Month 5	All direct workers including E&S specialists, GBV advisor, security management specialist, communication specialists
E&S reporting	Month 6	E&S specialists
Monitoring of E&S requirements	Month 7	E&S specialists
Virtual tools for E&S monitoring	Month 8	E&S specialists
Other sessions as required	To be offered based on the needs assessment and project demands.	

Table 7: Capacity building workplan

Activity	Year 1	Year 2	Year 3	Year 4	Responsibility	Resources
In-depth capacity needs assessment of MoH's institutional set-up for env. risk management					World Bank MoH	
Sourcing for capable in-country environmental specialists					MoH	WB to work with PCIU in drafting TORs
Training I: E&S risk management and ESF in general for focal points					World Bank	
Training II: introduction on HCF emergency preparedness and response					World Bank	
Training III: implementing the Infection Control and Waste Management Plan					World Bank	
Training IV: conducting follow-on EHS audits					World Bank	

Activity	Year 1	Year 2	Year 3	Year 4	Responsibility	Resources
and use of MSDS ⁴² at HCFs						
Training V: monitoring EFS compliance at FMSs					World Bank	
Evaluation of performance of env. focal points					PCIU World Bank	
Study tour for ESF focal points to other Bank-funded projects					World Bank	
Twinning of MoH ERM focal points with other Bank projects					World Bank	
Training on E&S risk reporting					World Bank	
Transition: towards establishing own E&S risk management system					MoH	

⁴² Material Safety Data Sheets

PROJECT'S BIOPHYSICAL AND SOCIOECONOMIC SETTINGS

OVERVIEW

98. This section focuses on the existing biophysical and socio-economic environments in the proposed states. Physio-geographically, Somalia is a country of limited contrasts, but for the purposes of the *Damal Caafimaad* project, this ESMF will treat the project sub-regions as three relatively distinct continuities:

- Hirshabelle and Puntland (arid agroecology)
- South-West State (semiarid agroecology)
- Mogadishu (coastal marine agroecology)

99. Ecologically sensitive sub-regions within the regions will be identified where possible.

ENVIRONMENTAL CONTEXT

100. The proposed project will be implemented in a context of ecologically fragile environments, in some places (such as Puntland) characterized by a high number of arid-adapted flora (including the deciduous species of *Acacia* and *Commiphora* in addition to *Euphorbia* and *Aloe* variants forming understory) and fauna (such as the Dorcas gazelle, Beisa oryx, gerenuk, the Somali wild ass *Equus africanus somaliensis* and the Somali warthog, *Phacochoerus aethiopicus delamarei*) species, many of them endemic. Some of these species used to thrive in the country's national parks and game reserves, which were relatively well protected in the reign of former central government. Following the collapse of the former regime, the parks have all but disappeared, and it was extremely difficult to gather any information on their current state, actual boundaries, management, etc.

101. Many of the aforementioned species are categorized as Critically Endangered (CR), Endangered (EN) or Vulnerable (VU) in international conventions, or are under preparation, and agreements, such as the World Conservation Union's Red List of Threatened Animals⁴³. Considering the mixed urban-and-rural environment settings of the proposed the Somalia health subprojects, it is unlikely that project interventions will affect such species. As a precaution, it will be critically important for the PCIU to engage with communities, contractors, civil society and other government MDAs to ensure that the project does not affect existing biodiversity.

CLIMATE

102. All the proposed project states share similar characteristics, climate-wise. There is generally warm and arid climate across most parts of the four states, though precipitation and the wind can be highly variable in places at certain times of the year (on account of proximity to the equator). Typically, the Somali climate is typically hot and semiarid to arid, with two annual rainy seasons (*Gu'*, which spans from April to June, and *Deyr*, which takes place from October to November). There are variations in spatial distributions of

⁴³ See <http://www.animalinfo.org/country/somalia.htm>

rainfall, with about 500 mm recorded annually in the northern highlands and between 300 and 500 mm in the southern regions. The coastal plains register only between 50 and 150 mm.

103. Annual potential evapotranspiration (PET) is high, exceeding 2,000 mm in the northern basins and can be as high as 3,000 mm in the Gulf of Aden. Over the dry period, the vegetation is sustained mainly through the shallow aquifers found along the dry riverbeds (*tog or wadis*) across the country. Fertile flood plains and continuous recharge from the Juba and Shabelle Rivers, both originating from Ethiopian highlands, also provide sustained development growth along the riverine areas.

ECOSYSTEMS

104. Somalia's environmental complement, especially the vegetation resources, offers contrasting experiences, and this is due to the spatial and temporal precipitation distributions. There are four main eco-regions in Somalia, whose distribution is determined by the spatial and temporal distribution of the two annual rainfall seasons:

- The dominant xeric grasslands and shrub-lands (accounting for 74 percent of the country's landmass),
- Somali montane xeric woodlands (14 percent),
- East African mangroves (11 percent), and
- coastal forest mosaic (11 percent).

105. Farms in the south-central region, urban centres and other settlements account for the remaining 1 percent of dry landmass.

106. **South West State.** This State, which forms part of the larger south-central and southwestern ecosystem of the country, is characterized by large swathes of grasslands, scattered farmlands, and are home to the two main river systems in the country (Jubba and Shebelle). The soils are best described as poorly drained clayey soils with high salt content. Well-watered and covering administratively the most arable portions of the country, the state is home to rich pasturage and features semiarid savannah grasslands, open woodlands, and thickets that include frequently abundant underlying grasses. Vulnerable groups in this State include the Somali Bantu community, which relies on small-scale irrigated agriculture on the banks of the two main river systems for their livelihoods. The Somalia health project will not be implemented where such groups or their assets or resources are present.

107. **Puntland.** Puntland's ecological characteristics are underlined by broken mountain terrain, shallow plateau valleys and usually dry watercourses known locally as the Ogo. The region is also characterised by generally high temperatures ranging between 25°C (in the Sool and Sanaag regions) and >35°C in the northern coastal regions (e.g. Bossaso), with the hottest temperatures recorded between July and September. In this region, the arid climate means that all rivers are ephemeral and flashy, with water flowing for only a few hours to days after rainfall events. There are no river gauging stations in these rivers.

108. The high plateaus of northern Somalia are comprised mainly of low formations of arid scrublands and scattered grass clumps crossed by broad, shallow and generally dry watercourses. These watercourses have water for short periods during rainy seasons and are thus able to provide short-term fodder (usually no more than 5 to 6 months in a year) for transhumant livestock populations.

109. In Puntland, an important ecological feature, is the long and broad Nugaal Valley, with its network of extensive and intermittent seasonal watercourses that collect runoff from the periodic and erratically low rainfall. There are large herds of small stock (sheep – sheep and goats) belonging to nomadic pastoralists who eke out a living in this marginal land. Productivity in this region is hobbled by not only precipitation challenges but also by the high prevailing temperatures.

110. With increase in elevation and rainfall in the mountain ranges of the north-western Puntland, the vegetation becomes denser and includes aloes, woodlands, and remnants of juniper forests and candelabra euphorbia. The area receives the highest rainfall in the whole of Somalia. The fauna and flora of the habitat are relatively stable due to low human encroachment thanks to the distant escarpments and plateau areas though hunting larger animals have reduced their population. Strict endemic reptiles of the area include the *spalerosophis* and *Leptotyphlops* snakes and the *pseudereimias* lizard. The Somali Pigeon and thrush are found in this area. The gazelles are more widely distributed than other mammals but suffer from over-hunting and overgrazing of the livestock.

111. Important to note too that in this fragile ecosystem, *Boswellia* and *commiphora* trees are sources, respectively, of frankincense and myrrh, production of which Somalia (and Puntland) has been renowned for since ancient times. However, vegetation in large parts of the northern coastal plains is denuded: thus, large areas are almost bereft of vegetation even in the best of times, due to inappropriate land uses, including extensive production of unregulated charcoal.

SOCIO-ECONOMIC ENVIRONMENT

112. **Geography, landmass and population.** Population numbers are difficult to come by. Somalia, with a landmass of about 627,340 km², has a population estimated to be 15,294,151⁴⁴. Estimates show that, out of the total population, 4,968,526 people in 2018 are living in urban centers. This accounts for a relatively highly urbanized society (standing at ~33 percent). The population density in Somalia is estimated at 24 persons per km², one of the lowest in East Africa.

113. The median age in Somalia is estimated to be 16.6 years. The population’s livelihoods are connected to either livestock husbandry, smallholder dryland agriculture, itinerant commerce or remittances from diaspora. Somalia is reportedly the world’s fourth-most remittance dependent country, which makes up about 20-50 percent of local economy⁴⁵.

114. The United Nations Population Fund (formerly the United Nations Fund for Population Activities) estimated that in 2014⁴⁶ the total population of Somalia was 11,800,833, which was broken down to 1,830,073 for Puntland, 508,180 for Somaliland and 6,462,580 for the rest of Somalia.

115. **Poverty in Somalia.** The United Nations classifies Somalia as a least developed country. The socio-economic situation of the country is described as “very poor” in the National Development Plan

⁴⁴ These estimates are based on information from <http://www.worldometers.info/world-population/somalia-population/>

⁴⁵ See https://en.wikipedia.org/wiki/Economy_of_Somalia

⁴⁶ UNFPA Population Estimates Survey of Somalia 2014

(2017-2019)⁴⁷, with approximately 69 percent of Somalis reportedly living below the poverty line. Poverty cuts across sectors, location, group and gender, and its forms and causes vary. An understanding of Somalia's geography, recent trends in its economy and consequences of the civil strife is important to determining the nature and extent of its poverty. There is more stability in the northern regions (Somaliland and Puntland), and consequently less poverty. Poverty in Somalia is more pronounced in the IDP camps, where it is estimated to be 88 percent, followed by rural areas with 75 percent and urban areas with 67 percent.

116. Agriculture, livestock and livelihoods. Only about 10 percent of Somalia's land can be described as arable and suitable for crop production. Somalia's agricultural sector, which accounts for 65 percent of the GDP and employs 45 percent of the active workforce (Somalia Agriculture Report, 2018), relies on the state of health of the country's natural capital (vegetation and water resources). It is worth noting that the livestock sub-sector alone accounts for between 80 to 90 percent of agricultural GDP and contributes about US\$2.4 billion (or about 40 percent of total GDP) and more than 90 percent of export earnings (ibid) and grows 6 percent annually.

117. According to the Somalia Agriculture Report (2018), total agricultural exports have climbed every year since the late 2000s, to a peak in 2015 of \$634 million, more than five times the value before the civil war. The Somalia Supply and Market Outlook Assessment report by FEWSN (2017) identifies the country's four main staple foods as maize, sorghum, rice, and wheat. While maize and sorghum are grown locally, rice and wheat are almost entirely imported.

118. Women make up 57 percent of the workforce in agriculture and pastoralism (both of which constitute nearly 70 percent of the local economy). The number of women working in government departments and agencies in Somalia is estimated at just 19 percent of the workforce. The situation is also dire in the education sector, where only 36 percent of pupils in the upper primary education are girls. Gender disparity is higher in upper grades due to economic constraints and early marriage.

119. In Somalia, the women are significantly involved in trading and commerce, from micro-enterprises to large-scale businesses. While the women butcher and sell small ruminants (goat and sheep), they however make up most of the fruits and vegetables vendors. The women are also engaged in the sale of local imported goods (e.g., rice, sugar, wheat, sorghum, etc.). The project will likely make a positive impact for women in the rural areas and smallholder farmers in terms of improving their health prospects (medical care, ante- and post-natal care, etc.). Environmental and social risks mitigation should also ensure women's needs are addressed.

120. **Health Sector.** The country currently has some of the lowest health and well-being indicators globally. Extended periods of conflict and insecurity, exacerbated by recurrent extreme droughts and floods and subsequent food insecurity, have devastated the health status of the population and severely damaged its fragile health system. Droughts result in displacements, which have led to unprecedented levels of malnutrition, health emergencies and epidemics. A large proportion of the population is prone to a wide range of natural and human-induced disasters due to Somalia's geography and setting.

⁴⁷ See <http://extwprlegs1.fao.org/docs/pdf/som169866.pdf> for a copy of the Plan –

121. The country's overall morbidity and mortality remain very high, particularly women and children. Somalia currently has the world's highest child mortality rate. One out of seven children die before the age of five. Somali mothers experience the sixth highest maternal death risk in the world, with skilled health personnel attending only one in 10 births. The average Somali woman has 6.7 children, the fourth highest fertility rate in the world. Despite the immense challenges, the country's health sector is emerging from the crises and is forging a path forward. The country is re-establishing health governance structures, rebuilding health institutions, re-engaging with development partners, and adopting a decentralized health governance system through MOH at the federal and member state levels.

122. Health service utilization is low, particularly in the public sector, it is estimated at 0.23 outpatient visits per person per year and 0.81 hospital discharges per one hundred people per year (SARA, 2016). Clan structures are believed to have a major impact on service utilization, dictating which facilities people visit. Traditional medicine and health seeking within families and outside of formal medicine are believed to be common, especially in rural areas where formal healthcare is absent or hard-to-access. In urban or semi-urban areas, patients seem to prefer private facilities over public facilities based on perceived higher quality, pharmaceutical availability, and easier access. Pharmacies are by far the most accessible health care delivery points in Somalia.

123. Socio-cultural factors play a significant role in the health seeking behaviors and status of women in Somalia. Responsibility for decisions related to health seeking, such as when to get treatment at a clinic, resides primarily with men and contributes to care seeking delays. According to the 2019 SHDS, 42 percent of women report needing permission to access services as a barrier to healthcare during pregnancy. Further, early marriage is prevalent and a significant contributor to early first pregnancies, high fertility rates and the high maternal mortality ratio. The high prevalence of female genital mutilation/circumcision (FGM/C) in the country contributes to early marriages and poor health among women of child bearing age. About 36 percent of women between 20 and 24 years old were married before 18 years of age, and average age at first marriage is 20 for women and 23 for men. Women, especially pregnant women and those in rural areas, find it difficult to access proper healthcare due to its absence in the areas they live in and/or due to poor infrastructure.

124. Patients seem to prefer private over public facilities based on perceived higher quality, proper management of the facilities, pharmaceutical availability, and easier access. Others prefer to seek medical assistance in NGO-run health facilities where the services are according to many satisfactory. In most areas, health facilities are owned and run by private companies while some have been established and run international and local NGOs with donor funding. Most government owned health facilities, such as hospitals, are run by NGOs due to the government's lack of capacity to manage. Pharmacies are by far the most accessible healthcare delivery points in Somalia due to easy dispensation of consultations and medicines.

125. **Gender and equality.** UNDP Somalia reports that Somalia has one of the highest gender inequalities in the world, at 0.776, which ranks fourth in the world. Gender segregation is deeply rooted in traditional Somali socio-cultural structures and remains a formidable barrier to women's participation in decision-making processes and access to – and control of – resources. Gender-related disparities remain an area of major concern, especially in the fields of education and health. More boys than girls are enrolled in primary, secondary and tertiary education. Moreover, there is a higher dropout rate for girls due to lack of

resources and the prioritization of education for boys. Reproductive health indicators are poor, with a maternal mortality ratio of 829 deaths per 100,000 live births and a high fertility rate of 6.9 (as of 2018).

126. Despite recent successes, the representation of women in political positions, such as parliament remains low. Efforts to codify a gender quota in electoral legislation has been unsuccessful. As result of the collapse of the State and the subsequent decades of conflict, women have been vulnerable to physical insecurity in the form of GBV such as rape and domestic violence. While these behaviors are still taboo, the combination of high rates of male unemployment and khat addictions have contributed to increased instances of these forms of violence against women. Women have become primary breadwinners in many households, yet they are still predominant in the small and petty trade sectors. In the Somalia civil service, women make up only 25 percent of the federal workforce.

127. Female Genital Mutilation/Cutting (FGM/C) is a deeply entrenched, near universal, cultural practice in Somalia. Ninety-nine percent of women between the ages of 15-49 have undergone FGM/C according to the 2019 SHDS. The survey also found that 72% of women aged between 15 and 49 years believe that FGM/C is a religious obligation and 76 percent would like it to continue. FGM/C contributes to obstetric complications such as obstructed labour, obstetric fistula and infections, which dramatically impact maternal health in Somalia. FGM/C violates the rights of women and girls, and the prevalence of FGM/C is compounded by socio-cultural barriers to reporting GBV and few quality GBV response services. Behavior change is challenging and will require in-depth understanding of the socio-cultural context and past experiences of individuals and communities, to develop effective and innovative ways to work with opinion influencers including religious and traditional leaders, female role models and traditional circumcisers and TBAs.

128. Somalia's maternal mortality ratio (829/100,000) is among the highest in the world but is lower than some comparable fragile countries. Only 24 percent of women receive four antenatal care (ANC) visits and 31 percent receive a first ANC visit. Thirty-two percent of births are attended by skilled birth attendants (SBA), which is notably higher than births at a health facility (21%), in a context where there are cultural preferences and geographic constraints that increase home births. Only 10.5 percent of women and 9.5 percent of newborns receive post-natal care (PNC). Forty-two percent of women described permission from their male partners to access services as a barrier to service access. Thus, community engagement and outreach activities should include efforts to engage men in the health activities.

129. Somalia's total fertility rate (TFR), at 6.9 births per woman, is higher than a range of comparable countries. There is no comparable past data, however the TFR appears stagnant at a high level. The adolescent birth rate is also high, at 140 births per 1,000 women aged 15-19, and by the age of 19, 39 percent of women have had a child, which is higher than comparable countries. The contraceptive prevalence rate (CPR) is the lowest among comparable countries, with only 1 percent of currently married women using modern contraceptives. The contracting partners will develop a community outreach strategy to raise awareness on the EPHS services and encourage uptake. This effort will build on past experiences and innovative approaches to behavioral change, given the socio-cultural context of the target communities.

130. **Employment of female health workers.** Recruitment of health professionals can be influenced by nepotism, clannism and elitism, thus leading to employment of unqualified medical professionals and endangering the lives of the communities. Further, female health workers may be excluded from

employment due to their gender and cultural beliefs about female health providers. According to the stakeholders, these practices can be overcome by putting strict recruitment policies in place within the LMP, establishing an accountability mechanism (e.g. posting the names of the applicants in newspapers or outside key government offices) and setting aside a quota for female health workers and ensuring that they are employed and deployed.

131. **Disadvantaged and vulnerable groups.** Disadvantaged groups, such as minority groups, nomadic pastoralists, IDPs, female headed households, and PWDs experience different social and economic barriers to accessing health services.

132. Minorities in Somalia can be considered to be those who fall outside the four main clans. There are three main groups of minorities occupational groups, coastal communities and bantu groups as briefly described below.

- a) Occupational groups – these communities, including Gabooye, Tumul and Yibir - traditionally fulfilled particular functions that were considered taboo by the main Somali clans. This included leatherworking, pottery, metalworking, hunting and some traditional health practices (including carrying out FGM). These communities are found all over Somalia. They experience extreme daily social discrimination. Inter-marriage between young people from these communities and those from the four main clans is socially unacceptable – with at times tragic consequences such as reprisal actions taken when occasionally such marriages take place.
- b) Coastal communities – these communities include Ashraf, Benadiri, Bajuni, Bravanese, which resulted from migrants from the Arabian Peninsula (but also Italians), who settled and inter-married with Somalis. Once living relatively privileged lives, often in larger coastal urban centres, many of these communities were displaced by conflict (both internally and internationally) and their communities decimated.
- c) Bantu groups – more often found in South Central, these communities may have originally migrated north from the Bantu lands of Central and Eastern Africa. These communities were more likely to earn a living by growing crops – often in the fertile riverine areas of South Central and coexisted with the major Somali clans who lived more by pastoralism with systems of patronage keeping the Bantu groups in a servile and sometime unpaid labourer positions.

133. Minority groups are estimated to represent up to one-third of the population in Somalia, continue to be excluded from political participation, have limited access to justice, are denied multiple rights and are disproportionately affected by natural hazards and conflicts. Women from minorities and/or among IDPs and those with disabilities are particularly affected by multiple violations of their rights, both as women and as members of disadvantaged and vulnerable groups. The marginalization and social segregation of disadvantaged groups is one of the key driving forces of the protracted massive displacement of people and the difficulty to find durable solutions for them.

134. These groups are often discriminated against and/or excluded against in accessing services and recruitment for jobs and typically do not participate effectively in government or other institutions. Consequently, their voices are often not represented in government and other development initiatives.

135. It is notable that nomadic groups, may miss out on community outreach and awareness raising, while services to IDPs are often controlled by gate keepers who may not be willing to ensure their participation. Female headed households may face additional barriers to accessing health services, particularly reproductive health services. Further, the health needs of PWDs may not be prioritized or recognized particularly mental health issues. People with disabilities are often not involved in consultations over planning of health service provision. Their accessibility of health services may be a key barrier, including physical access to buildings, thus ramps and rails should be considered in the construction and/or rehabilitation of facilities. In addition, PWDs' inability to communicate with the health service providers due to lack of interpretation facilities (use of sign language) or materials in forms that they can understand (such as braille) will need to be addressed by the FGS and FMS MoH.

CONSULTATIONS AND GRIEVANCE MECHANISM

CONSULTATIONS

136. The World Bank Environment and Social Standard 10 “Stakeholder Engagement and Information Disclosure”) recognizes the importance of open and transparent engagement between the Borrower and project stakeholders as an essential element of good international practice. Effective stakeholder engagement can improve the environmental and social sustainability of projects, enhance project acceptance, and make a significant contribution to successful project design and implementation. This Standard requires public consultation with relevant stakeholders (potential project beneficiaries, affected groups and local non-governmental organizations (NGOs) about the project environmental/social impacts and take their view into account.

137. The government will implement the SEP to build mutual trust, foster transparent communication with both the project beneficiaries and other stakeholders, and ensure E&S risks are identified and mitigated. Implementing partners will also develop regional specific SEPs as part of their overall ESMPs. In Somalia, consistent and meaningful dialogue with stakeholders is critical to maximize opportunities for the project’s success and to improve the social contract between the government and its citizens. In addition, the SEP can contribute to setting mutual expectations and clarifying the extent of the government’s commitment and resource allocation. The SEP includes a GM to allow for complaints and suggestions to be lodged and responded to in a timely fashion. All stakeholders will be engaged regularly throughout the life of the project, and the SEP updated as needed.

138. The PCIU will use innovative ways of consulting stakeholders and getting feedback on the project while adhering to the restrictions put in place by the government to contain any pandemic or health hazard arising during project implementation. Strategies to be employed include one-to-one interviews through phone and skype for community representatives, CSOs and disadvantaged and vulnerable groups as well as using other platforms such as WhatsApp groups for engaging community representatives and other others such as community meetings while observing social distancing and wearing of masks, and awareness creation through FM radios.

139. In February 2021, a series of virtual individual consultations and a stakeholder workshop were held with a range of stakeholders including government staff and civil society and NGOs working in the health sector under the parent project. The aim of these consultations was to solicit insights on the potential social risks and mitigation measures related to the implementation of the *‘Damal Caafimaad’* parent project. The stakeholder consultation workshops engaged 39 individuals, 6 of whom were women. A list of participants and summaries of these consultations are in Annex 8 and 9. Due to the COVID 19 pandemic, these engagements were done virtually with stakeholders in the project target locations. For the purpose of validating E&S SGs documents of the AF interventions and activities, a virtual consultation with key stakeholders and representatives of the community was held on June 27, 2023. Annex 10 presents more details about participants and feedback.

PROJECT’S GRIEVANCE MECHANISM(GM)

140. The GM is part of the broader process of stakeholder participation, that provides stakeholders a means to have their concerns amicably reported and resolved at the earliest possible time. The mechanism takes into consideration lessons learned in other development projects implemented in the country, as well as the existing traditional practices such as the customary “xeer” system which is the most preferred form of justice for the majority of Somalis.

141. For the ‘Damal Caafimaad’ project (both parent and AF), the FGS MoH will have the responsibility to resolve all issues related to the project in accordance with the laws of FGS and the World Bank ESSs through a clearly defined GM that outlines its process and is available and accessible to all stakeholders. The entry point for all grievances will be with the social specialists at the FGS and FMS levels who will receive grievances by phone, text or email to publicized mobile phone lines and email addresses. The social safeguards specialists will be the focal point initially, but the GM officers will be employed as needed. The social safeguards specialists will acknowledge, log, forward, follow up grievance resolution and inform the complainant of the outcome. The complainant has the right to remain anonymous, in which case the identifying details will not be logged. The FGS social specialist will carry out training of FMS social officers and project officers on complaints’ handling and reporting.

142. A Grievance Committee (GC) has been established at both levels of the Federation (required within 2 months of effectiveness), consisting of the project coordinator, and relevant staff, with the social safeguards specialist acting as the secretary to the meeting and taking minutes and conducting following up the grievance resolution process. The GC meets every two months throughout the project implementation period to review non-urgent appeals and the functioning of the GM. The social safeguards officers are responsible for noting critical trends emerging in the GM process such as an increase/decrease in types of grievances to share with relevant project stakeholders as well as tracking complaints expressed on social media and whether and how these should be addressed e.g., through improved communication and stakeholder engagement. Throughout this process, the social safeguards officers should receive support from the FGS MoH PCIU and relevant project consultants. For serious complaints or those which may pose a risk to the project reputation, the FMS social safeguards officer is expected to immediately inform the FGS safeguards specialist.

Objective and Types of GM

143. The objectives of the GM for ‘Damal Caafimaad’ project are to:

- Provide an effective avenue for aggrieved persons/entities to express their concerns and secure redress for issues/complaints caused by the project activities;
- Promote a mutually constructive relationship among community members, project affected persons, the FGS and FMS MoH and the World Bank;
- Prevent and address community concerns;
- Assist larger processes that create positive social change; and
- Identify early and resolve issues that would lead to judicial proceedings.

144. **Types of grievance:** Complaints may be raised by partners, consultants, contractors, beneficiaries - members of the community where the programme is operating or members of the general public, regarding any aspect of project implementation. Potential complaints may include:

- Fairness of contracting;
- Fraud or corruption issues;
- Inclusion/exclusion;
- Inadequate consultation;
- Social and environmental impacts;
- Payment related complaints;
- Quality of service issues;
- Poor use of funds;
- Workers’ rights;
- GBV/SEAH;
- Forced or child labour; and
- Threats to personal or communal safety.

145. **Note:** A separate GM mechanism will be established to manage GBV-related GM mechanism will be established at the workplaces for labour-related complaints and grievances for project workers – both direct and contracted workers.

Building Awareness on GM

146. The FGS MoH PCIU will initially brief all its staff, and the staff of the line ministries at FMS level, on the GM procedures and formats to be used including the reporting and resolution. A public awareness campaign will be conducted to inform all communities and staff on the mechanism. A one pager will be developed providing details, while a poster and leaflet will be produced for ease of reference. Various mediums will be used including social media and FM radio to reach out to communities at the different project locations, including call-ins with panels including community and government representatives. The radio stations will be strategically selected to reach different groups within project target communities. The GM details will also be published on FGS MoH website indicating a phone number, email address and address for further information. The GM will be represented in simple visual formats as well as in Somali dialects, as needed.

147. The project will aim to address grievances through using the steps shown in Table 8 and indicative timelines.

Table 8: Grievance resolution timelines

No	Steps to address the grievance	Indicative timeline*	Responsibility
1	Receive, register and acknowledge complaint in writing. Serious complaints immediately reported to the PM who will report to the PCIU and the World Bank.	Within two days	SS specialist at FGS level and SS Officer at FMS level supported by PMT
2	Screen and establish the basis of the grievance. Where the complaint cannot be accepted (for example, complaints that are not related to the project), the reason for the rejection should be clearly explained to the complainant and where possible directed to the relevant department.	Within one week	SS specialist at FGS level and SS Officer at FMS level supported by PCIU.
3	Program manager and social specialist to consider ways to address the complaint if required in consultation with the GRC and where appropriate the complainant.	Within one week	Program manager supported by PCIU.
4	Implement the case resolution and feedback to the complainant.	Within 21 days	Program manager with support from GRC.
5	Document the grievance and actions taken and submit the report to PMT.	Within 21 days	SS specialist and GRC supported by PMT
6	Elevation of the case to the government judiciary system, if complainant so wishes.	Anytime	The complainant
* If this timeline cannot be met, the complainant will be informed in writing that the GRC requires additional time.			SS specialist, GRC supported by PMT/consultant

Grievance Management Process

148. Grievance resolution requires localized mechanisms that take into account the specific issues, cultural context, local customs and tradition, and project conditions and scale. The following is the outline of the grievance process to be followed (the structure is illustrated in Figure 3):

- Receive, register and acknowledge complaint (see Annex 5) for a Grievance Registration Form Template;
- Screen and establish the basis of the grievance (e.g. nuisance complaint may be rejected but the reason for the rejection should be clearly explained to the complainant);
- GRC to hear and resolve the complaint;
- Implement the case resolution or the unsatisfied complainant can seek redress at a formal court of justice;
- Elevation of the case to a formal court if complainant is not satisfied with the GRC resolution; and
- Document the experience for future reference.

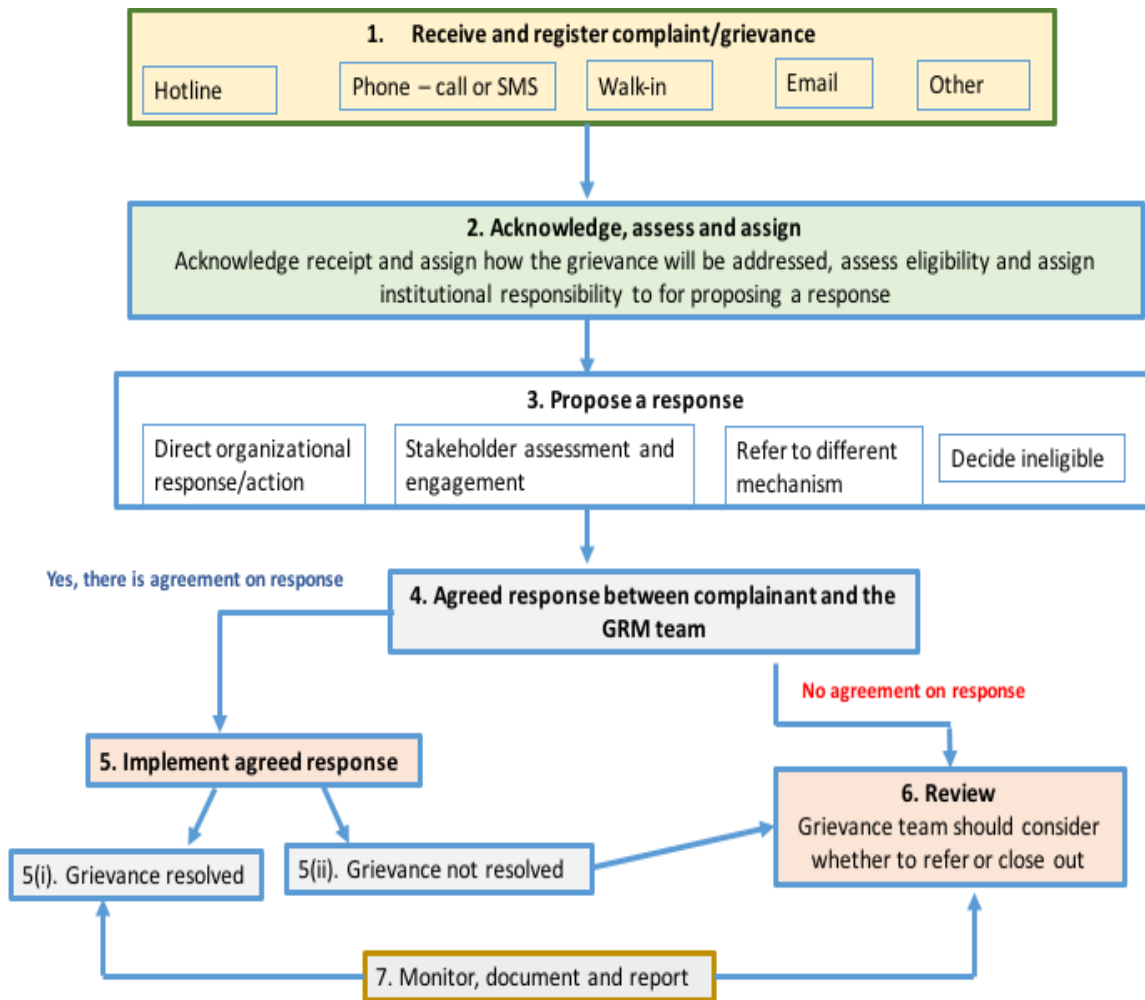


Figure 3: Structure of Grievance Mechanism

GRIEVANCES RELATED TO GBV/SEAH

149. To avoid the risk of stigmatization, exacerbation of the mental/psychological harm and potential reprisal, the GM shall have different channels and protocols to enable a confidential and sensitive approach to GBV related cases that ensures the safety of survivors and enables survivor-centred care.

150. Women, girls and other at-risk groups often have less access to information and available services. They are also more likely to receive inaccurate information, due to existing unequal power structures and/or create opportunities for exploitation. Specifically, targeted information campaigns, radios and other means of communication modalities will be used and will include information on GBV risks related to the project and potential response services (such as hotline numbers and where to seek services).

151. Where such a case is reported to the GM, actions undertaken will ensure confidentiality, safety and survivor-centred care for reporting survivors. Any survivors reporting through the GM should be offered immediate referral to the appropriate service providers based on their preference and with informed consent, such as medical, psychological and legal support, emergency accommodation, and any other necessary services (the project will identify and support the provision of GBV services in the supported States). Data on GBV cases should not be collected through the GM unless operators have been trained on the empathetic, non-judgmental and confidential collection of these complaints. Only the nature of the complaint (what the complainant says in her/his own words), whether the complainant believes the perpetrator was related to the project and additional demographic data, such as age and gender, will be collected and reported, with informed consent from the survivor. If the survivor does not wish to file a formal complaint, referral to available services will still be offered, the preference of the survivor will be recorded, and the case will be considered closed. Recorded cases should be reported to the World Bank project team within 24 hours.

152. In consultation with the FGS MoH and relevant community stakeholders, separate channels and protocols for reporting and addressing allegations of GBV/SEAH will be identified and integrated into the GM. This will include information on disclosure and reporting guidelines/protocol for GBV/SEAH, processes for referral, and accountability and verification processes to manage cases should they arise. The complaints can be presented in person or by letter to:

Corso Somalia Street,
Shangaani District,
Mogadishu, Somalia,
Email: Fmoh.complaints.seah@gmail.com,
Url: <http://moh.gov.so>

WORLD BANK'S GRIEVANCE SERVICE

153. World Bank Somalia Office: If no satisfactory resolution of complaints has been received from the NPIU, complaints can be raised with the World Bank Kenya office on somaliaalert@worldbank.org.

154. World Bank's Grievance Redress Service: Communities and individuals who believe that they are adversely affected by a World Bank supported project may submit complaints to existing project-level GMs or the WB's Grievance Redress Service (GRS). For more information: <http://www.worldbank.org/grs>, email: grievances@worldbank.org or address letters to:

The World Bank
Grievance Redress Service (GRS)
MSN MC 10-1018
1818 H St NW
Washington, DC 20433, USA
Email: grievances@worldbank.org
Fax: +1 – 202 – 614 – 7313

155. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and World Bank's country office has been given an opportunity to respond. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. For information on how to submit complaints to the World Bank Inspection Panel, visit www.inspectionpanel.org.

156. More details on the stakeholder engagement (including consultations conducted for project preparations and GRM) and information disclosure are presented in the SEP for the parent project and for the AF.

POTENTIAL ENVIRONMENTAL & SOCIAL RISKS & IMPACTS AND MANAGEMENT MEASURES

INTRODUCTION

157. This section highlights the generalized E&S risks and impacts along with generalized associated mitigation measures for the expected potentially deleterious E&S risks and impacts linked to proposed project activities including those risks and impacts expected by additionally financed interventions and activities under Components 1 & 3.

158. This section also provides proposed mitigation and management measures proportionate to the level of identified E&S risks and impacts. These management measures are based mainly on requirements of WB’s ESF, WBG’s EHSGs (incl. GIIP), and pertinent local laws and regulations, such as National Environmental Policy and Labour Code. Additionally, this Section outlines means of monitoring and responsibilities thereof, throughout life cycle of the Project, as well as key steps for screening sub-projects envisaged under parent and AF components against possible high E&S risks and impacts.

159. The E&S mitigation and management measures provided are also expected to lay the ground for preparation of other specialized Safeguards instruments, such as SEP, GBV Action Plan, LMP, as well as preparation of Environmental and Social Management Plans (ESMPs) for applicable sub-project activities (inclusive of AF interventions and activities).

160. Adding to previous consultations held for the parent Project’s components, the PCIU has conducted a follow-on consultation on June 27, 2023, and collected feedback on possible E&S risks and impacts brought about by additionally financed sub-components of 1&3. Consultations also aimed to present updated E&S SGs instrument prior to clearance and disclosure, after which the AF interventions and activities, in particular, are to take off.

ENVIRONMENTAL RISKS AND IMPACTS

161. Assessment of risks for the *Damal Caafimaad*-financed subprojects will be determined according to their environmental risk level.

162. The risk level is to be estimated based on the intrinsic environmental risks associated with:

- The type of intervention to be carried out (e.g., the extent of the proposed small-scale expansion of health facilities, associated solid and liquid waste infrastructure, etc.), and
- Other specific type of infrastructure investments proposed, if any, for the project.

163. The environmental risk is classified as “substantial” under ESF, mainly because of the risks linked to the management of biomedical waste, and because of the risks linked to small scale renovation of health facilities. Other potentially significant risks and impacts that contribute to this classification include wastewater disposal problems, indoor air quality issues, and worker and community health and safety exposure. The proposed AF interventions and activities would also result in harmful releases to air, soil, and water. In addition, health and safety risks also need to be taken into account given the limited capacity of the PCIU and the PMTs on these issues.

164. **Resource consumption, pollution, and waste generation.** The main environmental impacts of health activities supported under this project will come during the rehabilitation and operational phases of the project from the possible heavy consumption of energy and water resources, pollution, possible greenhouse gas emissions, use and disposal of toxic chemicals, and generation of hazardous and non-hazardous wastes and wastewater and their disposal. The project activities with environmental risks proposed under the project include construction activities, such as possible small-scale rehabilitation and/or refurbishment of health centres, as well as lifecycle infection control and the possible use of designated waste disposal pits or medical incinerators (especially in large urban centres) or other waste management facilities for medical waste disposal.

165. Generally, there are no waste management and disposal systems in public health facilities in Somalia. As a result, improper disposal of bio-medical waste by health centres, hospitals, primary health centres, community health centres and diagnostic centres pose a health hazard to the general public. Therefore, medical and hazardous waste disposal outside of these facilities will need to be included in the bid package to be announced at project implementation. In addition, findings from the EHS audits should be made available to bidders in order to generate ideas for the management of these wastes.

166. The project activities will produce medical and hazardous waste, such as mercury-containing items (thermometers) contaminate the environment; ash residue, which, if not properly disposed of, can contaminate groundwater at unlined waste disposal pits. On the other hand, significant amounts of pathologic waste with high moisture content requires significant energy to combust properly etc. Due diligence will be carried out by the PCIU at contracting stage to ensure that the siting, design and operation of waste management pits do not exacerbate environmental risks and impacts, however it is anticipated that they will be outside existing health facilities.

167. The use of medical waste incinerators requires trained operators, monitoring of waste segregation, appropriate waste transportation to site, and ash residue disposal. There are few trained operators in the country, and there is limited experience generally with modern medical waste management systems. The project's PCIU will support the health facilities in designing and establishing SOPs based on WHO and WB standards, including WB ESHS guidelines.

168. **Environmental risks and impacts by AF components.** Interventions and activities of Additionally Financed sub-components may result in harmful releases to air, soil, and water. This is specifically expected through transport and installation of solar power and climate friendly cold chain equipment (under component 1). Of special concern is the accidental release of refrigerants from Solar Direct Drive (SDD) refrigerators and appliances, and breakage of hazardous materials contained in solar power equipment. Transporting, installing, operating and dismantling of solar power and cold chain equipment may encounter accidental release of hazardous materials, which if occurred, may lead to contaminating the surrounding physical and biological environments. Also, there is risk of contamination by means of improper dismantling and disposal of obsolete kerosene-operated cooling and power generating equipment and decommissioning aged cold storage facilities, targeted by “enhancing policy and regulatory environment” of AF/component 3.

169. While there are no global warming emissions associated with the deployment of solar technology in support of cooling needs for hospitals, there are emissions associated with other stages of the solar life cycle, including manufacturing, materials transportation, installation, maintenance, decommissioning and dismantling. There are positive outcomes though, associated with changing from the use of kerosene to solar powered refrigerators, in particular reductions in greenhouse gas (GHG) emissions. The Table 9 below summarizes environmental related risks and impacts of parent Project AF1 and AF2.

170. The interventions and activities introduced under the AF2 for Family Planning (FP) services are considered moderate in environmental risk. The potential risks primarily arise from the generation, handling, and disposal of healthcare waste associated with FP service delivery (such as sharps, used syringes, blood-contaminated materials, and expired or damaged pharmaceutical commodities (including contraceptives and related supplies)). If not properly segregated, stored, transported, and disposed of, these wastes may contaminate soil and water sources or expose health workers and the public to infections. Minor refurbishment works in FP rooms and storage areas may also cause short-term impacts such as dust, noise, and occupational hazards for workers. The risks are site-specific, limited in scale, and can be mitigated through implementation of good international industry practices (GIIPs), including strict adherence to infection prevention and control (IPC) protocols, health-care waste management procedures, use of personal protective equipment (PPE), and provision of appropriate waste treatment facilities such as incinerators and placenta pits. The social and environmental measures proposed in this updated ESMF including those developed after the stakeholder consultation meetings held on 17–18 June 2025 adequately address these risks and ensure compliance with the World Bank Environmental and Social Standards (ESS1, ESS2, ESS3, and ESS4).

Table 9: Project components and envisaged environmental risks and impacts

Component	Project activities	Environmental risks
<p><i>Component 1 - Expanding the coverage of a prioritized EPHS in selected geographic areas</i></p>	<p><u>Child health services; maternal and neonatal health services</u> including testing and interventions during ANC visits;</p> <p><u>disease surveillance</u> (strengthening and maintaining disease surveillance and response as well as preparedness and response to disease outbreaks;</p> <p>Procurement of drugs, incl. contraceptives, and other specialized medical equipment, basic facility refurbishment, medical supplements, vaccines, testing kits, etc.</p> <p>Provision of climate friendly cold chain equipment, specifically purchases of Solar Direct Drive (SDD) refrigerators along with equipment for solar power generation and cooling for selected PHUs and health centers.</p>	<p>Medical wastes, other wastes (pathological, hazardous, expired drugs, etc.), release of e-waste and hazardous materials.</p> <p>Pollution risks – soil, air, water</p> <p>GHG emissions</p> <p>Outbreaks of infectious diseases</p> <p>Generation of pharmaceutical waste and expired commodities.</p> <p>Risk of soil/water contamination from improper disposal.</p>

Component	Project activities	Environmental risks
	<p>Procurement, storage, and distribution of FP commodities (contraceptives, injectables, implants, IUD kits, condoms).</p> <p>Provision of FP clinical services (insertion and removal of implants and IUDs)</p> <p>Community outreach and mobile FP service delivery</p>	<p>Storage temperature failure causing product spoilage and waste.</p> <p>Sharps and infectious waste, infection risk from poor sterilization of instruments.</p> <p>Increased risk of occupational incidents particularly for remote areas.</p>
<p><i>Component 2 - Strengthening government's stewardship to enhance service delivery</i></p>	<p>Capacity enhancement activities, contract management, regulatory reforms</p> <p>Capacity-building and training of FP service providers on infection prevention, HCWM, and OHS</p>	<p>Occupational health and safety risks for contracted workers, including healthcare staff</p> <p>Training-related generation of sample waste (used materials).</p> <p>Risk of non-compliance with HCWM protocols if training not institutionalized</p>
<p><i>Component 3 - Project management, M&E, knowledge management, and learning</i></p>	<p>Day-to-day project management including coordination, administration, communication, management, procurement, M&E, and dissemination of project activities at both FGS and FMS levels</p> <p>Technical assistance to improve the policy environment for climate friendly cold chain and power/ disposal of obsolete cold chain equipment, such as kerosene powered cold chain equipment, and systems to ensure continuous maintenance and security for SDDs and solar power systems</p> <p>Environmental and social supervision, data collection, and monitoring of FP services</p>	<p>Benign</p> <p>Improper disposal of hazardous material to the physical and biological environment by means of dismantling and decommissioning obsolete Kerosene-operated equipment</p> <p>Possible under reporting of OHS or waste-related incidents.</p>

171. **Environment, Health and Safety audits.** The PMT will conduct a full EHS audit of each existing HCF facility under their jurisdiction and supply the results of the audit to prospective contractors. This will be important for the bidders and prospective contractors to properly understand the existing HCF conditions (including all existing EHS liabilities). With the benefit of this audit and their own understanding, bidders

can properly and adequately include in their bids (both technical measures and their implementation costs) all needed EHS measures (including medical waste management, water supply, wastewater management, indoor air quality, hazardous materials management, waste management, requirements related to ESS4 and healthcare infrastructure and equipment design and safety of services). This EHS audits will cover both construction but more importantly the HCFs’ operational phase (inclusive of operations of solar power and cold chain equipment under AF). In addition, subsequent EHS audits, post HCF contracting, will serve other functions, including:

- helping to identify and correct compliance issues, which can improve workplace safety and help to reduce facility and personal liability at the HCFs;
- serve as an educational tool for the benefit of regulators working with the Ministry of Health in the Somali government, and can be used as a standard even beyond the life of this project;
- increase awareness and understanding of environmental and safety regulations, including the ICWMP and the World Bank’s ESF and EHS Guidelines; and
- be an opportunity to demonstrate the facilities’ commitment to compliance.

172. Prevention of infectious disease transmission will complement other World Bank supported projects, including the Somalia Crisis Recovery Project (SCRCP), which includes a Contingent Emergency Response Component (CERC) support for COVID-19 coordination and monitoring, surveillance, contact tracing, risk communication, laboratory support, infection prevention and control, and case management, as well as essential health services to complement the Government’s and other partners’ emergency response efforts. In the medium term, the project will strengthen health preparedness capacity such as Critical Care Units (CCUs) in a few major hospitals nationwide, as well as surveillance and laboratory capacity for pathogen detection (including COVID-19).

SOCIAL RISKS AND IMPACTS

173. It is notable that the Project will cause some negative social impacts that would need to be mitigated. These social impacts are considered to be “substantial” given the fragile context of Somalia and the weak governance institutions, continued insecurity, and conflictual socio-political dynamics that contribute to a myriad of risks. Social-related risk and impacts in this regard may include, but are not limited to: potential exclusion of disadvantaged and vulnerable groups from project benefits and elite capture; potential risks of increased social tension in the community (for example, on types or how services are delivered, or siting of services); as well as contextual risks of operating in a conflict zone and a complex social context where effective and inclusive community consultations, stakeholder engagement, and community participation and safety of staff are challenging.

174. **Conflict and security risks for project workers, patients and the community.** Potential security risks include: targeting of health workers, facility users and project staff by parties involved in the conflict; risks to health workers and other project staff due to conflict; and inability to access project areas for both providers and users, due to conflict; (iv) labour risks, including OHS risks, sexual exploitation and abuse (SEA), sexual harassment (SH), and other forms of gender-based violence (GBV) that may occur in recruitment or retention of skilled or unskilled female workers and the delivery of services; (v)

175. **Labour disputes over terms and conditions of employment.** Like any other project, labour-related disputes are possible in the “Damal Caafimaad” project. According to the stakeholder interviews, labour-related disputes may emerge between health professionals (and consultants) and the MoH (or contracted agencies) over labour wages, working hours, payment delays, health and safety concerns in the work environment and working conditions. In turn, there is also a risk that employers may retaliate against workers for demanding legitimate working conditions, or raising concerns regarding unsafe or unhealthy work situations, or any grievances raised. Such situations could degenerate into labour unrest and resultant disruptions in service provision and damage to project property.

176. **Occupational Health and Safety.** As the Project is planned to have limited refurbishment of HCFs/PHUs, it is expected that associated civil works would result in a variety of Occupational Health and Safety (OHS) related impacts. These include specific healthcare occupational risks, moving equipment and heavy machines, noise, vibration, welding, chemical hazard, working environment temperature, working at height (using ladders), slips trips and falls, electrocution of the workers/staff, and exposure to air pollution hazards, including elevated dust levels and potential exposure to building hazards such as asbestos containing materials (if there are any existing structures to be removed), lead based paint, potential safety and health risks due to manmade fires or natural disasters, and hygiene in worker camps during civil works. Project workers are also expected to get risk of various injuries while dismantling/ disposing obsolete Kerosene-powered cold chain equipment. These shall be managed with reference to the World Bank’s EHS General Guideline. The primary risk to worker safety is health-related due to the potential for exposure to highly infectious diseases such as Covid-19 and HIV/AIDS, and other communicable diseases, as well as security risks in the workplace or for workers as they travel to carry out their work. Lack of personal protective equipment (PPE) and safe workplace practices may put the workers at risk. In addition, physical structures from which workers provide services to the community may not cater for females, which may limit their functionality and accessibility of services for women.

177. **Child labour and forced labour.** Somalia is within top 10 countries of the world with highest child labour risks. Close to 40 percent of all children under 15 of age are put to work in Somalia, where they engage in the worst forms of child labour, according to the UNHCR. Although child and forced labour risks are less likely as the project will recruit skilled field staff with post-secondary school academic qualifications, children may be used in rehabilitation works or to provide security.

178. **AF sub-components.** AF interventions and activities of the project will include installation, operation, maintenance, and decommissioning of solar power generating equipment, as well as climate friendly cold chain equipment/ SDD refrigerators. In addition to the above aforementioned labour related risks and impacts, these interventions could pose specific OHS risks and impacts on suppliers’ workers during transport and installation, and similarly on PHU workers during operation. These would include, but are not limited to, physical injuries, electrical shocks, and exposure to refrigerants. Forced labor within the solar supply chain. This will be managed through contract documents with specific clauses on forced labor. Under Component 1 of the Additional Financing for the World Bank financed COVID-19 Emergency Vaccination Project (P178886) being implemented in Somalia, UNICEF has been contracted to install solar powered cold chain equipment. Also, under the parent project UNICEF will be contracted for the purpose of supplying and installing solar powered cold chain equipment. The contract with UNICEF is also expected to include hands-on training that will basically target the technical teams at selected HCFs on installing operating and dismantling solar powered cold chain equipment and SDD refrigerators. This AF will benefit

from these arrangements. The FGS and FMS will therefore benefit from the experience and capacity in place in UNICEF to conduct the required due diligence and put in place risk mitigation measures for forced labour related risks that is expected during supplying and installing solar-power cold chain equipment.

179. It is important that the social risks are adequately identified and managed by applying due diligence into the Project cycle. This ESMF provides a robust guidance on how to identify and manage the social risks, particularly via genuine and inclusive stakeholder consultations and feedback. Management measures related to EHS will basically be drawn from WBG’s general and HCF-specific Environment, Health and Safety Guidelines (EHSGs). Further details on labour related risks and impacts and specific management measures are discussed in Project’s LMP, and updated for AF.

180. **Stakeholder engagement.** The stakeholder engagement risk is also rated substantial. The current context in Somalia, characterized by lack of trust between key groups in society, and accompanying high levels of contestation and violence, presents a high risk for the Project in relation to the stakeholder environment. There may also be contestation on the types of services to be provided by the project including child spacing that could be opposed on religious and cultural grounds. Fragmented donor support in the health sector also contributes to intensifying such political divisions within the Government. For this reason, the selection of the project target areas and subsequent project funds allocation may be highly contentious and lead to a backlash from some FMS. Key mitigation measures will include: strong involvement of both FGS and FMS authorities throughout project preparation; effectively using the GFF-supported country platform for improved coordination among stakeholders and; closely engaging with Office of the Prime Minister (OPM) in addition to the MoH, to better manage FGS-FMS relationships. Moreover, the project’s GM will help manage grievances from communities and enhance feedback.

181. **Grievance Mechanism.** Developing effective and trusted GMs is complicated by difficulties in accessing rural areas and the collective nature of traditional complaints handling processes. This ESMF has provided more insight to the Project’s GM in section 5.2. in line with requirements of WB’s ESS10 on Stakeholder Engagement and Information Disclosure.

182. **Capacity challenges.** Lastly, the service providers’ implementation capacity in complying with E&S safeguards guidelines may be varied from one organization to another. The contractor selection process will require bidders to demonstrate their capacity in implementing E&S safeguard measures. In addition, the Project’s PCIU includes a full-time Environmental and another full-time Social Safeguard consultant at federal level, and a full-time Social and GBV consultant at the PMT. Experience with ESF is low and during implementation of the parent and AF project capacity building will be undertaken as detailed in the ESCP. The following Table 10 summarizes social risks and impacts of both parent Project and AF.

Table 10: Social risks and impacts associated with Project components (parent & AF)

All the project components (all project activities)	
Conflict and Security Risks	<ul style="list-style-type: none"> Though the country has made tremendous progress towards improving security, insecurity remains an issue of concern in some parts of the country. Deteriorating security conditions in the project locations may hinder access and the ability to

ESMF – Improving Healthcare Services in Somalia (P172031) and the AF (P178876)

	<p>implement activities and also affect the security and well-being of workers and communities.</p> <ul style="list-style-type: none"> • During the implementation of all project activities, Al Shabaab attacks or flare-ups of clan conflict in the project locations are particularly likely in Hirshabelle and Southwest states. Due to insecurity in these areas, government workers, staff and communities are vulnerable to security threats. However, security threats are minimal in Puntland’s project locations.
<p>Exclusion and Selection Bias</p>	<ul style="list-style-type: none"> • Recruitment of project staff, health professionals and consultants can be influenced by nepotism, clannism, corruption and elitism where women, people from minority groups, IDP groups, and PWDs are excluded, particularly at higher levels. • Elite capture of project benefits, especially recruitment and contracts for supplies and of private healthcare providers is possible. • Access to health facilities, once established and running, may be hindered due to clannism and other barriers (e.g. religious and cultural factors).
<p>Sexual Exploitation Abuse and/or Harassment (SEAH)</p>	<ul style="list-style-type: none"> • Female healthcare workers (whether civil servants or consultants) may be subject to GBV/SEAH in the recruitment or retention process since men dominate the hiring processes in most government and NGO offices. • Women may also be excluded from employment due to clan dynamics specially if they are married to a clan that is not dominant in the project area or if they are from minority groups. There is an acute lack of integrated policies providing a protective environment free from GBV/SEAH. • Women and girls from the community may be subjected to GBV/SEAH if they seek services from the health facilities.
<p>Implementation of labour policies</p>	<ul style="list-style-type: none"> • The LMP will reinforce the need to implement policies and comply with ESS2 for project workers. • There may be discrimination in the workplace based on minority groups, IDP status, disability and gender considerations. • Women are often discriminated against as health workers and only widely engaged at the community level. • While official government policy is to allow for female employees to take maternity leave and have access to time off for breastfeeding, women are vulnerable to losing their jobs after pregnancy since these policies are not adhered to fully. • Forced labour associated with the solar supply chain.
<p>Occupational Health and Safety (OHS)</p>	<ul style="list-style-type: none"> • In health facilities, physical structures from which workers provide services to the community may not cater to females, in terms of distance or appropriate facilities including for female workers.

	<ul style="list-style-type: none"> • Health workers may be exposed to infectious diseases such as coronavirus and HIV/AIDS, especially if they are not well trained on prevention and they do not have adequate personal PPE. • There is a risk of GBV/SEAH at the workplace. • During the delivery of an essential package of health and nutrition services in selected areas, health workers and staff may be directly targeted by violence for their affiliation with the government. This a particular threat for those working in areas outside of government control, and where people congregate e.g. health centres or public spaces during meetings.
<p>Socio-cultural beliefs</p>	<ul style="list-style-type: none"> • During the delivery of the essential package of health and nutrition services, socio-cultural beliefs may affect the health-seeking behaviour of some community members. For example, since decision-making at the household is invested in men, there could be delays in seeking medical assistance at health centres for women, particularly for certain medical procedures or by particular groups. • Clan structures and cultural practices are believed to have major impacts on the utilization of formal healthcare services and health practices of individuals and groups. Clan based health seeking behaviour may also limit access. • Most communities in Somalia often prefer traditional medicine (use of herbal medicinal products) due to its perceived value over conventional medicines and cost. This has affected the popularity and the use of conventional medicines in many parts of Somalia, including vaccinations. The predominance of cultural practices e.g. FGM and perception of GBV/SEAH also affects health seeking behaviour. • There could be tension and conflict between the communities and the health system due to opposition to some of the proposed interventions including FP and addressing FGM.
<p>Component 1: Expanding the coverage of a prioritized EPHS in selected geographic areas</p>	
<p>Gender-based Violence (GBV)</p>	<ul style="list-style-type: none"> • Female health workers may face GBV/SEAH during recruitment and delivery of healthcare services, especially when they have to travel to work alone and/or on foot in the evenings or at night to provide health services. • Limited training for key personnel providing services to GBV survivors, cultural perceptions, lack of confidentiality as well as lack of information on who provides what can increase harm, violence, and death. • Due to limited understanding of survivor-centred approaches, reinforcement of community conflict resolution in some cases may cause harm to women and girls including re-victimization, stigma, and marriage to the perpetrator. • The form of health services (e.g. FGM and child spacing) may lead to GBV against the users and providers.

ESMF – Improving Healthcare Services in Somalia (P172031) and the AF (P178876)

<p>Traditional healthcare providers and other sources of healthcare</p>	<ul style="list-style-type: none"> • The focus of support exclusively to formal healthcare may marginalize TBAs who are the primary providers of pre- and post-pregnancy care, as well as other traditional healers who may influence health seeking behaviour of the target populations. • The community health outreach strategies will encourage engagement and collaboration with traditional health providers including encouraging TBAs to refer women for antenatal care.
<p>Ownership of facilities or land or eviction of occupants in leasing of new facilities</p>	<ul style="list-style-type: none"> • The health facility mapping will screen health facilities for any ownership conflicts or possible forced eviction of occupants in case new buildings are leased. In which, case abbreviated resettlement action plans (ARAPs) or government mediated land agreements will be developed.
<p>Disputes over terms and conditions</p>	<ul style="list-style-type: none"> • Disputes may emerge over labour wages, working hours, payment delays, health and safety concerns in the work environment and working conditions. • Retaliation against workers for demanding legitimate working conditions, or raising concerns regarding unsafe or unhealthy work situations. • Such situations could degenerate into labour unrest and resultant disruptions in service provision and damage to project property.
<p>OHS</p>	<ul style="list-style-type: none"> • During refurbishment of HCFs/PHUs and associated civil works though limited, there will be exposure to a variety of workplace hazards, including moving equipment and heavy machines, noise, vibration, welding, chemical hazard, working environment temperature, working at height and safety and hygiene in worker camps, as well as exposure to highly infectious diseases. • During transport, installation, and operation of solar power generating and SDD cold chain equipment there will be additional risks and impacts, including physical injuries, electrical shocks, and exposure to refrigerants.
<p>Child/forced labour</p>	<ul style="list-style-type: none"> • During limited civil works at HCFs/PHUs suppliers and contractors are expected to engage child labour within different types of field works, as this is quite common in the country. • Child/forced labour is also expected during transport and installation of planned solar power and cold chain equipment, including carrying heavy equipment to the site, preparing foundation and/or wiring, among others.
<p>Component 2: Strengthening Government’s stewardship to enhance service delivery</p>	
<p>Investments in institutional capacity building with a significant</p>	<ul style="list-style-type: none"> • The training/capacity building activities may discriminate against low cadre staff, or staff from particular clans, those with disabilities and/or women.

focus on public financial management	
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E&S RISKS SCREENING

183. The environmental risks screening is the first step in the ESMF preparation process. All proposed subprojects (including small-scale refurbishment and other upgrading works at HCFs) will be subjected to the E&S screening process to determine and assign them an E&S risk rating category and further identify potential sensitive environmental and social receptors likely to be negatively impacted. The process will also identify critical issues that might be triggered by the subproject and would need further detailed investigations during E&S assessments. This process will also help in advising what safeguards tools (site-specific ESMPs, LMPs, OHSs, SEPs, SecMPs, etc.) will be required for the various subprojects.

184. In addition, relevant consultant services contracts and studies to be performed under the Project will be assessed for potential EHS aspects, and applicable requirements will be included in the TORs and consultant and study result. This will be reviewed by EHS specialists in PIU and at the FMS level.

185. Most importantly, it will help in re-aligning, re-designing and where not possible dropping out sub-projects that have extreme high risk and the potential to negatively impact on the environment and natural habitats and people’s health. The E&S screening would involve:

- reconnaissance of the subproject areas (including the siting of the medical waste incinerators or waste pits⁴⁸) and their surroundings, as well as understanding characteristics of beneficiary communities, by way of field visits to all the sites;
- identification of the major subproject activities taking place;
- preliminary assessment of the impacts of these activities on the social, ecological, physicochemical and the larger biophysical environment of the subproject surrounding areas;
- periodic environmental health and safety audits (as described in Section 6.1) above. The PIU will use the audits, during the operational phase of the project, to verify and record the effectiveness of prevention and control of exposure to occupational hazards, and maintaining accident and incident investigation reports on file for a period of at least three years, as per the recommendations of the World Bank’s EHS Guidelines.

186. A template form for E&S screening for sub-project activities is presented in Annex 2. This will be reviewed and updated as needed during the process. Key E&S risks identified as crosscutting for the project include OHS risks, community health and safety, and waste management issues. If, for any reason, the PIU encounters substantially more complex E&S risks, an Environmental and Social Impact Assessment (ESIA) is recommended. Annex 16 provides the TORs for such an exercise.

⁴⁸ Final decision on waste disposal type pending

PREPARATION OF E&S ASSESSMENT INSTRUMENTS

187. The project will require the preparation of both environmental and social risk management instruments. An Environmental and Social Commitment Plan (ESCP) has been prepared for the project. The ESCP requires, among other items, compliance with all provisions of the following environmental and social instruments, which have all been prepared, or are under preparation, for this project:

- This ESMF.
- The Stakeholder Engagement Plan (SEP).
- The Labour Management Procedures (LMP).
- The Security Management Framework (SecMF).
- Project and regional security risk assessments and management plans.
- Contractor Environmental and Social Management Plan (C-ESMP), to be developed and implemented by the contractors running the health facilities, and which will be structured to cover social and environmental risks and impacts during both the (minor) construction and operational phases of the healthcare facilities. The C-ESMPs will meet contractual EHS requirements.

188. This ESMF focuses on identifying and characterizing the relevant E&S risks and impacts the project is likely to face, including risks and impacts on physical and biological environments, releases to soil, air, and water, community health and safety, labour issues, social exclusion and gender-based violence risks. The ESMF and associated instruments, including the Labour Management Procedures (LMP) and Security Management Framework (SecMF), will be included in all bidding and other contractor management related documents at project implementation. Other instruments include the

- Infection Control and Waste Management Plan, which is designed to minimize biohazard wastes, collection, treatment, and disposal of laboratory generated wastes and control infection during the operation of the project in identified Federal Member States (FMS).
- HCF Environmental Health and Safety (EHS) audits, a systematic, objective tool to assess regulatory compliance in the healthcare facilities (HCFs), and which will entail a survey of the social context of beneficiary communities, and workplace environment, and examine how far these facilities in Somalia comply with the applicable World Bank and FGS regulations⁴⁹ apply to the facility.
 - The World Bank has already prepared the framework for conducting the EHS audits, and guidelines forwarded to the Somali government for implementation at the healthcare facilities targeted for improvement under the project. The audits will be carried out at the same time as the mapping of healthcare facilities for the project.

⁴⁹ Caveat: where they (FGS regulations) actually exist

- The audits will determine whether the existing management in place and health care workers are adhering to environmental and workplace safety requirements or other corporate policies and procedures regarding compliance.
- The EHS audits can be conducted if there is sufficient technical competence in the PIU: if this is not the case, a competent external EHS inspection team should be appointed and contracted.
- The PIU will also allow potential bidders to visit project supported HCFs and review baseline EHS conditions, and present options to address EHS issues in bids for management of these facilities.

189. Environmental Health and Safety Management Plans (EHSMPs) for each of the HCFs to be upgraded and operated under this project. The EHSMPs would include a more complete list of potential impacts and risks due to HCF operation activities, and an updated list of potential and needed mitigation measures, monitoring and indicators. This will be done when project implementation starts. The standard EHSMP should include ESS requirements, good practice for HCF EHS management, and ICWMP. The standard EHSMP will be used as part of the subproject screening process and can be modified as key issues are identified. The HCF contract bid package will then include the standard EHSMP and key issues which can be used by selected contractors as a base for their development of the C-ESMP.

190. The ESCP also requires compliance with sub-project Environmental and Social Management Plans (ESMPs) which will include a GBV Action Plan, Stakeholder Engagement Plan (SEPs) and Labour Management Plan (LMP), and Security Management Plan, which will be prepared by the contractors for subprojects under the project.

MITIGATION AND MONITORING MEASURES

191. In order to address the aforementioned potentially adverse environmental and social risks and impacts, an E&S screening process has been proposed under this ESMF. This will be applied in such a way as to ensure that potential negative risks and impacts of the project are prevented or mitigated appropriately, and positive impacts are enhanced.

192. To mitigate these risks during project implementation, the PCIU will oversee the inclusion of detailed environmental health and safety (EHS) requirements in subproject bids and contracts. The PIU and FMS-based ES specialists will develop these standard requirements, which then will need to be modified for each subproject specific conditions and issues, based on the results from the screening process. The PIU will require all HCF contractors to prepare and implement a C-ESMP, and report monthly on its implementation status. In addition, the project team will make use of third-party monitoring of contracts including related to EHS performance.

193. Potential social risks are those related to labour and working conditions, such as work-related discrimination, sexual harassment and other forms of GBV, OHS and security risks. To address labour-related risks, a LMP will be prepared and the GBV/SEAH risks will be addressed in a GBV Action Plan contained in Annex 12. The LMP will set out the Project's approach to meeting national requirements as well as the objectives of ESS2 and ESS4 on Community Health and Safety. It will include procedures on incident investigation and reporting, recording and reporting of non-compliance, emergency preparedness

and response procedures and continuous training and awareness to workers. The LMP will include a CoC for project workers who will receive an orientation on the same.

194. Key ESF instruments will be prepared and activated in the life of the project. These are as follows:

- Stakeholder Engagement Plan (SEP), which has set out effective and transparent management of consultation and information disclosure processes: the SEP includes a Grievance Redress Mechanism (GRM) as a key component.
- An Environment and Social Commitment Plan (ESCP), which summarizes the Borrower's commitments and obligations to adopt and implement these measures during project implementation.
- The Labour Management Procedures, which also highlights occupational health and safety risks and procedures for minimising them.
- The Security Management Framework which outlines the security risks and mitigation measures;
- The GBV action Plan.
- This Environmental and Social Management Framework (ESMF), which provides the overall framework for the management of E&S risks and impacts of the project including the Infection Control and Waste Management Plan: the PIU will update the proposed draft ICWMP at implementation, to reflect the specific needs of each project funded healthcare facility. The updated context-relevant ICWMP will cover not only the technical aspects related to waste management such as waste handling, storage, transportation, treatment, and disposal, but also capacity-building and awareness creation.
- HCF Environmental Health and Safety (EHS) audits, which will examine how far the project funded healthcare facilities in Somalia comply with the applicable World Bank and FGS regulations apply to the facility.
- Environmental Health and Safety Management Plans (EHSMPs) for each of the HCF to be upgraded and operated under this project. The EHSMPs would include a more complete list of potential impacts and risks due to HCF operation activities, and an updated list of potential and needed mitigation measures, monitoring and indicators. This will be done when project implementation starts. The standard EHSMP should include ESS requirements, good practice for HCF EHS management, and ICWMP. The standard EHSMP will be used as part of the subproject screening process and can be modified as key issues are identified. The HCF contract bid package will then include the standard EHSMP and key issues which can be used by selected contractors as a base for their development of the Environmental and Social Assessment and Management Plan (ESMP).

195. This section presents the mitigation and monitoring measures proposed for adverse environmental and social risks and impacts anticipated for the Somalia health project, including for interventions and activities under AF. Proportionate to the level of identified E&S risks and impacts, this section has proposed a set of management and monitoring measures based mainly on requirements of WB's ESF, WBG's EHSGs

(incl. GIIP), and pertinent local laws and regulations, such as National Environmental Policy and Labour Code.

196. The PCIU will prepare a more complete list of potential impacts and risks due to the proposed small-scale rehabilitation of HCF, including for AF interventions and activities, and updated list of potential and needed mitigation measures, monitoring and indicators. This is to be prepared prior to the start of project implementation. This updated list will be used as part of the subproject screening process and revised as needed for specific subprojects. This updated version will then be included as standard practice into contract bid packages. If on the other hand the bidding process starts before project effectiveness, the contractors will prepare their sub-project plans (ESAMPs) and update the risks profile for the project.

197. During the operation of healthcare facilities, based on the EHS audits, the contractors will prepare a complete standard EHS Management Plan (EHSMP) for the HCFs. This will include a more complete list of potential impacts and risks due to HCF operation activities, and an updated list of potential and needed mitigation measures, monitoring and indicators.

198. The standard EHSMP will include ESS requirements, good practice for HCF EHS management, and ICWMP. The standard EHSMP will be used as part of the subproject screening process and will be modified as key issues are identified. The HCF contract bid package will then include the standard EHSMP and key issues which can be used by selected contractors as a base for their development of the ESMP. Tables 11 & 12 below present more detailed E&S management and monitoring plans to account for expected environmental and social risks and impacts.

Table 11: Proposed mitigation and monitoring plan for environmental-related risks and impacts

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US\$) ⁵⁰
Construction phase⁵¹						
Noise and vibration during small-scale refurbishment and construction activities + AF solar power and SDD equipment	<ul style="list-style-type: none"> - Notify the public of any activities that may be perceived of as noisy and intrusive prior to starting. - Establish a GRM for the public to contact the engineers-in-charge (i.e., provide telephone number, email, etc.) and the procedures to handle complaints. - Provide hearing protection gears for use by workers when exposed to noise levels above 85 dB(A). - Put in place controls for high noise equipment and/or noise controls for works near sensitive receptors 	<ul style="list-style-type: none"> # complaints received over noise # complaints registered via GRM mechanism # hearing protection and aids provided to workers 	<ul style="list-style-type: none"> Records Field visits Records 	Monthly	<ul style="list-style-type: none"> - Env. specialist of the contractor to implement - Env. specialist of the PMT to monitor - PIU to coordinate implementation - 	<ul style="list-style-type: none"> - Included in contract price - Monitoring cost embedded in operational cost
	<ul style="list-style-type: none"> - Ensure that noise and excessive vibration from construction activities are within permissible levels as per the 					

⁵⁰ The actual costs for the mitigation measures will be established at project effectiveness, and the PMTs will update this section accordingly.

⁵¹ These risks are provisional and may not be exhaustive. The PIU will prepare, prior to implementation of project activities, a more complete list of potential impacts and risks due to the proposed HCF construction activities, and updated list of potential and needed mitigation measures, monitoring and indicators. This will be prepared prior to the start of project implementation. This updated list will be used as part of the subproject screening process and revised as needed for specific subprojects. This updated version will then be included as standard practice into contract bid packages.

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US\$) ⁵⁰
	<p>provisions of World Bank’s OHS guidelines: this includes among others adhering to permissible noise and vibration level.</p> <ul style="list-style-type: none"> - Use modern construction equipment, which produces less noise; and - Use of noise shielding screens should be used and the operation of such machinery restricted to when actually required 					
Airborne emissions + AF solar power and SDD equipment	<ul style="list-style-type: none"> - Motorised equipment be maintained in good operating condition to reduce exhaust emissions; - Handling of solar power equipment and SDD refrigerators should be done in great care and only performed by experienced hands. Ensure full packaging during transport and unloading. Store in clean areas, free of sharp edge/hard objects, with enough spacing and ventilation. Follow manufacturer instructions for unpackaging and installation. - Construction sites, transportation routes, diversions and materials handling sites to be water-sprayed on dry and windy days to contain dust; 	<ul style="list-style-type: none"> - # health facility records on respiratory diseases - Visual observations of dust emissions - Complaints from community about dust - 	# Records from nearby health facilities	Monthly	<ul style="list-style-type: none"> - Env. specialist of the contractor to implement - Env. specialist of the PMT to monitor - PIU to coordinate implementation 	<ul style="list-style-type: none"> - Included in contract price - Monitoring cost embedded in operational cost

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US\$) ⁵⁰
	<ul style="list-style-type: none"> - Haulage trucks to be covered or the aggregates sprayed with water before loading; - Health facilities and the associated project areas under refurbishment in the FMSs to be cordoned off to minimize dust migration to nearby facilities by wind; - Staff working in dust generating activities e.g. site preparation, excavation, concrete mixing, stone dressing should be provided with personal protective equipment (PPE) - The use of PPE shall be enforced; and - Avoiding open burning of solid wastes 					
Soil and water pollution + AF solar power and SDD equipment	<ul style="list-style-type: none"> - Open stockpiles of onsite construction materials should be covered with tarpaulin or similar fabric during rainy season; - Prevention of the washing away of construction materials, soil, silt or debris into any drainage system; - All machinery and equipment be regularly maintained and serviced to avoid leak oils; - Maintenance and servicing of heavy vehicles, machinery and equipment 	# incidents on soil and water pollution reported	# Field reports	Monthly	<ul style="list-style-type: none"> - Env. specialist of the contractor to implement - Env. specialist of the PMT to monitor - PIU to coordinate implementation 	<ul style="list-style-type: none"> - Included in contract price - Monitoring cost embedded in operational cost

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US\$) ⁵⁰
	<p>must be carried out in a designated area (protected service bays);</p> <ul style="list-style-type: none"> - Oil products and materials should be stored in site stores or in the contractor’s yard; - Oil interceptors shall be installed along the drainage channels leading from such areas; - For disposing of obsolete Kerosene-powered refrigerators: dismantle the equipment by experienced technicians only, following best international practices (or using manufacturer’s manual if exists), ensure hazardous substances safely separated/contained away from the body equipment. Never pour residual Kerosene down your drain or into the sewer and keep it out of your recycling and garbage. Seek for recyclable parts and avoid disposal in domestic waste stream. Never store dismantled parts close to heat/spark source. And ensure enough distance from soil and water resources. See ICWMP for mor information. - All applicable national laws, regulations and standards for the safe use, handling, storage and disposal of hazardous waste to be followed; and 					

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US\$) ⁵⁰
	<ul style="list-style-type: none"> - Implementation of erosion and sediment control measures such as silt fences, where applicable and where resources permit 					
<p>Other construction risks associated with minor facility repairs and rehabilitation works and construction safety + AF solar power and SDD equipment</p>	<ul style="list-style-type: none"> - Construction worker first-aid - Community health and safety - Construction equipment handling training - Construction debris management - Provision of PPEs to construction workers - Adhering to ESS4 requirements related to Infrastructure and Equipment Design and Safety, and (ii) Safety of Services; - The PIU to ensure coordination and efficient management of significant material suppliers; - Appropriate management of construction waste: including construction debris, non-hazardous wastes, hazardous wastes, liquid waste management; - Provide training on OHS measures in rehabilitation, construction and maintenance of health facilities, as well as installation, operation, and 	<p># incidents involving safety of workers</p>	<p>Field reports GRM incident logs</p>	<p>Monthly</p>	<ul style="list-style-type: none"> - Env. specialist of the contractor to implement - Env. specialist of the PMT to monitor - PIU to coordinate implementation 	<ul style="list-style-type: none"> - Included in contract price • Monitoring cost embedded in operational cost

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US\$) ⁵⁰
	decommissioning of solar power equipment and SDD refrigerators - Traffic management at and near site; - If worker camps are established, adequate EHS provisions should be put in place; - Construction works under appropriate national Covid-19 guidance, or international best-practice guidelines in the absence of national guidelines, with strict adherence and regular monitoring by the PIU and reporting -					
Operational phase⁵²						
Increased safety and health risks, including exposure of medical personnel and waste handlers to dangerous and infectious	- Medical staff should be medically screened, briefed and trained on risks; - Regular supervision of health facilities to ensure that safety conditions are met while any deviation from safety regulations is immediately reclaimed following the best practices regarding safety at work;	# medical personnel exposed to infectious wastes	# PMT reports	Monthly	- HCF management to implement - PCIU and PMTs to monitor	Embedded in operational cost

⁵² These risks are provisional and may not be exhaustive. The PIU will prepare a more complete list of potential impacts and risks due to the proposed HCF construction activities, and updated list of potential and needed mitigation measures, monitoring and indicators. This will be prepared prior to the start of project implementation. This updated list will be used as part of the subproject screening process and revised as needed for specific subprojects. This updated version will then be included as standard practice into contract bid packages.

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US\$) ⁵⁰
health care waste	<ul style="list-style-type: none"> - Develop evacuation procedures to handle emergency situations; - Controlled entry and exit from the health premises; - Post in prominent places informative signage and notices in Somali language to inform of safety hazards and controls; - Provision of appropriate Personal Protective Equipment and enforcement of their use; - Hire qualified personnel in all Damal Caafimaad-financed sub-projects; and - Adhere to provisions of the World Bank’s EHS guidelines 					
Poor indoor air quality and risks of contracting communicable diseases in restricted spaces	<ul style="list-style-type: none"> - Ensure that there is enough ventilation - Prohibition of smoking of cigars and related sources of indoor air pollution, with adequate signage posted - Use a dehumidifier and/or air conditioner to reduce moisture, funds allowing - Follow protocols for spacing and the minimisation of spread of COVID-19 in the supported HCFs 	# cases of indoor air pollution reported	HCF records EHS audit findings	Yearly	<ul style="list-style-type: none"> - HCF management to implement - PCIU and PMTs to monitor and coordinate 	Embedded in operational cost

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US\$) ⁵⁰
<p>Healthcare wastes and general waste management</p>	<ul style="list-style-type: none"> - Implement the Infection Control and Waste Management Plan (Annex 7) - Practice waste minimization segregation and proper disposal according to internationally accepted guidelines and (where possible) municipal bylaws - Contractors appointed under this project will be required to develop project Environmental and Social Assessment and Management Plans, which will include area specific ICWMPs, capturing waste volumes and categories expected from health centres; - These ESAMPs will highlight the measures designed to ensure the safe and environmentally-sound management of healthcare wastes in order to prevent adverse health and environmental impacts from such wastes, including the unintended release of chemical or biological hazards, including drug-resistant microorganisms, into the environment; - The contractors will be responsible for instituting and implementing a simple medical waste tracking system allows for the identification of current waste streams while determining how much 	<ul style="list-style-type: none"> - Quantities of wastes generated - Quantities of waste disposed of - GRM incidents reported on waste disposal 	<p>Waste records</p> <p>Field reports</p>	<p>Monthly</p>	<ul style="list-style-type: none"> - HCF + contractor to implement - PCIU and PMTs to monitor and coordinate 	<ul style="list-style-type: none"> - Waste collection – contract price - Operational cost

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US\$) ⁵⁰
	<p>waste is being generated from the health facility;</p> <ul style="list-style-type: none"> - The contractors will be responsible for keeping documentation showing details of interventions put in place for tracking, measuring and optimizing medical wastes and recycling processes as appropriate; - A sample waste tracking system has been provided in Annex 7 of this ESMF, with appropriate guidance notes; - Contractors will be required to (a) disaggregate wastes in terms of typologies (infectious waste, pathological waste, sharps, pharmaceutical waste, genotoxic waste, chemical waste, wastes with high content of heavy metals, pressurized containers, radioactive waste, general solid waste and micro-organisms), (b) report on volumes of each typology of wastes generated, (c) report on volumes of each typology of wastes collected, and (d) report on available capacity for on-site handling, collection, transport and storage; - Pre- treatment of operation process water before flushing into the existing sewage system or soak pits or into the 					

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US\$) ⁵⁰
	<p>ecosystem (where there is no built receiving system);</p> <ul style="list-style-type: none"> - The treated effluent being discharged to the sewer line should conform to the international limits for effluent discharge into public systems; - Minimize entry of solid waste into the wastewater stream by collecting separately urine, faeces, blood, and vomit from patients treated with genotoxic drugs to avoid their entry into the wastewater stream; - Ensure that sewerage discharge pipes are not blocked or damaged; and - Put in place mechanism for wastewater management and disposal, both for sanitary wastewater and wastewater that may contain medical wastes or hazardous wastes 					
Water management	<ul style="list-style-type: none"> - Supported health facilities to obtain water abstraction permits from the municipalities, where these laws exist; - HCFs to ensure that adequate potable water is provided for operations; - Implement, at the supported health facilities, water saving devices for domestic water use e.g. dual flush toilets, automatic shut-off taps, etc.; 	#Water permits obtained	#Field reports on water use efficiency and water consumption audits	Yearly	<ul style="list-style-type: none"> - HCF management to implement - PCIU and PMT to monitor and coordinate 	- Operational cost

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US\$) ⁵⁰
	<ul style="list-style-type: none"> - Cleaning methods utilised for the cleaning of vehicles, floors, containers, yards etc. must aim to minimise water use; - Practice rainwater harvesting (RWH) by including RWH structures in sub-projects’ design and construction; - Conducting of regular audits of water systems to identify and rectify any possible water leakages; - Implementing a system for the proper metering and measurement of water use to enable proper performance review and management; - Regularly test the water through accredited laboratories to ensure the biological and chemical components are as per national water quality regulations 					
Increased surface or stormwater runoff generation	<ul style="list-style-type: none"> - No surface water shall be directed into the sewer system to avoid overloading the sewerage system; - Harvest rainwater from roof for non-portable uses e.g. cleaning and watering plants as well as cleaning the health facilities 	# Flooding events within the health facilities	Field reports	Twice a year	<ul style="list-style-type: none"> - HCF to implement - PCIU and PMT to monitor and coordinate 	- Operational cost

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US\$) ⁵⁰
<p>Community health and safety, including lapse of confidentiality and possible assault by medical staff worker; unrealistic expectations of level of healthcare or sub-par quality or inefficacy of medical goods procured (drugs, supplies, equipment); or expiration of medicines and unnecessary or improper disposal of medical goods</p>	<ul style="list-style-type: none"> - Medical staff hired should be experienced, professional and trained - MoH to prepare adequate procedures on staff hiring requirements, code of conduct and ensure training is made available to health staff - Patients are told and aware of the services available and understand procedures offered as well as their consequences - Complaints and grievances aired should be registered and processed - All waste storage and disposal sites are adequately cordoned off from the public (see Annex 7) - Practice cold chain, storage and transport management system for efficiency in the medical logistics chain for the entire project - Computerized and manual inventory system as well as disposal SOPs for medical logistics 	<p># Proportion of skilled healthcare staff</p> <p># of training opportunities provided on client management</p>	<ul style="list-style-type: none"> - Hiring reports - Training reports - GRM records 	Yearly	PCIU and PMT to implement aid/ awareness programmes and to monitor	<ul style="list-style-type: none"> - Cost of awareness programmes - Operational cost

Table 12: Potential Environmental and Social Risks and Mitigation Measures (AF2 Family Planning Activities)

<i>Project Activities</i>	<i>Potential E&S Risks</i>	<i>Proposed Mitigation Measures</i>	<i>Indicator</i>	<i>Responsible</i>
<p>Procurement, storage and distribution of Family Planning (FP) commodities (pills, injectables, implants, IUD kits, condoms)</p>	<p>Generation of expired or damaged pharmaceutical waste.</p> <ul style="list-style-type: none"> • Risk of pollution from improper disposal of expired commodities. • Inadequate storage conditions (temperature control failures) 	<p>Apply national HCWM guidelines for pharmaceutical waste.</p> <ul style="list-style-type: none"> • Integrate FP commodities into existing waste segregation and disposal system. • Dispose expired commodities through approved incineration or return to suppliers. 	<p><i># of facilities with proper pharmaceutical waste handling</i></p>	<p><i>Implementation: Health facility managers/ PSI</i></p> <p><i>Supervision: PCIU/PMTs</i></p>
<p>Provision of FP services including IUD and implant insertion/removal</p>	<p>Occupational exposure to blood and bodily fluids.</p> <ul style="list-style-type: none"> • Improper sterilization of instruments causing infection risk. • Generation of sharps and contaminated waste. 	<p>Enforce Infection Prevention and Control (IPC) protocols and OHS measures.</p> <ul style="list-style-type: none"> • Provide adequate PPE and puncture-proof sharps boxes. 	<p><i>% of facilities applying color coded segregation.</i></p> <p><i># of training and supervision activities implemented</i></p>	<p><i>Implementation: PSI/ contractors</i></p> <p><i>Supervision: PCIU /PMTs</i></p>

Table 13: Proposed mitigation and monitoring plan for general social-related risks and impacts

Potential Social Risks	Mitigation Measures	Monitoring	Person/Agency responsible
<p>Labour-related potential risks (parent project + AF): OHS</p>	<ul style="list-style-type: none"> - As for general civil works: - Abide by OHS requirements as set out in Labour Code (Articles 101-104), ESS2 (including WBG EHSs both general and Health Care Facilities) including: - Develop and implement an approved Contractor ESMP, including OHS Management Plan. - Select legitimate and reliable contractor through screening OHS records. - Address adequately OHS risks with non-compliance remedies in procurement documents. - Require the contractor to engage qualified ESHS staffing and apply adequate PPE and safety measures onsite. - Enhance workplace OHS awareness and training. - Conduct routine monitoring and reporting. - As for AF solar power equipment and SDD cold chain: <ul style="list-style-type: none"> a) Tidy wiring for easy maintenance and reduces the risk of accidents. (Implementation phase) b) Need to raise community awareness on electrical hazards and health and safety concerns, as well as proper maintenance of solar panels (Implementation and post-implementation phases) c) Need to raise community awareness on proper disposal of solar panels, specifically avoiding disposal of panels near water bodies (Post-implementation phase) - A LMP will be prepared for the project before the bidding process. 	<ul style="list-style-type: none"> - Monitor implementation of OHS plans onsite - Monitor work related grievances and remedy measures - Monitor application of housekeeping measures and PPE use - Monitor incidents related to OHS onsite 	<ul style="list-style-type: none"> - Contractors and suppliers during construction to implement - PCIU and PMTs to monitor and coordinate

Potential Social Risks	Mitigation Measures	Monitoring	Person/Agency responsible
<p>Labour-related potential risks (parent project + AF): Child/forced labour -</p>	<ul style="list-style-type: none"> - Include minimum age in procurement documents. - Raise awareness on child protection with contractors and in the communities. - Maintain labour registry of all contracted workers with age verification. - Develop remedial procedures to deal with child labor incidents 	<ul style="list-style-type: none"> - Monitor implementation of age verification measures by contractors and suppliers - Spot checks on child/forced labour including work agreements (terms and conditions) and age verification - Monitor complaints related to labour during construction and installation of solar power and SDD equipment. 	<ul style="list-style-type: none"> - Contractors and suppliers to abide and implement verification measures - PCIU and PMTs to monitor and coordinate with available labour inspectorates
<p>Exclusion and selection bias</p>	<ul style="list-style-type: none"> - Awareness raising of all project implementers, contractors and primary suppliers on the requirements and implementation of the inclusion plan. - Promote inclusion of disadvantaged and vulnerable groups in consultations and access to project benefits. - Promote diversity in recruitment including all disadvantaged and vulnerable groups, PWDs and women. There may be a need to put quotas for gender and PWDs. 	<ul style="list-style-type: none"> - Monitoring of the inclusion plan. - Awareness raising on the need for inclusion and that complaints can be raised through the project GM. - For direct workers, contracted workers and primary suppliers any complaints related to recruitment will be channelled through the project GM if they are unable to raise or resolve issues with their immediate supervisors or heads of human resources. - Civil servants under the project will follow the MoLSA Civil Service Commission Policy to articulate their complaints. - The civil servants will also have access to the project GM to lodge their complaints regarding the project. 	<ul style="list-style-type: none"> - PCIU at the FGS level. - PMTs at the FMS MoHs. - Civil Service Commission.
<p>Security related incidents:</p>	<ul style="list-style-type: none"> - The MoH will develop and adopt a Security Management Framework and contract an internationally certified security risk management firm to carry out project and area-based security risk assessments and security management plans. Contractors will also prepare area specific activity SecMPs 	<ul style="list-style-type: none"> - The sub-projects SEPs will ensure buy-in from communities through regular consultations and trust building which will improve security for service provision. 	<ul style="list-style-type: none"> - Contracted NGOs and companies (and by extension FGS and FMS PMTs).

Potential Social Risks	Mitigation Measures	Monitoring	Person/Agency responsible
<p>Threats and attacks from Al-Shabaab and clan conflicts</p>	<p>before implementation, which will be reviewed and cleared by the PCIU and the World Bank and regularly reviewed and updated, to protect staff, patients and communities and healthcare centres.</p> <ul style="list-style-type: none"> - These will be regularly monitored by dedicated IP security specialists and any lapses addressed promptly. - The contracted NGOs and private companies will ensure that regularly updated security measures are in place to protect staff and health facilities. - Serious security incidents will be reported to the PM within 24 hours and mitigation actions developed and implemented. 	<ul style="list-style-type: none"> - Staff will be required through their CoC to report any security concern and/or incident within 24 hours to the PC. - The project GM will further allow for submission of complaints from citizens related to insecurity caused by the project. - The project will allow for whistle blowing on all matters affecting any aspects of implementation. 	<ul style="list-style-type: none"> - Contracted security (public or private).
<p>(GBV/SEAH)</p>	<p>The GBV risks are assessed as substantial. The Plan describes the necessary operational measures and protocols needed to address GBV/SEAH related to the project. Based on the GBV Action Plan annexed to this ESMF (Annex 12), the project will:</p> <ul style="list-style-type: none"> - Healthcare staff will be made aware of the increased risk of sexual violence faced by minorities, IDPs and PWDs. - identify a full range of actions to mitigate GBV/SEAH risks among staff, patients, and community members. - carry out capacity building and training of relevant stakeholders, including project workers and government partners on GBV/SEAH. - Healthcare staff will be trained on safe identification and care of PWDs who have experienced sexual violence, respecting their confidentiality. 	<ul style="list-style-type: none"> - The SEP will ensure regular community awareness on GBV/SEAH issues. - The project GM will identify specified channels to allow for the safe, confidential and survivor-centric submission of complaints from citizens related to GBV/SEAH. - A GBV Advisor will be employed throughout the project and provide regular reports See Annexes 13 and 14 on the ToRs for the GBV specialists at the FGS and FMS levels). - The LMP will provide for CoCs with clear guidance on GBV/SEAH. 	<ul style="list-style-type: none"> - Contracted NGOs and companies (and by extension FGS and FMS PMTs) - Social Safeguards specialists. - GBV/SEAH focal point.

Potential Social Risks	Mitigation Measures	Monitoring	Person/Agency responsible
	<ul style="list-style-type: none"> - conduct consultations, sensitization and awareness raising activities with communities on GBV/SEAH risks. - develop an effective GM with separate channels to manage GBV-related complaints in order to enable reporting of GBV/SEAH incidents in a safe, confidential and survivor centric manner. - Disseminate policies and protocols to all staff. - Train staff in GBV health care, counselling, referral mechanisms, and rights issues. - Include GBV Action Plan in health and community service contingency planning in case of humanitarian emergency. - Integrate GBV medical management into existing health system structures, national policies, programs, and curriculum. - Include GBV provisions in all CoCs to be signed by the contractors and project workers. 		
<p>Socio-cultural barriers to uptake of EPHS services, exclusion of disadvantaged groups.</p>	<ul style="list-style-type: none"> - The E&S assessment and management plan will document the socio-cultural barriers to the uptake of EPHS services including traditional and religious beliefs, and exclusion of disadvantaged groups. - The contractors’ E&S assessment and management plan and community outreach plan will identify and address socio-cultural barriers through appropriate awareness raising and engagement with opinion influencers. - Implementing partners will consider socio-cultural beliefs and behaviours as part of their community outreach strategy. 	<ul style="list-style-type: none"> - The SEP will ensure that the communities (project beneficiaries) receive information about the services offered by the project and have an opportunity to provide feedback. - The project GM will also allow for submission of complaints from the beneficiaries/communities and use the same channels to provide feedback on the complaints. - Regular community feedback session and monitoring on project. 	<ul style="list-style-type: none"> - Contracted NGOs and companies (and by extension FGS and FMS PMTs)

Potential Social Risks	Mitigation Measures	Monitoring	Person/Agency responsible
	<ul style="list-style-type: none"> - The inclusion plan (see section 6 of this SocMF) will promote services for all groups in the project sites. - The SEP and GM have been developed in order to address these risks. In addition, plans may be developed to target specific groups with information including traditional healers, TBAs and religious leaders given their influence in society. - Measures will be put in place to encourage participation and inclusion of disadvantaged and vulnerable individuals and groups. 		
Social unrest and disputes over properties	Conflict over ownership of facilities or land or foreseeable eviction of occupants in leasing of new facilities	The health facility mapping will screen health facilities for any ownership conflicts or foreseeable eviction of occupants in case new buildings are leased and if necessary an abbreviated resettlement action plan (ARAP) will be prepared or government mediated community land donation will be facilitated.	PCIU and PMTs through social SGs specialists

ENVIRONMENTAL AND SOCIAL MONITORING BY CONTRACTORS

199. The MoH, through the PCIU and the PMT, will ensure contractors and other parties working on the project directly monitor, keep records and report on the following E&S issues for their activities⁵³:

- Preparation of Environmental Health and Safety Management Plans (EHSMPs) for each of the HCF to be upgraded and operated under this project.
- Preparation of the subproject ESMPs.
- Safety: hours worked, recordable incidents and corresponding Root Cause Analysis (lost time incidents, medical treatment cases), first aid cases, high potential near misses, and remedial and preventive activities required (for example, revised job safety analysis, new or different equipment, skills training, and so forth).
- Data on environmental performance during HCF operations, including, but not limited to, such parameters as potable water supply, water quality, wastewater generation and disposal volumes, non-hazardous waste management, medical and hazardous waste management, indoor air quality, as well as energy use and management, etc.
- E&S incidents and near misses: environmental incidents and high potential near misses and how they have been addressed, what is outstanding, and lessons learned.
- Major works: those undertaken and completed, progress against project schedule, and key work fronts (work areas).
- E&S requirements: noncompliance incidents with permits and national law (legal noncompliance), project commitments, or other E&S requirements.
- E&S inspections and audits: by contractor, engineer, or others, including authorities—to include date, inspector or auditor name, sites visited, and records reviewed, major findings, and actions taken.
- Workers: number of workers, indication of origin (expatriate, local, non-local nationals, IDPs), gender, age with evidence that no child/forced labour is involved, and skill level (unskilled, skilled, supervisory, professional, management).
- Training on E&S management issues: including dates, number of trainees, and topics.
- Footprint management: details of any work outside boundaries or major off-site impacts caused by ongoing construction—to include date, location, impacts, and actions taken.
- External stakeholder engagement: highlights, including formal and informal meetings, and information disclosure and dissemination—to include a breakdown of women and men consulted and themes coming from various stakeholder groups, including vulnerable groups (e.g., disabled, elderly, children, etc.).

⁵³ The following list should be used in a manner proportional to the size, risk and impacts of each sub-project

- Details of any security risks: details of risks the contractor may be exposed to while performing its work—the threats may come from third parties external to the project.
- Worker grievances: details including occurrence date, grievance, and date submitted; actions taken and dates; resolution (if any) and date; and follow-up yet to be taken—grievances listed should include those received since the preceding report and those that were unresolved at the time of that report. time taken to resolve grievances.
- External stakeholder grievances: grievance and date submitted, action(s) taken and date(s), resolution (if any) and date, and follow-up yet to be taken—grievances listed should include those received since the preceding report and those that were unresolved at the time of that report. Grievance data should be gender disaggregated.
- Major changes to contractor’s environmental and social practices.
- Deficiency and performance management: actions taken in response to previous notices of deficiency or observations regarding E&S safeguards performance and/or plans for actions to be taken—these should continue to be reported until municipalities/PCIU and PMT determine the issue is resolved satisfactorily.

ENVIRONMENTAL LIABILITIES OF CONTRACTORS

200. Contractors will be legally and financially accountable for any environmental damage or prejudice caused by their staff, and thus are expected to put in place controls and procedures to manage their environmental performance. One suggestion to be considered as project preparation progresses, and if feasible, is to – where feasible - provide a breakdown for the cost of noncompliance for each mitigation measure will be enclosed in bidding documents. These will include:

- Mitigation measures as specified in this ESMF will be included in the contract, in consultation with World Bank procurement team
- Deductions for environmental noncompliance will be added as a clause in the Bill of Quantities (BOQ) section
- Environmental penalties shall be calculated and deducted in each submitted invoice
- Any impact described in this ESMF that is not properly mitigated will be the object of an environmental notice by Somali authorities
- For minor infringements complaints, an incident which causes temporary but reversible damage, the contractor will be given a notice to remedy the problem and restore the environment.
- If the contractor hasn’t remedied the environmental impact during the allotted time, the PCIU will provide the contractor a notification indicating a financial penalty according to the non-complied mitigation measure that was specified in the bidding document. The measures implemented will not impede HCF operations, while the PCIU will contact Procurement to agree on the next steps of action.
- All workers signed code of conducts.
- All worker’s grievances resolved.

- Through stakeholder’s engagement plans ensure that the process of hiring local labour is agreed with all the stakeholders and clearly understood.
- Human rights are observed for all the workers.

ROLES AND RESPONSIBILITIES OF IMPLEMENTING ENTITIES

INTRODUCTION

201. The successful implementation of the ESMF for the Damal Caafimaad project depends on the commitment of the Ministry of Health, participating territorial governments in Somalia, non-governmental organisations, health facilities and other private sector players in the health sector, and the capacity within the institutions to apply or use the ESMF effectively. The ESMF also requires appropriate and functional institutional arrangements, among others. The section below describes the detailed roles and responsibilities of the key institutions involved in the implementation of the ESMF by project components.

PROJECT COORDINATION AND IMPLEMENTATION UNIT (PCIU)

202. Project Coordination and Implementation Unit (PCIU) at the FGS-level has been established within the framework of the project. The PCIU will have the overall responsibility for project management, coordinating project implementation, monitoring and evaluation, and reporting of results to stakeholders and developing environment safeguards frameworks and plans. The capacity in the PCIU will be enhanced through on-the-job training and mentoring by the World Bank’s technical staff working on safeguards and the task team leader. The PCIU will also prepare the annual work plan and budget for the Project, by no later than November 1st of each year, commencing on November 1, 2021

203. In the long term, the PCIU aims to serve as a single coordination and management unit for development partner financing and activities in the FGS MoH, to support the Government’s objective of increasing on-treasury resources and coordination.

204. The PCIU will provide overall responsibility for E&S safeguards due diligence, and compliance monitoring. During the meetings with World Bank Safeguards Specialists, the various territorial officials from the different ministries in charge of health were encouraged to appoint persons from within their ranks, who are qualified and up to the task, as E&S safeguards for the project: this will be both at the State- and Federal-levels. With regards to E&S Safeguards, the PCIU will:

- Appoint a full-time Environmental and Social Safeguards Specialists at the FGS level, and work with the PMTs at the FMS level to appoint part-time Environmental and Social Safeguards Specialists
- Ensure compliance with World Bank Environment and Social Standards and other relevant country laws as contained in this ESMF
- Support the smooth and efficient implementation of the project, and
- Undertake effective preparation, review, approval and implementation of sub-project ESMPs, based on this ESMF

ROLES AND RESPONSIBILITIES OF THE MINISTRY OF HEALTH (FGS)

205. The MoH is the lead implementing agency of the project. Its roles and responsibilities are enumerated below:

- Take the lead in screening, scoping, review of draft contractor ESMPs for the government, receiving comments from stakeholders during public hearing of the project,
- Convening a technical decision-making panel (if required), ensuring conformity with applicable standards, conduct environmental liability investigations, and perform monitoring and evaluation work;
- Provide overall leadership during public consultation meetings with critical finance and monetary sector stakeholders, in order to gain their support/cooperation/consensus in established policy direction; and
- Ensure that the project implementers comply with all relevant environmental laws and policies.

206. At the FMS-MoH level, each FMS will enter into a subsidiary agreement with the FGS to ensure project implementation and monitoring at the designated FMS-MoH level and secure the FGS-FMS collaboration under the Project. Each FMS will form a PMT at the FMS-MoH. The PMT will be primarily responsible for project management at FMS-level, including managing and tracking implementation progress, identifying opportunities for implementation improvements and solving day-to-day issues that may delay implementation. Key responsibilities of the PMT include reviewing project activity design, technically supporting implementation agencies, project M&E, and coordinating with the FMOH PCIU. Overall, the Project Managers in in the PMTs will coordinate efforts within their respective governments, across other World Bank-financed projects in the health sector, as well as between the FGS and the FMS.

207. The FGS-MoH, specifically the PCIU, will enter into contracted service agreements with competitively selected NGOs to support the implementation of health service delivery of the EPHS. The contract will be lump-sum and include delivery of the EPHS with a focus on facility-level health service delivery and community outreach, where feasible. The contract will include the development of contractor E&S assessments and management plans including SEP, inclusion plan, GBV Action Plan, labour management plan, SecMPs in line with the project E&S instruments and the World Banks ESF. Payments will be based on deliverables, with a bonus linked to a small performance-based component that is paid in addition to the base payment.

208. The FGS-MoH will contract a TPM firm to monitor and verify the performance results through a balanced scorecard, evaluated during health facility assessments. The findings of the balanced scorecard will determine bonus payments to be made based on the results of these assessments but will not impact base payment amounts and timeliness. Biannual Ministry of Finance (MoF) audits will be conducted to ensure invoices are received and payments are made to service providers. The TPM will provide an additional layer of project oversight and will monitor the following:

- a. GBV and FGM/C Mitigation, response and multisectoral response services
- b. Community satisfaction/community information
- c. Community satisfaction, perceptions of health service quality, perceptions of different types of services offered at facilities
- d. Community knowledge of and feedback on GM
- e. Health seeking behaviour of community members

- f. Assessment of health system effectiveness in terms of access to and utilization of health services and level of satisfaction by different wealth quintiles/socio-economic groups
- g. Fertility desires, beliefs (influences/barriers), and child spacing knowledge
- h. Utilization of health services by disadvantaged and vulnerable groups including minority groups, IDPs, PWDs and people from remote areas, etc.
- i. Patient satisfaction, perceptions of quality, and experiences of different types of services offered at facilities.

PROJECT MANAGEMENT STRUCTURE

209. All Project Governance Structures (e.g. Project Monitoring Meeting, Project Steering Committee, Project Leadership Committee) will be formed and organized by the FMoH to review the project's progress towards the PDO, discuss implementation challenges, and provide solutions/directions to move implementation forward, with the first meeting to be held within three (3) months of project effectiveness. At the FMS level, a Project Monitoring Meeting will occur quarterly at the FMS MoH level one month prior to the Project Steering Committee Meeting, and monitor project progress within the respective FMS. The Project Monitoring Meetings will be chaired by the Project Manager of the PMT, to be established at every FMS-MoH with technical staff, the Component 1 contractor representatives, and Regional Health Officials from Component 1 implementing regions. The Project Monitoring Meeting will monitor the progress of Component 1 and 2 interventions within the respective FMS of project target areas, as well as discuss and report on day-to-day challenges to inform the Project Steering Committee meetings at the FMoH level.

210. The Project Steering Committee will also meet on a quarterly basis throughout the project period, and be chaired by the Director General, FMoH and attended by the Director General of each FMS-MoH as well as the Director General, Federal Ministry of Finance, and the Office of the Accountant General. The annual work plan will also be discussed and agreed at the Project Steering Committee for onward discussion and agreement with the World Bank, as well as serve as a platform for knowledge sharing of best practices across FMSs. A Project Leadership Committee will also be organized bi-annually between FGS and FMS, chaired by the Federal Minister of Health, with participation by the FMS Ministers of Health. The presence of the Federal Minister of Finance to at least one of two Project Leadership Committee would be required/essential. The Project Leadership Committee will provide strategic direction to the project and resolve any issues that require high-level interventions and/or inter-sectoral coordination, with the first meeting held within six (6) months of project effectiveness. For the Project Steering Committee and the Project Leadership Committee, the PCIU (to be established in the FMoH) will act as the Secretariat, organizing meetings, taking minutes, etc.

211. The Environment and Social Commitment Plan (ESCP) outlines responsibilities and timelines. Also, to help navigate project implementation, a Project Operations Manual (POM) was prepared by the PCIU for submission to the World Bank for No Objection within two (2) months of project effectiveness. The POM describes the project components and activities; implementation modalities for each project component; fiduciary/disbursement and safeguard responsibilities and arrangements; and coordination

mechanisms at different levels. The POM also includes monitoring of the project progress according to the Project’s results framework and the ESCP.

WORLD BANK ROLES AND RESPONSIBILITIES

212. The World Bank will:

- Provide guidance on the compliance to Bank’s Environment and Social Standards;
- Perform compliance monitoring of the project to ensure that its ESSs are complied with and conduct regular project review missions;
- Maintain an oversight role, review and approve the project’s ESMF, and environmental assessment instruments such as any ESIA or ESMPs of sub-projects, if any;
- Conduct regular supervision missions to check on the performance of the project and assess its compliance to agreed grant covenants;
- Recommend measures for improving the performance of the project to the PCIU in charge;
- Recommend the holding of appropriate training program intended to improve the capacity of PCIUs as necessary.

213. Table 14 presents a summary of the institutional arrangements proposed for the project cycle, while Figure 4 presents an illustration of the management framework for the project.

Table 14: Institutional arrangements for E&S

Entity	Responsibility
Federal level Implementation	
Senior Health Programme Coordinator (Lead at PCIU at FGS-MoH)	<p>The Coordinator will report to the Project Steering Committee.</p> <ul style="list-style-type: none"> • Lead the project team and have overall responsibility for the management and oversight of project implementation. • Responsible for day-to-day coordination activities, manage and track implementation progress, identify opportunities for improvements of project implementation and to solve day-to-day issues that may be slowing down or blocking implementation. • Ensure overall compliance with operational policies pertaining to the project’s implementation and management, including for procurement and management of financial resources. • Ensure timely reporting to the Steering Committee and to the World Bank.
Contract Management Sub-unit (Legal)	The specialists will report to the PCIU Senior Health Programme Coordinator.

Entity	Responsibility
Advisor and Security Advisor)	<ul style="list-style-type: none"> • Develop TORs, bidding documents, carry out review and due diligence of bids, initiate and execute the procurement of contractors. ▪ Develop a framework (indicators and results framework) on how to monitor performance, monitoring and supervision processes, verify results, payment of all contracts, assessing the security context of project implementation areas, and providing legal advice on all contracts. ▪ Ensure accountability and efficient use of project funds, including tracking of and monitoring requests for financial resources and ensuring accuracy and reliability of financial reports. ▪ Process requisitions, purchase orders, payment requests, and funds withdrawal requests from the MoF, and ensure monthly delivery updates to the project manager on financial delivery performance.
Communication Specialist	<p>The specialists will report to the PCIU Senior Health Programme Coordinator.</p> <ul style="list-style-type: none"> ▪ Develop a comprehensive project communication strategy and plan, provide regular and timely analysis and distribution of Project information to all key stakeholder groups and project beneficiaries. As needed, produce (contribute to the production of) communication materials.
Senior Environmental Safeguards Specialist at FGS	<ul style="list-style-type: none"> ▪ Prepare and submit for review all contractor ESMPs, reports and documents and ensure compliance to the World Bank Environment and Social Standards ▪ Ensure that the sub-project designs, specifications and budget adequately reflect the recommendations of the Contractor ESMPs developed in the project ▪ Prepare draft EHS requirements for subproject bid packages based upon standard requirements and any subproject specific issues ▪ Review and approve the Contractor’s ESMP using the ESMF as guide ▪ Co-ordinate application, follow up processing and obtain requisite clearances and approvals from the World Bank for the Contractor ESMPs submitted by the individual sub-projects, after their own review and approval at the onset ▪ Prepare regular monthly/quarterly/semi-annual progress reports with statutory requirements, including performing onsite supervision/monitoring visits to HCFs, including quarterly E&S performance reports for the Bank, in addition to fulfilling E&S notification requirements, as per ESCP for the project ▪ Develop, organise and deliver appropriate environment safeguards related training courses for the PCIU staff, contractors, local government/community representatives and others involved in the project implementation ▪ Liaise with the Contractors and the PCIU/PMTs on implementation of the Contractors ESMPs and all other EHS contractual requirements

Entity	Responsibility
	<ul style="list-style-type: none"> ▪ Liaise with various Government agencies on environmental monitoring and management matters ▪ Continuously interact with relevant NGOs and community groups ▪ Establish dialogue with the affected communities and ensure that the environmental concerns and suggestions are incorporated and implemented in the project ▪ Review the performance of the project in terms of environment safeguards, through an assessment of the periodic internal monthly and quarterly environmental monitoring reports; provide summaries of same and initiate necessary follow-up actions ▪ Provide support and assistance to the Government MDAs and the World Bank during Project Review Missions.
<p>Social Safeguards Specialist at FGS</p>	<ul style="list-style-type: none"> ▪ The specialists will report to the PCIU Senior Health Programme Coordinator. ▪ Ensure compliance with World Bank’s ESF and other relevant country laws in line with this SocMF. ▪ Oversee the development and updating of social safeguards instruments and inclusion in all project documents and contracts. ▪ Train and orient all project workers on social risk management. ▪ Ensure smooth and efficient implementation of the SEP; SocMF, GBV Action Plan, LMP, Security Management Framework; and sub-project specific environmental and social assessment and management plans. This officer will work closely with the Environment Safeguards Specialist. ▪ Effective review, approval and submission for clearance to the World Bank of the sub-project ESMPs based on the E&S instruments. ▪ Assist contractors and PMTs at FGS MoH to fully comply with World Bank’s ESF and other relevant country laws. ▪ Oversee the functioning of the GM and act as the focal person for the FGS GM and secretary for the GRC. ▪ Ensure adequate review and quality of all safeguards reports (quarterly) before sending to World Bank. ▪ Collaborate closely with the GBV Advisor and jointly support the FMS social specialists. ▪ Seek technical support and guidance where necessary from the World Bank social safeguards specialists. ▪ Collaborate and synergise with FGS social specialists on World Bank projects, especially RCRF and SCRP, which have health components. ▪ The terms of reference of the social safeguards specialist are included in Annex 13.

Entity	Responsibility
	<ul style="list-style-type: none"> ▪ Other technical consultants reporting to the Coordinator at the PCIU will be hired on need basis, based on the needs of the FMoH.
<p>GBV Specialist</p>	<p>The specialists will report to the PCIU Senior Health Programme Coordinator</p> <ul style="list-style-type: none"> ▪ Ensure the completion and adoption of the GBV Action Plan. ▪ Draft the ToRs for the GBV Service Provider. ▪ Ensure the implementation of the provisions in the GBV Action Plan. ▪ Support the training of project workers on GBV in close coordination with the GBV Service Provider. ▪ Monitor the management of GBV reporting on the GM (both workplace and project-based). ▪ Collaborate closely with the Social Safeguards Specialist for the project. ▪ Seek technical support and guidance where necessary from the World Bank GBV advisors. ▪ Collaborate and synergise with FGS social and GBV specialists on World Bank projects, especially RCRF and SCRP, which have health components. <p>The terms of reference of the GBV Advisor are included in Annex 13.</p> <p>Other technical consultants, who will report to the Project Coordinator at the PCIU, will be hired on need basis, based on the needs of the FMoH.</p>
<p>State level Implementation</p>	
<p>Project Manager</p>	<p>The Project Manager will report to the PCIU Senior Health Programme Coordinator.</p> <p>Similar to the Senior Health Programme Coordinator at the PCIU, the state Project Managers will lead the FMS project team in project areas only and will have the following responsibilities:</p> <ul style="list-style-type: none"> ▪ Overall responsibility for the management and oversight of project implementation including safeguards. ▪ Coordinate efforts within their respective governments, across other World Bank-financed projects in the health sector, as well as between the FGS and the FMS. ▪ Ensure timely and regular reporting of project activities including the performance of the GM and all other social activities to the FGS and World Bank.

Entity	Responsibility
Environmental and Social Specialists at FMS	<p>The specialists will report to the Project Manager.</p> <ul style="list-style-type: none"> ▪ Oversee compliance at FMS level of the project with World Bank’s ESF, cleared instruments and other relevant country laws. ▪ Support all implementing partners and contractors in implementation of E&S requirements. ▪ Monitor and report on SRM implementation. ▪ Be the focal point for grievances at the FMS level. ▪ Liaise closely with the senior environmental and social specialists at FGS level in the PCIU. ▪ Work closely with other peer members of FMS E&S safeguards specialists. ▪ Ensure adequate screening and scoping of projects in line with the appropriate safeguard instruments. ▪ Ensure adequate review of all safeguard reports (quarterly) before sending to World Bank. <p>The terms of reference of the social safeguards specialist is included in the Annex 13.</p>
Contracted NGOs and private companies	<p>The specialists will report to the Project Manager for activities specific to the State.</p> <ul style="list-style-type: none"> ▪ Develop and implement contractors’ EMSPs including the SEP, GBV Action Plan, labour management plan, SecMP in line with project documents and World Bank’s ESF to be cleared by the World Bank, before the implementation of project activities. ▪ Comply with all ESF requirements including those outlined in the E&S instruments, including this ESMF. ▪ Report any significant incident and mitigation measures to the PM within 24 hours of occurrence. ▪ Submit monthly progress report on the implementation of its approved ESMP including provisions from the SEP, Inclusion Plan, GBV Action Plan, labour management plan, SecMP and GM. ▪ Submit itself to periodic and special inspections by the MoH, Third Party Monitoring Agent and World Bank and comply with instructions and corrective measures for identified deficiencies in its ESMP implementation.
Third Party Monitoring Agent	<p>The TPM Agent will report to the PCIU while working closely with the Project Management Team at the state level:</p>

Entity	Responsibility
	<ul style="list-style-type: none"> ▪ While reporting to the FGS-MOH and the WB, the TMP agent will provide monitoring support to the project throughout the project cycle; including on community feedback and E&S implementation. ▪ Generally, the TMP agent will: <ul style="list-style-type: none"> ○ execute and report on all monitoring activities outlined below; ○ develop and disseminate quarterly health service bulletins/interactive dashboard and annual report; and ○ developing Government capacity for monitoring design and oversight; data analysis and dissemination; and data use for decision making. ▪ There will be an annual survey and balanced scorecard (beneficiary feedback) including the following indicators: <ul style="list-style-type: none"> ○ GBV FGM/C services; ○ Community satisfaction/community information; ○ Community satisfaction, perceptions of health service quality, perceptions of different types of services offered at facilities; ○ Community knowledge of and feedback on GM; ○ Health seeking behaviour of community members; ○ Assessment of health system effectiveness in terms of access to and utilization of health services and level of satisfaction by different wealth quintiles / socio-economic groups; ○ Fertility desires, beliefs (influences / barriers), and child spacing knowledge; and ○ Utilization of health services by disadvantaged and vulnerable groups including minority groups, IDPs, the poor, and people from remote areas, etc.; ○ Patient satisfaction, perceptions of quality, and experiences of different types of services offered at facilities. ▪ The TMP will use approaches that will facilitate the participation of the disadvantaged and vulnerable members of the target communities including one-on-one interviews, group discussions (while observing the Covid-19 protocols) and use of local leadership structures. Reports generated should capture information on disadvantaged and vulnerable individuals and groups.
Additional Technical Support	
RCRF project	<ul style="list-style-type: none"> ▪ The project will collaborate closely with the RCRF project to help develop contract management capacity, which includes additional technical staff with expertise in M&E, contract management, E&S safeguards and community/public health. For selected FMS

Entity	Responsibility
	implementing the EPHS package, financing and reporting lines for these positions will transition to the project.
World Bank	<ul style="list-style-type: none"> ▪ Provide technical support on all aspects of the project and as requested by the FGS. ▪ Review and clear E&S instruments and plans. ▪ Assess the implementation of the SocMF and other instruments and recommend additional measures for strengthening the management framework and implementation performance, as necessary. ▪ Review and approve the ToRs for contractors, TMPs and consultants recruited for the project. ▪ Approve the reporting framework, screening procedures and preparation of management and mitigation plans with the PMT at the FGS MoH during the early part of project investment identification stage before disbursement. ▪ Hold review meetings and provide timely feedback to the FGS.

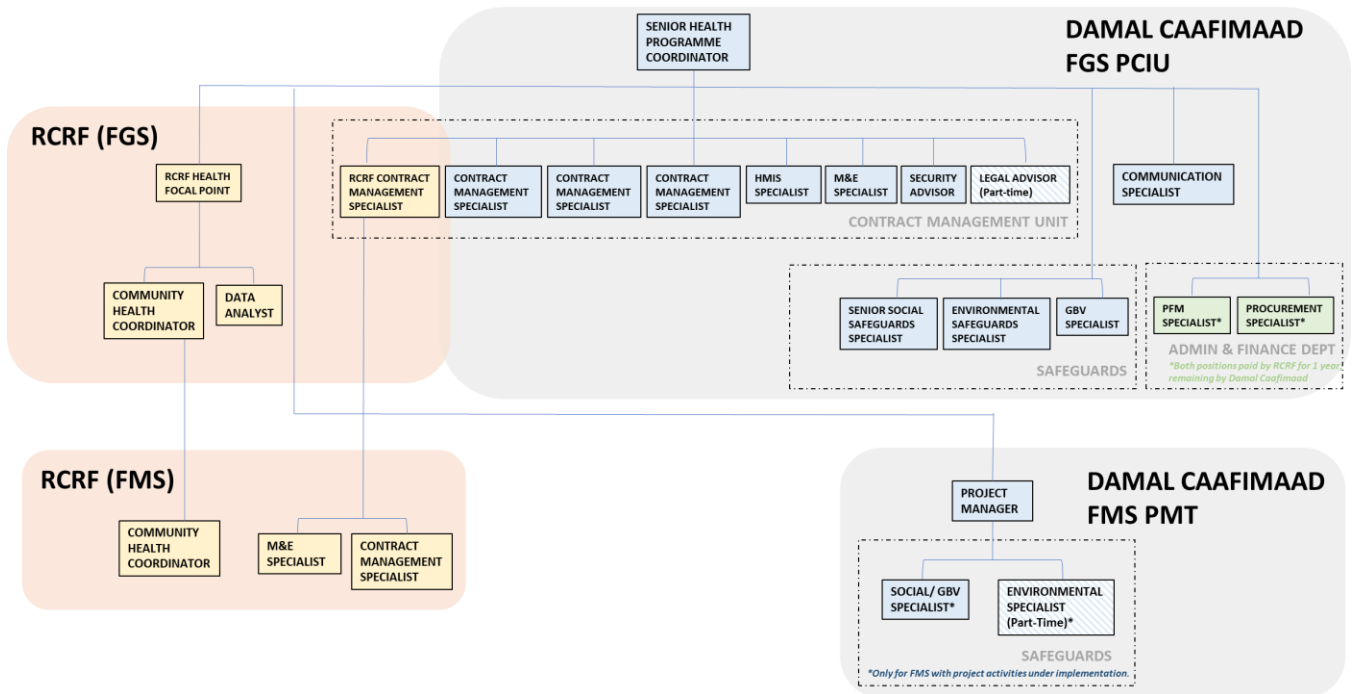


Figure 4: Proposed implementation arrangements

BUDGET FOR IMPLEMENTING THE ESMF

214. To effectively implement the E&S management measures suggested as part of the ESMF, resources will be required, to the tune of US\$2,000,000⁵⁴. An indicative budget has been provided in the Table below, meant to cover only E&S safeguards related expenses such as capacity building programs, coordination and public consultation meetings, planning workshops, monitoring and field work, and environmental, social, and security consultancy services.

215. This estimated budget does not include the cost for mitigation and enhancement measures, which will be integrated into the contractors’ cost. Likewise, all administrative costs for the operation of the PCIU Safeguard unit as well as those of PMTs at the FMS level, are including in the overall project cost. However, it is important to note that not all the EHS related costs are included in this budget. These costs include EHS costs of subproject contractors for adequate EHS management during construction works and most importantly HCF EHS management during HCF operations.

Table 15: Indicative budgetary requirements for implementing the ESMF (parent Project & AF)

ESMF Requirements	Budget basis and assumptions	Total Cost (US\$)
Capacity building on E&S aspects of the Project	E&S risk management and ESF in general for focal points; Introduction on HCF emergency preparedness and response; Implementing the ICWMP; Follow-on EHS audits and use of MSDS at HCFs; E&S risk reporting; and monitoring EFS compliance at FMSs	40,000
Meetings	All related quarterly and follow-up meetings of the Project	20,000
Conferences /workshops	Study tour for ESF focal points to other Bank-funded projects; participation in Project-related conferences	40,000
Fieldwork	In-depth capacity needs assessment of MoH’s institutional set-up for env. risk management; EHS site audit; monthly visits of E&S specialists in FMSs to monitor implementation	30,000 Cost of visits in FMSs is included in operational cost.
Documentation work	All QC of Project documentation	20,000
Salaries	E&S Safeguards Specialists and officers at PCIU	300,000

⁵⁴ Estimated – based on the cost of implementing ESMF and other Safeguards instruments – further work is needed to establish well-grounded estimates

ESMF Requirements	Budget basis and assumptions	Total Cost (US\$)
Salaries	E&S Safeguards Specialists and officers at PMTs	350,000
Budget for implementation of SEP	All activities related to the implementation of the SEP by MoH (contractors SEPs will be included in the contract amount)	120,000
Implementation of GBV action plan	All activities related to the implementation of the GBV action plan	400,000
Implementation of LMP	All activities related to the implementation of the LMP	200,000
Contracting risk management firm to conduct a project and regional security risk assessment and management plans and support the security officer	An internationally certified security risk management firm will be contracted for the assignment based on key qualifications	400,000
IPs/TPM/Contractor’s pre-bidding	Workshop to orient implementing partners and TPM and other contractors on ESF requirements before bidding	30,000
Inception with SRM + progress of SRM	Workshops to input SRM into all project components + Workshops on SRM progress and strengthening	20,000
Subtotal		1,970,000
Contingencies		30,000
Total		2,000,000

UPDATING THE ESMF

216. This ESMF will be used for screening of sub-projects and as a guide for the preparation, review and approval of environmental assessment instruments (ESIA and ESMP). It will also be a reference in the implementation of the sub-projects and their respective ESMPs. Since there may be new developments, guidelines or national legislations issued after its (ESMF) approval and posting on the World Bank website, the ESMF may need to undergo updating from time to time. Updating this document is also required when the Project enters into an Additional Financing (AF) stage, where new interventions included and relevant management measures required, which is the case by which this revision being issued.

DISCLOSURE OF ENVIRONMENTAL AND SOCIAL RISK MANAGEMENT INSTRUMENTS

217. This ESMF has been prepared in consultation with the relevant stakeholders in Somalia (with meetings held between MoH officials and counterparts in the health sector in Somalia). Consultative meetings have been held for the purpose of preparing this ESMF. The stakeholder meetings were conducted virtually on diverse dates, including December 14, 2020, January 21, 2021, February 3, 2021, and on March

24, 2021. The meetings were attended by stakeholders in the health sector in Somalia. As a pre-requisite for clearing and disclosing this updated ESMF document, including for AF subcomponents, a stakeholder consultation was held on 27th of June 2023. This ESMF has been updated to incorporate the Additional Financing 2 (AF2) activities on Family Planning following the stakeholder consultation meeting held on 17-18 June 2025.

218. Copies of this ESMF and other safeguard instruments developed later (ESMPs), prepared for the sub-projects to be financed under the project, should be disclosed in compliance with relevant country regulations and the World Bank Environment and Social Standards. The ESMF will continue being disseminated within Somalia in all project sites. The executive summary will also be made available into Somali language and disclosed in two daily newspapers for 21 days, or as required by country laws, while the World Bank will post the approved document at WB's official website.

MONITORING AND REPORTING

219. The FGS E&S specialists will monitor and report on the implementation of the ESF instruments and the ESCP. The FMS specialists will be responsible to monitor the implementation of the ESMPs by the contractors and report to the FGS E&S specialists.
220. The PCIU will submit quarterly progress reports or as otherwise requested by the World Bank on a case-by-case basis.
221. Internal Monitoring: The PCIU will prepare data on activities and outputs in regular quarterly reports. The M&E process will be participatory, engaging community members of the districts benefiting from the project investments. Virtual GIS tagged monitoring tools may be used as in the RCRF project, e.g. Kobo toolbox and patient and community phone surveys. An end-line beneficiary survey will be carried out to measure who and to what extent people benefited from the project as well as how it affects their lives and the social impacts.
222. External Monitoring: Given the persistent insecurity in some project areas, the ability to monitor and supervise project on the ground will continue to be limited. As such, the project will have an TPM agent for supervision of project implementation progress.
223. There will be an annual survey and balanced scorecard (including beneficiary feedback) including the following indicators:
- a. GBV/FGM/C services.
 - b. Community satisfaction/community information.
 - c. Community satisfaction, perceptions of health service quality, perceptions of different types of services offered at facilities.
 - d. Community knowledge of and feedback on GM.
 - e. Health seeking behaviour of community members.
 - f. Assessment of health system effectiveness in terms of access to and utilization of health services and level of satisfaction by different wealth quintiles / socio-economic groups.
 - g. Fertility desires, beliefs (influences/barriers), and child spacing knowledge.
 - h. Utilization of health services by disadvantaged and vulnerable groups including minority groups, IDPs, the poor, and people from remote areas, etc.
 - i. Patient satisfaction, perceptions of quality, and experiences of different types of services offered at facilities.
224. Reporting back to stakeholders: Regular stakeholder workshops will be held to enable feedback on project progress and improvements to all stakeholders. In addition, component 4 of the new RCRF project supports the designing and use of tools to advance transparency and generate citizen feedback mechanisms up to the facility level (for selected locations). It also supports the learning and evaluation of the possible
-

most impactful tools. A rigorous impact evaluation will be financed to assess the efficacy of citizen engagement on health access and quality with health teams.

225. Incident and Accident Reporting: Incident reporting will follow the management and reporting process shown in Figure 4.

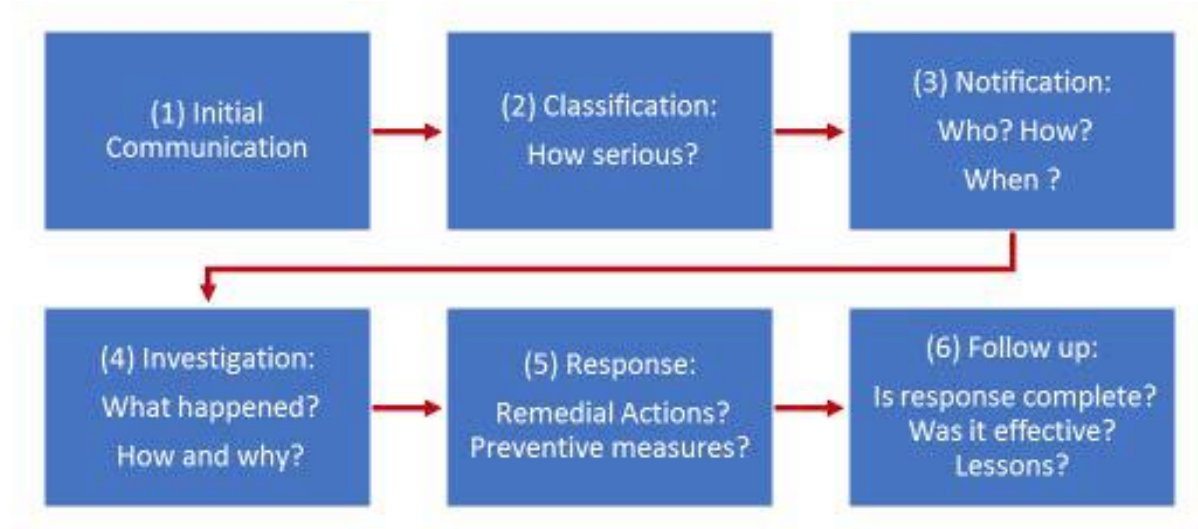


Figure 5: Incident reporting matrix

226. For Incidents will be categorized into ‘indicative’, ‘serious’ and ‘severe’. Indicative incidents are minor, small or localized that negatively impact a small geographical area or a small number of people and do not result in irreparable harm to people or the environment. A ‘significant’ incident is one that causes significant harm to the environment, workers, communities, or natural resources and is complex or costly to reverse. All GBV/SEAH cases are treated as severe. A ‘severe’ incident causes great harm to individuals, or the environment, or presents significant reputational risks to the World Bank.

227. Severe incidents (an incident that caused significant adverse effect on the environment, the affected communities, the public or workers, e.g., fatality, GBV, forced or child labour) will be reported within 24 to the PCIU and the World Bank.

228. Where grievances are of sexual nature and can be categorized as GBV/SEAH or child protection risks, the PCIU will handle the case appropriately, and refer the case to the GBV referral system, defined in the GBV/SEAH Action Plan. There is need to note the protocols for handing incident reporting and response for GBV/SEAH is different from other cases or complaint. The GBV reporting forms informed consent form, intake form and GBV case management forms.

ANNEX 1: WORLD BANK ENVIRONMENTAL AND SOCIAL STANDARDS

ESS1: Assessment and Management of Environmental and Social Risks and Impacts*⁵⁵

This Standard sets out the Borrower’s responsibilities for assessing, managing and monitoring environmental and social risks and impacts associated with each stage of a project supported by the Bank through Investment Project Financing (IPF), in order to achieve environmental and social outcomes consistent with the Environmental and Social Standards (ESSs).

ESS2: Labour and Working Conditions*

This Standard recognizes the importance of employment creation and income generation in the pursuit of poverty reduction and inclusive economic growth. Borrowers can promote sound worker-management relationships and enhance the development benefits of a project by treating workers in the project fairly and providing safe and healthy working conditions.

ESS3: Resource Efficiency and Pollution Prevention and Management*

This Standard recognizes that economic activity and urbanization often generate pollution to air, water, and land, and consume finite resources that may threaten people, ecosystem services and the environment at the local, regional, and global levels. This ESS sets out the requirements to address resource efficiency and pollution prevention and management throughout the project life-cycle.

ESS4: Community Health and Safety*

This Standard addresses the health, safety, and security risks and impacts on project-affected communities and the corresponding responsibility of Borrowers to avoid or minimize such risks and impacts, with particular attention to people who, because of their particular circumstances, may be vulnerable.

ESS5: Land Acquisition, Restrictions on Land Use and Involuntary Resettlement*

Involuntary resettlement should be avoided. Where involuntary resettlement is unavoidable, it will be minimized and appropriate measures to mitigate adverse impacts on displaced persons (and on host communities receiving displaced persons) will be carefully planned and implemented.

ESS6: Biodiversity Conservation and Sustainable Management of Living Natural Resources*

This Standard recognizes that protecting and conserving biodiversity and sustainably managing living natural resources are fundamental to sustainable development and it recognizes the importance of maintaining core ecological functions of habitats, including forests, and the biodiversity they support. ESS6 also addresses sustainable management of primary production and harvesting of living natural resources, and recognizes the need to consider the livelihood of project-affected parties, including Indigenous Peoples, whose access to, or use of, biodiversity or living natural resources may be affected by a project.

ESS7: Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities

⁵⁵ The asterisk sign (*) denotes that this Standard is applicable in the Somalia health project

This Standard ensures that the development process fosters full respect for the human rights, dignity, aspirations, identity, culture, and natural resource-based livelihoods of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities. ESS7 is also meant to avoid adverse impacts of projects on Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, or when avoidance is not possible, to minimize, mitigate and/or compensate for such impacts.

ESS8: Cultural Heritage*

This Standard recognizes that cultural heritage provides continuity in tangible and intangible forms between the past, present and future. ESS8 sets out measures designed to protect cultural heritage throughout the project life-cycle.

ESS9: Financial Intermediaries (FIs)

This Standard recognizes that strong domestic capital and financial markets and access to finance are important for economic development, growth and poverty reduction. FIs are required to monitor and manage the environmental and social risks and impacts of their portfolio and FI subprojects, and monitor portfolio risk, as appropriate to the nature of intermediated financing. The way in which the FI will manage its portfolio will take various forms, depending on a number of considerations, including the capacity of the FI and the nature and scope of the funding to be provided by the FI.

ESS10: Stakeholder Engagement and Information Disclosure*

This Standard recognizes the importance of open and transparent engagement between the Borrower and project stakeholders as an essential element of good international practice. Effective stakeholder engagement can improve the environmental and social sustainability of projects, enhance project acceptance, and make a significant contribution to successful project design and implementation.

More information on these Standards is available at <http://pubdocs.worldbank.org/en/837721522762050108/Environmental-and-Social-Framework.pdf#page=53&zoom=80>

ANNEX 2: INDICATIVE ENVIRONMENTAL SCREENING CHECKLIST⁵⁶

No	ITEM ⁵⁷	DETAILS				
INTRODUCTION						
1.	Project Name	Improving Healthcare Services in Somalia				
2.	Project Location					
3.	Sub-Project Description (brief)					
4.	Does the Sub-Project require any:	<i>yes</i>	<i>no</i>	<i>If yes, extent in ha.</i>		
5.	Reclamation of land, wetlands					
6.	Clearing of grazing lands					
7.	Felling of trees					
8.	Minimum land area required for the proposed development (ha)					
9.	Available total land area within the identified location (ha)					
10.						
11.	Responsible contact person, contact Information					
12.	Present land ownership	<i>State:</i>	<i>Private:</i>	<i>Other:</i>		
13.	Total Cost of the Project					
14.	Anticipated Date of Completion					
ENVIRONMENTAL IMPACT AND MITIGATION/ENHANCEMENT DURING CONSTRUCTION PERIOD (if any construction is undertaken)						
	Impacts	H ⁵⁸	M ⁵⁹	L ⁶⁰	N/A	Mitigation/Enhancement
15.	Soil erosion					
16.	Water pollution					
17.	Indoor air pollution					
18.	Hazardous waste generation					
19.	Noise pollution					
20.	Solid waste generation					
21.	Loss of vegetation cover					
22.	Habitat loss or fragmentation					
23.	General disturbance to animal behavior					
24.	Interference with normal movement of animals					
25.	Irreversible/irreparable environmental change					
26.	Presence of potential nearby receptors (inc. HCFs) + issues related to traffic during construction					
27.	EXISTING ENVIRONMENTAL LIABILITIES					
28.	Wastewater pits					

⁵⁶ This form will be used in the event that major construction works are undertaken in the project

⁵⁷ This Annex (screening form) must be updated prior to use

⁵⁸ High impact (irreversible impacts)

⁵⁹ Medium impact (can be reversible with some effort)

⁶⁰ Low impact (meaning easily reversible)

29.	Medical waste disposal					
30.	Waste dumps (above or below ground)					
31.	Contaminated soils					
32.	Buildings with safety or access issues					
33.	Buildings with potential for asbestos, lead based paint or other liabilities					
34.	ENVIRONMENTAL IMPACTS DURING OPERATION					
35.	Increased safety and health risks, including exposure of medical personnel and waste handlers to dangerous and infectious health care waste					
36.	Poor indoor air quality and risks of contracting communicable diseases in restricted spaces					
37.	Healthcare wastes and general waste management					
38.	Potable water management					
39.	Increased surface runoff					
40.	Community health and safety issues					
COMMUNITY ENGAGEMENT						
41.	Number and nature of public consultation meetings conducted so far	Type of Meeting	Number of Meetings	Nature of Participants	Participants	
					Male	Female
CONTACT DETAILS OF OFFICIALS AND RECOMMENDATIONS						
Name of the person completing form						
Designation and contact information						
List of team members						
Signature and date						
Name of officer who checked and approved this form						
Designation and contact information						
Remarks						
Signature and Date						

ANNEX 3: SCOPE OF AN EHS AUDIT OF EXISTING HEALTHCARE FACILITY

1.0 INTRODUCTION

1.1 Scope of the EHS audit

The scope of this audit includes the reviewing the safety and monitoring functions of applicable environmental health and safety regulations in place for development projects funded by the World Bank in Somalia.

1.2 Objectives of the audit

The objectives of the audit are to:

- review the functions of EHS systems in place in the audited healthcare facility (HCF) in Somalia, and
- determine whether environmental health and safety measures and monitoring processes in place are in compliance with FGS and World Bank policies and state regulations (if they are in existence).

The audit will identify the potential environmental and social impacts at HCF operations levels associated with the parent project and AF, and then provide a determination of the efficacy of the measures that are in place to manage those impacts.

2.0 AUDIT DESCRIPTION

The PCIU will ensure that a systematic, critical appraisal of all potential environmental health and safety hazards involving HCF personnel, healthcare physical infrastructure, services and operation methods are carried. The PCIU will also ensure that EHS system fully satisfies national legal requirements and those of the World Bank's ESHS Guidelines.

To achieve these objectives, the EHS audit will:

- Review existing FGS and FMS policies on environmental health and safety;
- Survey via questionnaires and interview relevant staff at the selected HCF;
- Review supporting documentation;
- Observe laboratory safety inspection(s); and
- Conduct limited testing.

3.0 TASKS

The following tasks will be undertaken in the EHS audits:

- Pre-Audit Data Request, submitted to the management of the HCF in question
- Opening Meeting to explain the objective, scope & methodology of the EHS audit
- HCF Walkthrough
- Site Study
- Discussions with HCF Personnel
- Study of Records Kept at the HCF
- Presentation of Salient Findings on-site.
- Submission of EHS Audit Report.

ANNEX 4: DRAFT TERMS OF REFERENCE FOR A CONTRACTOR ESMP FOR A HEALTHCARE FACILITY

A. Introduction and Project Description:⁶¹

Give a short description of the project

B. Purpose

Indicate the objectives and the project activities, the activities that may cause environmental and social negative impacts and needing adequate mitigation measures. Please refer to the overall project documents including: Stakeholder engagement plan, inclusion plan, GBV action plan, Environmental and social management frameworks including the GBV action plan, the labor management procedures, the security management framework and the project level and regional security management plan. Please ensure there is a section on each of the above showing how the recommendations are being planned given the contractor and regional specificities including how they will be included for any sub-contractors.

C. Tasks

The Contractors ESMP should cover:

- Potential environmental and social impacts resulting from project activities, based on ground level assessment and analysis;
- Proposed mitigation measures;
- Institutional responsibilities for implementation;
- Monitoring indicators;
- Institutional responsibilities for monitoring and implementation of mitigation measures;
- Costs of activities;
- Calendar of implementation; and
- Capacity needs.

The C-ESMP results and the proposed mitigation measures should be discussed with relevant stakeholders, NGOs, CBOs and community representatives including representatives of disadvantaged groups, local administration and other organizations involved in the project activities.

Recommendations from these public consultations should be included in the final ESMP.

D. Format

- Cover page
 - Table of Contents
 - List of Abbreviations, Acronyms and Units
 - Introduction
 - Project Site Description and Process
 - Applicable standards: including World Banks Operational Performance Standards. Country Standards, Other funding partner standards, other international standards, if appropriate (ISO, WMO, WHO and so on) and other elements of good international practice. If there are specific international standards or practices that need to be met, these should be listed
- Assessment of environmental and social impacts and mitigation measures for project activities;

⁶¹ This be further developed at start of project implementation. It should be updated based upon standard list of impacts/risks and standard EHSMP – which will provide a more complete description of all EHS areas/issues/topics

- Costed Plan within timing and responsibilities outlined, including:
- Regional specific Stakeholder engagement plan, inclusion plan, GBV action plan, and Labour management plan; area specific security management plans;
- Monitoring indicators
- ESMP training requirements, if any

E. Timescale

The contractor will produce the final ESMP one week after receiving consolidated comments from the World Bank, relevant Country institutions

F. Deliverables

Draft and Final ESMP (soft copy only)

ANNEX 5: SAMPLE GRIEVANCE REGISTRATION FORM⁶²

Example of Complaints Form (to be translated into Somali)

1. Complainant's Details

Full name or Reference number (if confidentiality requested): _____

Male/Female _____

Mobile _____

Email _____

District _____

Relationship to the project _____

Age (in years): _____

2. Which institution or officer/person are you complaining about?
Ministry/department/agency/company/group/person

3. Have you reported this matter to any other public institution/ public official?

Yes No

4. If yes, which one?

5. Has this matter been the subject of court proceedings?

YES NO

6. Please give a brief summary of your complaint and attach all supporting documents [Note to indicate all the particulars of *what* happened, *where* it happened, *when* it happened and by *whom*]

7. What action would you want to be taken?

Signature _____

Date _____

⁶² More details on registering grievances are elaborately indicated in the SEP for the Somali health project

**ANNEX 6: INDICATIVE ENVIRONMENTAL STEWARDSHIP
FRAMEWORK FOR CONTRACTORS⁶³**

**ENVIRONMENTAL STEWARDSHIP FOR ANY PHYSICAL INFRASTRUCTURE
DEVELOPMENT FOR “IMPROVING HEALTHCARE SERVICES IN SOMALIA”
PROJECT⁶⁴**

SN	ENVIRONMENTAL ISSUE	POTENTIAL IMPACT	CODE OF CONDUCT REQUIREMENT
Pre-construction/Construction Phase			
1	Land Use	<p>Passage of contractor’s vehicles through grazing reserves or cultivated and forested land resulting in a permanent loss of the resources.</p> <p>The environmental effects can amplify if proper operation and maintenance schedules are not followed.</p>	<p>Plan and file Vehicular Traffic Movements (VTMs) so as to as much as possible avoid trekking through grazing reserves or cultivated, thus minimizing loss of resources</p>
2	Material Use	<p>Excess extraction of local resources, such as wood, sand, soil, boulders, etc.</p> <p>Degradation of forests, erosion and landslide at steep locales due to boulder, stone extraction.</p> <p>Change in river and stream ecosystem due to unchecked sand extraction</p>	<p>Extract materials only on need basis</p> <p>Avoid sensitive areas, such as steep slopes</p> <p>Follow engineer’s directions at all times</p>
3	Slope Stability	<p>Extraction of forest products and cutting of trees in the steep slopes increases soil erosion and landslide due to loss of soil binding materials</p> <p>Wrong alignment can trigger slope failure</p> <p>Haphazard disposal of construction waste can disturb slopes</p> <p>Improper drainage facilities can result in erosion and landslides</p>	<p>Extract carefully and secure the topsoil within 25 cm from the surface</p> <p>Limit down grading of the infrastructure such as temporary road to 50</p> <p>If down grading exceeds 70, construction of side drainage is necessary</p> <p>Keep optimum balance in extraction and filling of soil works, geo-hazardous assessment and mapping</p> <p>Use designated disposal site and avoid side-casting of spoil</p> <p>Provide proper drainage</p>

⁶³ This form will be reviewed and updated in case there is major construction works undertaken in the project.

⁶⁴ This will be thoroughly reviewed and updated at project implementation.

SN	ENVIRONMENTAL ISSUE	POTENTIAL IMPACT	CODE OF CONDUCT REQUIREMENT
			Use bio-engineering on exposed slopes
4	Wildlife	<p>Wildlife habitats at forests, shrub-lands along water infrastructure corridor are affected by the infrastructure construction activities</p> <p>Wildlife and human conflicts increase as wildlife might destroy the crops or attack the construction workers</p>	<p>Avoid as much as possible areas with high biodiversity</p> <p>Efficient movement of machinery and other traffic</p> <p>Control poaching activities and regulate movement of labor force and their dependents into the forest area</p> <p>District Forest or Range Office and its subsidiary body should be involved in monitoring the activities of the construction workers and officials to minimize wildlife harassing, trapping and poaching</p>
5	Drainage	Higher flow rate of surface water and water logging induce landslides, erosion	<p>It is strongly recommended that the cross-drainage outlets must be channeled to the confirmed natural drains</p> <p>If horizontal slope exceeds 5%, construction of flow control device necessary every 20 m</p>
6	Protection of Vegetation	<p>Protected areas and highly forested areas</p> <p>Degradation of forest areas</p> <p>Degradation of agricultural land</p>	<p>Use minimum and efficient use of wood products for construction</p> <p>Initiate plantation at damaged and damage prone areas</p> <p>Increase liability of local forest user groups</p> <p>Avoid protected areas or densely forested areas</p>
7	Disposal of Construction Wastes	Dumping of wastes along the infrastructure such as roads or elsewhere	<p>Selected spoil dumping sites should be used</p> <p>After disposal, the area should be levelled and compacted</p> <p>It is recommended to conserve the soil by planting indigenous plants including grasses</p> <p>Wastes could also be used as levelling materials along the infrastructure</p>
8	Disposal of Sanitary Wastes	Unmanaged sanitary waste disposal creating health problems and public nuisance	Proper sanitation area needs to be demarcated

SN	ENVIRONMENTAL ISSUE	POTENTIAL IMPACT	CODE OF CONDUCT REQUIREMENT
			Check for hygiene of work force
9	Impacts on amenities	Infrastructure such as road crossings at water supply, irrigation lines may be disturbed or damaged	Avoid as much as possible the crossing over such amenities
10	Pollution	Dust generation from construction activities, construction vehicular movement increases air pollution Noise pollution likely from construction machinery operation and vehicular movement Sanitary problems likely at the construction and workforce quarters.	Possibly construction period should be during any of the two rainy seasons when soil moisture content is highest in Somalia (March-May or October-December) Enforce speed limit of vehicles and construct the infrastructure such as road according to volume and size of traffic movement
Operation Phase			
1	Encroachment	Unmanaged settlement, constructions near the new water points	Community zoning recommended, with enforcement
3	Pollution/Vehicle Emission	Dust generation from vehicular movement increases air pollution Noise pollution likely from vehicular movement	Enforce speed limit of vehicles Maintain traffic size movement Discourage use of horns
4	Aesthetics	Infrastructure such as water construction is likely to increase landscape scars In addition, if the construction spoils are disposed of improperly, the ground vegetation would be destroyed which will be visible from a distance	Such damage cannot be avoided but can be minimized through re-plantation of indigenous species and greenery development

ANNEX 7: INFECTION CONTROL AND WASTE MANAGEMENT PLAN⁶⁵

DRAFT PLAN FOR THE “IMPROVING HEALTHCARE SERVICES IN SOMALIA” PROJECT

A. Introduction

This Infection Control and Waste Management Plan (ICWMP) has been prepared for the proposed “*Damal Caafimaad*” project. It is meant to be implemented by the Federal Government of Somalia in order to minimize biohazard wastes, collection, treatment, and disposal of laboratory generated wastes and control infection during the operation of the project in identified Federal Member States (FMS). The Plan was also updated to tackle other wastes expected from dismantling of obsolete Kerosene-powered cooling equipment that is additionally financed under the Project.

B. Definitions and scope of the plan

Healthcare wastes (“HCW”) are wastes that primarily originate from the health sector and include sharps, non-sharps, blood, body parts, chemicals, pharmaceuticals, medical devices and radioactive materials. Healthcare waste constitutes an important factor concerning environmental contamination, a factor of significant health risk, threatening peoples’ quality of life. Healthcare workers are at great risk as most bloodborne occupational infections occur through injuries from sharps contaminated with blood through accidents or unsafe practices. Systematic management of such clinical waste from source to disposal is therefore integral to prevention of infection and control of the epidemic. Thus, managing this type of waste is a main concern for the Federal Government of Somalia and needs special attention by the ministries of Health at all levels of government, and as well as by the general public.

In many countries, including Somalia, poor handling of waste materials contaminated with infectious agents like HIV/AIDS has severe consequences among healthcare workers and waste scavengers. Poor handling of HCW including those originating during operation of the project exposes healthcare workers, waste handlers and the community to disease and injuries. The activity of the project is expected to generate wastes and by-products that are hazardous to both human health and the environment. Also, among the general population some people (particularly children who may live on the streets, particularly in Mogadishu and other large urban areas), usually search for reusable materials in landfills and public dumps. This activity is even graver because it leads to the manipulation and use of contaminated waste, increasing environmental and sanitary risks.

The Plan aims also to provide best management practices for handling obsolete Kerosene-powered cooling equipment, which has reached end of life already, and needs to be dismantled and disposed of. This type of waste includes in particular, hazardous parts, such as refrigerants, oils, lubricants, electronic boards, electrical wiring, and contaminated parts therewith.

C. Types of wastes for the project

For the purpose of the *Damal Caafimaad* project, we divide healthcare solid waste into the following categories

⁶⁵ This Infection Control and Waste Management Plan is only a draft. This draft will be updated to reflect specific subproject HCF conditions and issues at implementation.

- **Infectious Waste:** Waste suspected to contain pathogens e.g. laboratory cultures, waste from isolation wards, tissues (swabs), materials, or equipment that have been in contact with tubing’s, catheters, IGS toxins, live or attenuated vaccines, soiled plaster casts and other materials contaminated with blood infected patients, excreta.
- **Pathological Waste:** Human and animal tissues or fluids. E.g. body parts blood and other body fluids, foetuses, animal carcasses.
- **Sharps:** Sharp waste, e.g. needles, infusion sets, scalpels, knives, blades, broken glass that may cause puncture and cuts. This includes both used and unused sharps.
- **Pharmaceutical Waste:** Waste containing pharmaceutical e.g. pharmaceuticals that are expired or no longer needed; items contaminated by or containing pharmaceuticals (bottles, boxes).
- **Genotoxic Waste:** Waste containing substances with genotoxic properties. E.g. waste containing cytostatic drug (often used in cancer therapy), genotoxic chemicals.
- **Chemical Waste:** Waste containing chemical substances e.g. laboratory reagents; film developer, disinfectants, (disinfectants) that are expired or no longer needed solvents
- **Waste with High Content of Heavy Metals:** Batteries, broken thermometers, blood-pressures gauges, etc.
- **Pressurized Containers:** Gas cylinders, gas cartridges, aerosol cans.
- **Radioactive Waste:** Waste containing radioactive substances e.g. unused liquids from radiotherapy or laboratory research, contaminated glassware, packages, or absorbent paper, urine and excreta from patients treated or tested with unsealed radionuclides, sealed sources.
- **Hazardous non-biological waste:** refrigerants, oils, lubricants, grease, electrical and electronic boards of Kerosene-powered cooling equipment, including contaminated parts and broken glass.
- **General Solid Waste:** Waste generated from offices, kitchens, packaging material from stores.
- **Microorganisms:** Any biological entity, cellular or non-cellular capable of replication or of transferring genetic material.

These constitute a grave risk, if they are not properly treated or disposed, or are allowed to mix with other municipal waste. Therefore, this Infection Control and Waste Management Plan, adopted from the World Bank Group’s Environmental, Health, and Safety Guidelines for Health Facilities (2007) is proposed. Where potentially hazardous substances are being disposed of, a chain of custody document must be kept with the environmental register as proof of final disposal.

D. Management rules for wastes

Table A7-1: Bio-medical Waste Management Rules

Category	Waste Category	Treatment and disposal
1	Human Anatomical Waste (human tissues, organs, body parts)	Incineration / deep burial, placenta pits will consider local beliefs and customs
2	Animal Waste (animal tissues, organs, body parts carcasses, bleeding parts, fluid, blood and experimental animals used in research, waste generated by veterinary hospitals colleges, discharge from hospitals, animal houses)	Incineration / deep burial

Category	Waste Category	Treatment and disposal
3	Microbiology & Biotechnology Waste (wastes from laboratory cultures, stocks or specimens of micro-organisms live or attenuated vaccines, human and animal cell culture used in research and infectious agents from research and industrial laboratories, wastes from production of biological, toxins, dishes and devices used for transfer of cultures)	Local autoclaving / microwaving /incineration
4	Waste sharps (needles, syringes, scalpels, blades, glass, etc. that may cause puncture and cuts. This includes both used and unused sharps)	Disinfection (chemical treatment/autoclaving/microwaving and mutilation/shredding)
5	Discarded Medicines and Cytotoxic drugs (wastes comprising of outdated, contaminated and discarded medicines)	Incineration, destruction and drugs disposal in secured landfills
6	Solid Waste (Items contaminated with blood, and body fluids including cotton, dressings, soiled plaster casts, lines, beddings, other material contaminated with blood)	Incineration /autoclaving /microwaving
7	Solid Waste (wastes generated from disposable items other than the waste sharps such as tubing, catheters, intravenous sets etc.).	Disinfection by chemical treatment /autoclaving /microwaving and mutilation shredding
8	Liquid Waste (waste generated from laboratory and washing, cleaning, housekeeping and disinfecting activities)	Disinfection by chemical treatment and discharge into drains
9	Incineration Ash (ash from incineration of any bio-medical waste)	Disposal in municipal landfill
10	Chemical Waste (chemicals used in production of biological, chemicals used in disinfection, as insecticides, etc.)	Chemical treatment and discharge into drains for liquids and secured landfill for solids
11	Hazardous waste from obsolete Kerosene-powered (cooling gases/refrigerants, Kerosene, oils, lubricants, grease, electrical wiring, electronic boards, piping, insulation material, solid contaminated parts, others)	<u>Refrigerants:</u> retrieval for reuse. <u>Kerosene:</u> collection for containment, refining, and possible re-use <u>Used oils, lubricants and grease:</u> collection and use as heat source in certain industries, or safe disposal in hazardous waste dumpsites. <u>Electrical/ electronic parts and gas piping:</u> retrieval for recycling. <u>Insulation material:</u> safe disposal in licensed non-domestic dumpsites, or chemical treatment if applicable.

Category	Waste Category	Treatment and disposal
		<u>All contaminated solid parts</u> should be treated as hazardous materials and disposed of in licensed dumpsites.

Table A7-2: Medical Waste Management Plan: protocol for minimization, reuse, recycling, segregation, transport, and storage

Component	Actions recommended															
Waste minimization, reuse, and recycling	<p>Consider practices and procedures to minimize waste generation without sacrificing patient hygiene and safety considerations</p> <p>Use of efficient stock management practices and monitoring, e.g.,</p> <ul style="list-style-type: none"> ■ For chemical and pharmaceutical stocks; Small/frequent orders for products that spoil quickly and strict monitoring of expiry dates ■ Complete use of old product before new stock is used ■ Maximization of safe equipment reuse practices, including: reuse of equipment following sterilization and disinfection (e.g., sharps containers) 															
Waste segregation	<p>Waste should be identified and segregated at the point of generation.</p> <ul style="list-style-type: none"> ■ Non-hazardous waste, such as paper and cardboard, glass, aluminium and plastic, should be collected separately and recycled ■ Food waste should be segregated for composting ■ Infectious and/or hazardous wastes should be identified and segregated according to its category using a colour-coded system ■ Colour code for Biomedical adopted from the WHO colour code (<i>see below a nested table</i>) <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #FF0000; color: white;"> <th>Color coding</th> <th>Waste category</th> <th>Treatment option</th> </tr> </thead> <tbody> <tr> <td>Yellow</td> <td>Plastic bag Cat. 1, Cat. 2, and Cat. 3, Cat. 6.</td> <td>Incineration/deep burial</td> </tr> <tr> <td>Red</td> <td>Disinfected container/plastic bag Cat. 3, Cat. 6, Cat.7</td> <td>Autoclaving/Microwaving/Chemical Treatment</td> </tr> <tr> <td>Blue / White Translucent</td> <td>Plastic bag/puncture proof Cat. 4, Cat. 7. Container</td> <td>Autoclaving/Microwaving/Chemical Treatment and Destruction/shredding</td> </tr> <tr> <td>Black</td> <td>Plastic bag Cat. 5 and Cat. 9 and Cat. 10. (solid)</td> <td>Disposal in secured landfill</td> </tr> </tbody> </table> <p>Other segregation considerations include the following:</p>	Color coding	Waste category	Treatment option	Yellow	Plastic bag Cat. 1, Cat. 2, and Cat. 3, Cat. 6.	Incineration/deep burial	Red	Disinfected container/plastic bag Cat. 3, Cat. 6, Cat.7	Autoclaving/Microwaving/Chemical Treatment	Blue / White Translucent	Plastic bag/puncture proof Cat. 4, Cat. 7. Container	Autoclaving/Microwaving/Chemical Treatment and Destruction/shredding	Black	Plastic bag Cat. 5 and Cat. 9 and Cat. 10. (solid)	Disposal in secured landfill
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Black	Plastic bag Cat. 5 and Cat. 9 and Cat. 10. (solid)	Disposal in secured landfill														

Component	Actions recommended
	<ul style="list-style-type: none"> ■ Avoid mixing general health care waste with hazardous health care waste to reduce disposal cost ■ Segregate waste containing mercury for special disposal ■ Aerosol cans and other gas containers should be segregated to avoid disposal via incineration and related explosion hazard ■ Segregate health care products containing Polyvinyl chloride to avoid disposal via incineration and subsequent harmful air emissions
<p>On-site handling, collection, transport and storage</p>	<ul style="list-style-type: none"> ■ Seal and replace waste bags and containers when they are approximately three quarters full ■ Full bags and containers should be replaced immediately ■ Identify and label waste bags and containers properly prior to removal ■ Transport waste to storage areas on designated trolleys / carts, which should be cleaned and disinfected regularly ■ Waste storage areas should be located within the facility and sized to the quantities of waste generated, with the following design considerations: <ol style="list-style-type: none"> 1. Hard, impermeable floor with drainage, and designed for cleaning / disinfection with available water supply; 2. Secured by locks with restricted access; 3. Designed for access and regular cleaning by authorized cleaning staff and vehicles; 4. Protected from sun, and inaccessible to animals / rodents; 5. Equipped with appropriate lighting and ventilation; 6. Segregated from food supplies and preparation areas; 7. Equipped with supplies of protective clothing, and spare bags/containers ■ Store mercury separately in sealed and impermeable containers in a secure location ■ Store cytotoxic waste separately from other waste in a secure location ■ Store radioactive waste in containers to limit dispersion, and secure behind lead shields
<p>Transport to external facilities for treatment</p>	<ul style="list-style-type: none"> ■ Many of the health centres in Somalia which will be supported by the project likely do not have onsite waste treatment facilities at the moment ■ Therefore, during operation, solid waste segregation, collection, and storage shall be the responsibility of the health facilities, whereas waste transportation to treatment facility and treatment shall be the work of a contracted biomedical waste handler ■ Therefore, the MoH or its agent (such as the PCIU and the PMT) shall: <ol style="list-style-type: none"> 1. Appoint a waste handler who is licensed by the local authorities and permitted by the local government to handle, transport and treat biomedical wastes at approved treatment sites using recommended treatment procedures given by the legal framework and respective government agencies

Component	Actions recommended
	<ol style="list-style-type: none"> 2. The contractor shall transport waste destined for off-site treatment facilities according to the guidelines for transport of hazardous wastes biomedical wastes in international covenants to which Somalia is a signatory 3. Packaging for infectious waste should include an inner, watertight layer of metal or plastic with a leak-proof seal 4. Outer packaging should be of adequate strength and capacity for the specific type and volume of waste 5. Packaging containers for sharps should be puncture-proof 6. Waste should be labelled appropriately, noting the substance class, packaging symbol (e.g., infectious waste, radioactive waste), waste category, mass/volume being carried, place of origin within health facility, and final destination 7. Transport vehicles should be dedicated to waste and the vehicle compartments carrying waste sealed

Table A7-3. Hazardous Waste Management Plan: protocol for minimization, reuse, recycling, segregation, transport, and storage

Components of Hazardous Waste	Actions Recommended
Refrigerants/ cooling gases	<ul style="list-style-type: none"> - Assess types and quantities, as well as access Material Safety Data Sheets (MSDS) to learn more about various properties and best management measures. - Assess possibility for safe retrieval without causing accidental breakage to the external atmosphere. This is typical handled by experienced technicians using manufacturers’ manuals and having full knowledge of pressurized hazardous gases. - Analyse potential for uncontrolled reactions, such as skin and eye reaction, fire, and explosion. - Analyse potential consequences based on the physical geographical characteristics of the project site, including aspects such as its distance to settlements, water resources, and other environmentally sensitive areas. - Assess potential for local dealers after collection. - Only carry out retrieval of refrigerants by experienced technicians operating through licenced companies. - Use of transfer equipment that is compatible and suitable for the characteristics of the materials transferred and designed to ensure safe transfer. - Seek full coordination with health and civil defence authorities, to ensure enough emergency preparedness. - Safely transport refrigerant containers.

Components of Hazardous Waste	Actions Recommended
Kerosene	<ul style="list-style-type: none"> - Collect separately and do not mix with other fluids. - Only perform by experienced technicians operating through licenced companies. - Never pour Kerosene down your drain or into the sewer, and keep it out of your recycling and garbage. - Collect, handle, and store with great care, given the irritability and flammability characteristics of Kerosene as a Hydrocarbon fuel. - Ensure enough spaces for work, good ventilation, away from human and food contact, and far enough from soil and water resources. - Ensure enough and appropriate usage of PPE. - Seek full coordination with health and civil defence authorities, to ensure enough emergency preparedness. - Seek local licensed dealers for collection, transport, and final disposal. - Re-use if can be refined.
Oils, lubricants, and grease	<ul style="list-style-type: none"> - Assess types and quantities, as well as access MSDSs to learn more about various properties and best management measures. - Assess possibility for safe retrieval without causing accidental seepage to the external environment, including to soil, water and food resources. - Only commission experienced technicians who should have full knowledge of hazardous properties of Oils, Lubricants, and Grease. - Always use secondary containment tanks for collection of incapsulated oils though their drainage valves. - Be prepared with cleaning kits in case of accidental leakage. - Contain and store as hazardous material and seek local licensed used-oil collectors for transport and final treatment/disposal.
Electrical parts/ electronic boards/ refrigerant piping	<ul style="list-style-type: none"> - Assess types and quantities. - Only perform removal of electrical and electronic parts by qualified and experienced technicians, who should ideally operate within their licensed companies. - Ensure appliances unplugged, free of static electricity, free of hazardous residuals, with enough spacing and ventilation, use suitable PPE. - Seek recycling possibilities and do not dispose of in domestic/medical waste streams. - Do not burn wires for the purpose of uncovering and retrieving metal parts. - Ensure community members, who might be running after valuables, don't have access to the worksites.

E. Infection control

The four key areas of infection control for the project are:

- Immunization against nosocomial infections
- Availability and use of barrier protection
- Management of PEP
- Awareness

Activities of high risk include invasive diagnostic and therapeutic procedures, wound dressing, operation theatre procedures, handling of blood/serum/body fluids and tissues etc. and special attention should be paid to ensuring safety precautions during these activities. Barrier protection (gowns, masks, caps, gloves, shoes) should be maintained to prevent contact with contaminated blood/body fluids.

HC workers working in high risk areas should be immunized, at the minimum, against HBV. Daily cleaning of facility premises with appropriate disinfection should be done. Spills are an important source of infection and should be cleaned up immediately. The spill should be covered with absorbent material, disinfectant poured around the spill and over the absorbent material. The surface should be wiped again with disinfectant. HC workers must utilize barrier protection, specially gloves, when managing spills.

General observance of personal hygiene is important. All staff must be neat and clean always, with clean uniforms, nails, short or tied-up hair, etc. PEP is required when there has been contact with known HIV/AIDS infected materials resulting from:

- Percutaneous inoculation (needle stick, cut with a sharp, etc.)
- Contamination of an open wound
- Contamination of breached skin (chapped, abraded, dermatitis)
- Contamination of a mucous membrane including conjunctiva

In all such instances immediate post-exposure management is crucial to reducing the risk of acquiring infection. This should be done in the manner prescribed by the above-mentioned guideline to be developed by the Ministry of Health. All accidents whether needle stick injuries or spills should be reported.

F. Capacity building and awareness

Training and sensitization of various healthcare staff (HCS) and functionaries within and outside the health care system is vital for the successful implementation of this ICWM Plan. The training should focus on Universal Precautions, principles of waste management, identification of roles and responsibilities for implementation, monitoring and reporting. All awareness, training and communication initiatives should be oriented towards providing knowledge and information, building skills and competencies and bringing about a fundamental, mindset change in the attitudes of staff and personnel. The Training Plan and budget should be included into the MoH's plan of work and budget once the project goes into implementation.

The following steps should be followed for implementing training:

- Conduct baseline assessment of training needs for HCS involved in the implementation of the project.
- Develop a Training Plan based upon existing capacity and training needs.
 - At the outset, this plan should distinguish between trainers and non-trainers and elaborate the criteria for identifying trainers and their requirement for training.

- Training should be provided to all HCS, including doctors, nurses, ward boys, paramedics, laboratory technicians, and any housekeeping staff.

Training should be imparted through:

- Dissemination of Information, Education and Communication (IEC) material that will sensitize HCS and create general awareness on importance of ICWMP.
- Technical training for HCS with specific responsibilities for discrete activities related to ICWMP.

Training in Infection Control and in Waste Management should be a comprehensive package as the two are closely intertwined. The training topics will be determined through needs assessment, but the following are highly recommended:

- Training on general aspects of infection control and waste management
- Training on OHS and environmental health and safety guidelines, as outlined in the World Bank's manual⁶⁶
- Training on biosafety and biosecurity
- Training on emergency preparedness and response
- Training on handling pathogenic and potentially lethal agents
- Training on the use of MSDs⁶⁷, 'safe-work' practices, and appropriate PPE

The Train the Trainer program will have to be undertaken at two levels – federal (FGS) and federal member state (FMS) levels. Training should be provided on an annual basis, with refresher courses annually or biannually. In addition to classroom type training, IEC material and awareness-creating activities also need to be employed for training the HCS. Training should preferably be provided on site.

Each health facility should keep records of training provided to employees, by category of employee. The IEC material must be prepared in Somali language on both IC and WM and should be prominently displayed at various places. It should serve as a reminder for all the trained employees as well as sensitize patients visiting the facility.

G. Reporting, monitoring, evaluation and waste tracking

Monitoring & evaluation will be done through a mix of internal and external approaches. The internal reporting and evaluation mechanism on the ICWMP implementation should be integrated with overall PCIU project reporting. Management Information Systems (MIS) indicators pertaining to the ICWMP will be developed during implementation. External monitoring in the form of ICWMP implementation audits is also highly recommended.

Quarterly monitoring. Each health facility must establish a robust system of monitoring through regular documentation and assessments. Ideally, each facility should designate one senior employee responsible for documentation and another for internal evaluation. In the case of blood banks (if any), the laboratory technician should maintain records of waste sharps, gloves, etc. and infectious waste. The records must be maintained on a daily basis and internal assessments should be conducted on a monthly basis.

The monthly report from contracted NGOs (or other appointed service providers) maintaining the health centres should directly be sent to the PCIU in Mogadishu via the respective PMTs.

⁶⁶ Further information available at Environmental, Health, and Safety Guidelines' World Bank URL - <http://documents1.worldbank.org/curated/zh/157871484635724258/pdf/112110-WP-Final-General-EHS-Guidelines.pdf>

⁶⁷ Material Safety Data Sheets

Periodic implementation review. Periodic implementation review of the ICWMP should be undertaken, and as far as possible, this review should be inbuilt into the regular review process of the FmoH. This review should focus on consolidated information and reporting from individual health facility level. To facilitate regular and sustained monitoring, each NGO running the health center should develop annual Action Plans specifically for IC and WM, which should be included into the MoPH plan of work performance assessment.

Waste tracking. Implementing a tracking system allows the PCIU and the respective PMTs to identify their current waste streams from supported health facilities, while determining how much waste the facilities are generating. As a result, the project can maximize landfill diversion and capture what waste can be recycled or beneficially reused—significantly reducing the project’s environmental footprint.

Monitoring waste also reduces liability, cost and environmental impact through identifying and providing alternative solutions based on the project’s expected waste profile. This increases diversion, as well, and helps the project manage proper disposal and logistics.

For the benefit of the PCIU, the concept of “Intelligent Receptacle” is proposed. This system would comprise of a completely wireless setup that would monitor the garbage bins at the health centres and would track the level of bin. Each bin will be provided with a unique ID and would be embedded with low-cost devices. When the garbage in the bin reaches a particular level of the dustbin, the notification would be sent on the mobile app as well as to the web portal that the garbage bins are completely filled and needs urgent attention. This is then complemented by a Bar Code Automated Waste Tracking System.

The Bar-Code Automated Waste Tracking System was designed to be a site-specific program with a general-purpose application for transportability to outside facilities for disposal. The system is user-friendly, totally automated, and incorporates the use of a drive-up window that is close to the areas dealing in container preparation, delivery, pickup, and disposal. The system features ‘‘stop-and-go’’ operation rather than a long, tedious, error-prone manual entry. The system is designed for automation but allows operators to concentrate on proper handling of waste while maintaining manual entry of data as a backup. A large wall plaque filled with bar-code labels is used to input specific details about any movement of waste.

H. Implementation of all components of the IC-WM Plan

- Timely procurement and distribution of IC and WM consumables and equipment
- Regular and timely training programs undertaken
- Regular evaluation of training effectiveness and assessment of health centres’ employee behavioural practices
- Timely interventions and coordination with host facility on significant issues which could hinder effective implementation of IC and WM Plan
- Timely and regular reporting and evaluation undertaken, with corrective measures when necessary.

I. External implementation audits

The PCIU will be responsible for hiring of an external technical consultant firm to undertake an independent evaluation of the IC and WM program and its implementation. The agency to conduct this technical review should be chosen on the basis of their technical expertise and established experience in bio-medical waste management and environmental auditing. Such an independent audit review will be undertaken once during the life of the program, preferably before a mid-term evaluation is conducted for the Damal Caafimaad project. The appointment of the external technical consultant firm will be undertaken in close coordination with the World Bank.

ANNEX 8: INDIVIDUAL STAKEHOLDERS CONSULTED DURING THE DEVELOPMENT OF THE ESMF

A. Stakeholders Consulted

Stakeholder	Affiliation	Location
Amin Ambulance	Local organization	Hirshabelle state and Banadir
Iniskoy for Peace and Development Organization (IPDO)	Local organization	Southwest state
Integrated Services for Displaced Population (ISDP)	Local organization	Puntland state
Save the Children	International organization	Puntland, Galmudug, Southwest, Hirshabelle states
Relief International	International organization	Hirshabelle state
Habib Nur	MoH GFF Liaison Officer	FGS

B. Summary of the key risks and mitigation measures

Issue	Key Risks	Mitigation Measures
<p>Perception about the project and its implementation</p>	<ul style="list-style-type: none"> • The process of contracting NGOs may not be as transparent as required and this may lead to the delay of the project implementation. The contract may be awarded to an NGO with less capacity and the process may be flawed due to nepotism. Often the ministries officials have interest in the procurement processes. • Provision of health services to women and children may not be prioritized by the ministries and NGOs due to existence of high number of such facilities within the state (It is important for the ministry to know that these facilities do not have capacity to provide quality health services). • Elite capture - powerful individuals or groups may influence the project implementation process and end up benefiting their businesses and their process through employments and contracts. • Construction/rehabilitation of health facilities, can cause noise pollution and road blockages. • Environmental risks - disposal of syringes, injections and other equipment cause risks to the communities. There is no proper mechanism to dispose medical equipment. • Socio-cultural beliefs about medicines and vaccines within communities is however common in remote areas. For example, people may be discouraged to use conventional medicine, and instead encouraged to seek traditional medicines. • Community acceptance/ownership and participation: Acceptance of the project by the communities in the implementation areas. The communities have to understand the project components very well before implementation. • Recruitment of qualified people, especially the medical professionals – doctors, nurses, and midwives. <p>Challenges:</p> <ul style="list-style-type: none"> • Tension and fights between clans and village elders, and between the ministries and local administrations office over the management of the project. • The project may end up in the hands of the few people either through elite capture or contracts. • Lack of proper security assessment in the project locations may lead to selection of insecure areas. E.g. areas controlled by AS. • Duplication of activities i.e. health services already supported by other organizations. 	<ul style="list-style-type: none"> • The procurement process should be conducted in a transparent manner and due diligence followed. • The ministries should remain focused to the activities set in the project. • The ministries and World Bank should have supervision role in the implementation of the project and monitor it closely. • Proper consultation with the key stakeholders, community members and local administration in order to avoid exclusion of certain groups. • Conduct proper security analysis and prior site visit before the target locations are chosen. • Conduct needs assessment in the target locations and coordinate the activities with agencies working in the sector • Contracting of employees from the local areas and improving their capacity because they understand the dynamics of the areas, we operate it. • Review security risks in the target areas. • Social risks can be minimized if all clans and communities are consulted about the project equally. • Proper plan should be in place during the construction of the health facilities. Construction material should be disposed properly. • Proper disposal mechanism for health equipment such as burning of the equipment. • Selection of proper sites for construction of health facilities (always avoid flood-prone areas). • Awareness raising conducted by experienced and respected women regarding misperceptions of vaccines • Support by the FGS and FMS MoH. • Adopt manageable approach. • Community representation should be increased especially women. • Recruitment of medical professionals from local communities.

Issue	Key Risks	Mitigation Measures
	<ul style="list-style-type: none"> • Transparency in the procurement and contracting processes. • The project implementation process may be flawed because of tribalism. • Exclusion of certain clans and groups within the communities especially minority clans and women in consultations and provision of health services. <p>Role of gate keepers in implementation they often play an intermediary role between the IDPs and the services providers.</p>	
<p>Exclusion during project implementation</p>	<ul style="list-style-type: none"> • Yes. There could be exclusion of certain groups such as minority groups, IDPs and PWDs due to elite capture. • People from minority clans have little representation in the ministries and local administration, therefore they may also be excluded from receiving services provided at the health facilities and the contracts awarded. Similarly, IDPs may be excluded from receiving health services because they are regarded as external community. • Issues such as child spacing and GBV services may be rejected by the communities and cause tension. • Exclusion of certain groups such as IDPs are expected especially in consultation and benefits. They are supposed to be treated as part of community but they are most often treated as an external group. IDPs are not in most cases considered to be part of the communities. • Similarly, PWDs are supposed to be part of the communities and should equally benefit from health services provided. • Dominant clans and elite groups may take over the implementation of the project. For example, the project workers may be selected from dominant clans and leave out minority clans. For example, the project workers may be recruited from dominant clans leaving out minority clans and NGOs owned and led by dominant clans may be contracted. • Yes, there will be rejection of child spacing services and GBV services by community elders, imams etc. • Dominant clans and elite group might take over the project but it depends on the NGO implementing the activities. The organization can put systems in place to avoid clan/elite capture. • Child spacing services might cause tension and rejection in some communities if proper awareness raising is not conducted. 	<ul style="list-style-type: none"> • Proper consultation with these communities, and awareness to the communities regarding their rights to be part of the project. • Awareness raising. • Put policies in place. • Procurement of staff and services must be done in a balanced manner. • Be conscious of the IDPs and minority groups and include them in the implementation of the project. Make the project as inclusive as possible. • Make the health facilities a disability-friendly premises. • Establish health centres in IDP populated areas/districts.

ESMF – Improving Healthcare Services in Somalia (P172031) and the AF (P178876)

Issue	Key Risks	Mitigation Measures
Labour-related risks	<ul style="list-style-type: none"> • Non-compliance of Somali labour laws are expected during the project implementation. For example, recruitment of workers may be flawed due to nepotism and elite capture. • Somali labour laws are not often followed in many organizations in the country and the rights of workers are abused. For example, fair recruitment may not be practiced during the implementation of the project. • Risks related to pay and working hours, GBV are expected from the project. • Recruitment of project workers may be flawed - many people from dominant clans may be recruited and people from minority clans/groups excluded. • Non-Somalis in the top management of the project within the ministry of health. • Non-equal payment for project workers. Some employees are paid incentives while others are paid salaries. 	<ul style="list-style-type: none"> • The WB should establish an advocacy group to counter this flawed process. • Safeguarding the Somali labour laws • Awareness raising • Equal payment for project workers depending on the qualifications and experience.
Security issues and conflict	<ul style="list-style-type: none"> • The project can be implemented in all the locations where there is presence of Somali government forces/AMISOM. • Presence of security forces may increase attention from AS, even though AS do not target health agencies. • Lesser security threats in Puntland. 	<ul style="list-style-type: none"> • Project, regional and district SecMPs. • Specific security protocol for health workers may increase security threats against them. • Medical workers should minimize unnecessary movements and limit their operations in AS-controlled areas.
Socio-cultural beliefs	<ul style="list-style-type: none"> • Some health facilities are associated to certain clans; therefore, some clans (especially minority clans) may not feel comfortable seeking medical assistance from it. This is because these medical facilities are dominated by certain clans. 	<ul style="list-style-type: none"> • Awareness raising. • Put policies in place to stop influence of clans in recruitment of health workers and initiate elimination of discriminatory behaviour in recruitment processes.
GM	<ul style="list-style-type: none"> • Grievance feedback mechanisms do exist but people are not confident of using it because they believe that their problem will not be solved. These mechanisms are not effective and transparent. • Somalis are oral society; people would prefer phone calls rather than suggestion boxes or email. It is important to provide a toll number where they would call and pass their concerns. • Due to security reasons, they do not trust anyone so it is difficult for them to complain about issues regarding a project. • In many projects, beneficiaries do use suggestion/feedback boxes provided to air their views and grievances about the project (Hirshabelle state). 	<ul style="list-style-type: none"> • If a toll-free hotline number is established and the calls are managed by an external actor, the people may be comfortable conveying their grievances. • Provide a toll-free phone number to the project beneficiaries. • Contract a third party to manage GM on behalf of the MoH. • Conduct forums/meetings at the community level regarding the implementation of the project.

ESMF – Improving Healthcare Services in Somalia (P172031) and the AF (P178876)

Issue	Key Risks	Mitigation Measures
	<ul style="list-style-type: none"> • People do not use suggestion boxes due to high illiteracy level. It is better for them to call and air their grievances (Puntland state). 	
Gender-based violence (GBV)	<ul style="list-style-type: none"> • Female health workers may be sexually exploited even though this is minimal. Security may cause GBV to FHWs. • Due to Somali culture which denounces GBV, such cases are expected to be minimal in the project locations, but it may happen in some places. • Due to the Somali culture and religious teachings, GBV is not expected. 	<ul style="list-style-type: none"> • Awareness raising about the consequences of the GBV in workplaces.
Occupational health and safety	<ul style="list-style-type: none"> • AS do not mostly target/attack health facilities. • If proper security analysis and security management planning is not conducted in target locations, the health workers may be attacked. • They can protect themselves from infectious diseases if they use PPEs. • Medical professionals are prone to infectious diseases and PPEs are not sufficient for them. They are at risk of contracting diseases. • Employees are likely to witness violence and injuries and death at work place. • Most health workers do not have PPEs and are not able to protect themselves from infectious diseases. 	<ul style="list-style-type: none"> • Security Assessments and management plans conducted for the project and target regions conducted by a certified risk management firm. Implementing partners develop district level SecMPs as part of their ESMPs. • Security advisor oversees and monitors the implementation of the SMPs. • Emergency response. • Provide PPEs to the health workers including the FHWs. • Awareness raising on protection of health workers • Capacity building for health workers on protection of infectious diseases.
Stakeholder engagement	<ul style="list-style-type: none"> • Stakeholder engagement can be conducted through meetings, community forum and bilateral meetings with elders. 	<ul style="list-style-type: none"> • Engage various groups/segments within the community including women, community elders, religious leaders, youth, women groups and professionals through meetings and community forums. • Use media platforms such as TVs and radio especially during peak hours.
Recommendations	<ul style="list-style-type: none"> • Proper implementation of the project and engagement of wide range of stakeholders throughout the implementation process. • It is important to invest on the local ownership of the project and its sustainability after the funding ceases. 	Close monitoring by 3 rd party and World Bank

**ANNEX 9: Stakeholders Consultation Meeting for AF FP Components – 17th of June, 2025.
Somalia**

Participants: Representatives from Federal MoH (PCIU and Specialists), State-level PMTs It was attended above 45 participants as shown in table below; (Jubaland, Banadir, Puntland), PSI, private hospitals (Banadir, Puntland, Galmudug IDPs, women's groups, minority group and people with disabilities. The meeting was chaired by– PCIU Senior Programme Coordinator at the Ministry of Health and the meeting was facilitated by the Safeguard team and acting Communication Specialist.

Meeting Objectives

- To engage stakeholders, especially private health facilities, on the additional financing under the Damal Caafimaad Project via the GFF Challenge Fund.
- To gather feedback on project implementation, risks, and mitigation measures.
- To provide updates to the Stakeholder Engagement Plan (SEP) of the Damal Caafimaad Project based on the new Family Planning (FP) intervention in urban areas.

Opening Remarks

Dr. Abdikamal (FMoH project coordinator) gave an overview of Damal Caafimaad, highlighting its support to EPHS across 230 facilities in 5 regions. He announced the GFF Challenge Fund grant focused on enhancing FP services in four cities, primarily through private hospitals. He stressed the importance of stakeholder inputs in shaping implementation and risk mitigation strategies.

Key Presentations and Highlights

1. Public-Private Partnerships in FP – Dr. Mustafe Awil

Explained Somalia’s FP situation and integration into RMNCAH, EPHS, and HSSP strategies. Justified private sector focus due to accessibility and service delivery reach. Highlighted franchising success, current MoUs, and UNFPA-supported partnerships. Identified challenges: cultural resistance, data issues, training gaps. Recommendations: Develop BCC materials, advocate for funding, improve training, involve men.

2. Project Overview – PSI Team

Presented rationale: need for innovative, private sector-led solutions to FP. Goals: improve access, quality, and stakeholder engagement. Activities include: facility readiness assessment, contraceptive supply, STI epidemiology study, digital health solutions. Targets: 20,000 women with modern contraceptives, 10,000 men engaged, 500,000 reached via awareness. Emphasized stakeholder coordination, integration, and data-driven tracking.

3. Environmental & Social Safeguards – PCIU Team

Discussed environmental and social risks (ESS1–ESS10) related to FP service delivery. Emphasized importance of Code of Conduct, medical waste management, grievance redress mechanisms (GRMs), and inclusive community engagement. Outlined mitigation plans including ESMP, supplier compliance, and federal/state-level GRM integration.

Plenary Discussion & Stakeholder Feedback – PCIU Team

Key Issues Raised

No	Question/Issue	Stakeholder Insights and Feedback
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1	How much consultation fee for the services will they be charging?	It depends, the services are free when commodities are received in free manner, like when it received from the government, for instance, the FMOH, or international and UN organizations like UNFPA. But, for the commodities purchased by the hospital, the cost is passed to clients usually.
2	How will they package the information to sensitize the community about the availability of the services?	Awareness is raised through direct communication, posters, and informal networks. However, they acknowledge the need to improve structured and culturally sensitive communication, using trusted voices like local doctors via IVR, and engaging couples and male decision-makers.
3	Is there a CoC that applies to private service providers?	Currently, there is no Code of Conduct in place. However, private the hospitals showed that they are open to receiving training and adopting ESF-aligned.
4	Do they have a GRM system both internal for employees and external for the community?	They also do not have formal GRM systems for clients or staff or the community. They currently rely on informal feedback, and small boxes in the clinics. They are open to adopting GRM mechanisms and welcome support in this area too.
5	How would they want to be consulted, do they have focal points for consultation or network?	Yes, the private hospitals have experience in providing this service, they have designated focal persons and existing networks that have been involved in previous service delivery. They prefer to be consulted through these structures.
6	What challenges do they foresee during implementation of the services?	Many challenges including: limited of FP- experienced and trained staff, weak IPC systems, inconsistent commodity supply, cultural resistance (especially among men), risk of GBV or backlash to users, misinformation, limited provider counseling skills, and clients self-selecting inappropriate methods etc.

Expanded ESF Risks and Mitigation Measures for Family Planning Scope

Expanded GBV Risks and Mitigation Measures

ESF Standard	Risks	Mitigation Measures
SS1 – Assessment and Management of E&S Risks	Poor quality service delivery at private facilities may result in harm to clients.	Conduct comprehensive service readiness assessments and ensure adherence to national FP protocols. Provide refresher training and supportive supervision.

ESS2 – Labor and Working Conditions	Private facilities lack formal HR policies, job protections, or worker grievance systems.	Develop standard HR policy templates, promote safe working environments, and integrate internal GRM for staff.
ESS3 – Resource Efficiency and Pollution Prevention	Inadequate disposal of contraceptive waste and biohazardous materials	Ensure private facilities implement appropriate waste segregation and disposal systems. Provide capacity-building and SOPs.
ESS4 – Community Health and Safety	ESS4 – Community Health and Safety	ESS4 – Community Health and Safety
ESS8 – Cultural Heritage	ESS8 – Cultural Heritage	ESS8 – Cultural Heritage
ESS10 – Stakeholder Engagement and Information Disclosure	ESS10 – Stakeholder Engagement and Information Disclosure	ESS10 – Stakeholder Engagement and Information Disclosure

GBV Risks	Mitigation Measures
Clients (especially women) may face intimate partner violence (IPV) for seeking FP services without spousal consent.	Promote couple counseling and male engagement sessions. Train providers in GBV-safe communication and screening.
Lack of confidential service areas may expose clients to risks of stigma or harassment.	Enforce privacy protocols in all facilities. Retrofit counseling spaces where possible.
GBV survivors may not be identified or referred due to lack of provider training	Integrate GBV referral pathways into private health facilities. Conduct basic GBV case identification training
Staff harassment or abuse due to lack of formal reporting channels.	Introduce internal GRMs with anonymous reporting channels. Establish clear CoC with zero-tolerance for abuse.
Stigmatization or abuse of women using FP methods in conservative communities.	Community dialogues led by religious leaders; develop IEC materials that emphasize shared decision-making and benefits.
GBV survivors may avoid FP services due to lack of privacy or fear of being blamed.	GBV survivors may avoid FP services due to lack of privacy or fear of being blamed.

Notable Comments and Feedback

- Dr. Maimun (Women's Clinic): Highlighted women's fear and lack of counseling time. She stressed the importance of awareness raising about the various contraceptives and the benefits of each. She also spoke about how building trust with women can help educate them and increase their trust in FP.

- Saido Ahmed (Yashfiin Hospital): Removal of methods sometimes charged; need for more training and staffing support.
- Ismail Haji (Justice & Religious Affairs): Need for stronger engagement with religious leaders.
- Muse Adam (Kismayo): Inquired on supply access—confirmed this is under assessment by PSI.
- Abshir (Jubaland): Stressed importance of quality supplies and provider competency.

Environmental & Social Safeguard Concerns

- ESS1: Risk of harm from poor service delivery.
- ESS2 & ESS3: Gaps in staffing, IPC, and waste management.
- ESS4 & ESS8: Risks of GBV and cultural backlash.
- ESS10: Inadequate stakeholder engagement and grievance systems.

Agreed Next Steps

- PCIU to document risks in a specific FP risk matrix.
- PSI and MoH to enhance provider training and improve culturally sensitive communication.
- Stakeholder Engagement Plan (SEP) to be updated to reflect new stakeholders (private facilities, male champions).
- IPC tools and method eligibility checklists to be shared with private clinics.
- GRM channels to be extended to private FP service points.

Conclusion

The meeting was a constructive and timely opportunity to hear directly from key stakeholders, especially private health providers and community representatives. It helped surface useful ideas, practical concerns, and areas where support is most needed as the project moves forward. The discussions made clear that there is strong interest and willingness among private facilities to play a bigger role in family planning service delivery. They also highlighted the importance of regular engagement to ensure that implementation is responsive, inclusive, and aligned with local realities. As Somalia works to better integrate the private sector into its national health efforts, continued dialogue like this will be essential.

Stakeholder Engagement GFF Challenge Fund Meeting Attendance (Table 1: List of participants)

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ANNEX 10: Stakeholders Consultation Meeting for AF FP Components – 18h of June, 2025 Somaliland.

Meeting Minutes: Virtual Stakeholder Consultation on Family Planning Concept Note – Private Sector Engagement (Somaliland)

Date: Wednesday, 18 June 2025

Time: 2:00 PM – 4:30 PM (East Africa Time)

Mode: Virtual (Microsoft Teams)

Organizer: Ministry of Health Development, Somaliland

Facilitators: MoHD Planning Department & PSI-SOM

Chair: Dr. Khalid, Director of Planning, Policy and Strategic Information, MoHD

1. Opening Remarks

Dr. Khalid Balayax, Director of Planning at the Ministry of Health Development, welcomed the participants and emphasized the critical role of inclusive engagement in the expansion of family planning (FP) services in Somaliland. He highlighted the significance of leveraging the private health sector and building on the GFF Challenge Fund to advance FP goals, particularly in Maroodijeex Region.

2. Presentation – FP Landscape & Private Sector Engagement

Presenter: Umulkhayr Mohamed, FP Focal Point, MoHD

The presentation covered:

- Provided an overview of FP indicators in Somaliland, including low contraceptive prevalence and high unmet need.
- Outlined key milestones in Somaliland's FP programming and the role of MoHD in shaping national FP strategies.
- Described the existing partnerships with private providers and associations to increase access and equity.
- Stressed the importance of standardizing FP service provision through social franchising and training.
- Called for stronger integration of private sector FP reporting into the national HMIS and LMIS platforms.
- Highlighted the need for building a coordinated network of franchised private service providers.
- Discussed the Ministry's role in supplying contraceptives, building provider capacity, and conducting supportive supervision.
- Presented challenges encountered in current PPP efforts such as lack of routine data, limited training in LMIS/HMIS, and inadequate counseling infrastructure.

3. Presentation – Concept Note & Scope of GFF Support

Presenter: Fadumo Jama Yusuf, PSI -SOM

Key highlights included:

- Presented the objectives and rationale of the GFF Challenge Fund Additional Financing.
- Highlighted linkages to the Universal Health Coverage (UHC) roadmap, FP-CIP, and broader SDG commitments.
- Explained how the new FP initiative aims to fill gaps in underserved areas through outreach, free contraceptives, and private sector partnerships.
- Described planned integration with existing projects such as Damal Caafimaad and the COVID-19 response.
- Shared expected results: improved contraceptive uptake, male engagement, digital awareness campaigns, and performance-based facility ratings.

4. Presentation: FP Commodity Security Plan

Presenter: Abdirahman Ibrahim, Supply Chain Manager, PSI-SOM

- Introduced the FP Commodity Security Strategy and objectives.
- Demonstrated how the Warehouse Inventory Management System (WIMS) will support real-time stock monitoring.
- Shared tools for tracking expiry dates and improving commodity forecasting.
- Emphasized the need for continuous capacity building for private providers on commodity reporting.

5. Presentation – Environmental & Social Framework (ESF)

Presenters: Hamse Ahmed Guleid (Environmental Safeguard Specialist) & Ayanle Jama Farah (Social Safeguard Specialist), PCIU Team

Key topics discussed:

- Outlined key environmental and social risks of the expanded FP initiative.
- Detailed risk mitigation strategies in line with World Bank ESF guidelines.
- Presented the Grievance Redress Mechanism (GRM) to capture and address client/community feedback.
- Shared tools for accountability, stakeholder consultations, and employee welfare safeguards.

6. Focus Group Discussion – Private Sector Reflections

Moderated by MoHD & PSI

Discussion questions included:

1. Are FP consultation services free, or is there a fee?
2. What communication strategies should be used to raise community awareness?
3. Do you have a Code of Conduct governing service delivery?
4. Is a Grievance Redress Mechanism in place for clients and staff?
5. How would you prefer to be consulted in the future (e.g., through networks/focal points)?
6. What challenges do you foresee in implementation?

Key insights shared:

- Private facilities currently charge fees but expressed willingness to deliver free services if commodities and training are provided.
- There is strong support for localized community engagement led by trained providers.
- Some facilities have informal service codes; others asked MoHD for standardized guidelines.
- GRM systems are largely absent but welcomed by participants.
- Suggested forming a consultation network to ensure inclusion and consistent communication.
- Noted challenges include irregular supply chains, lack of LMIS knowledge, and data reporting burdens.
- It was noted that legal and policy issues, such as the need for spousal consent for FP services and the protection of health workers, were also raised. Given that the Somaliland Health Act is currently under development by the Ministry and Parliament, this presents a critical opportunity to address these systemic concerns through formal legislation and policy frameworks.

7. Summary of Key Action Points

- MoHD and PSI to finalize the FP Concept Note and ToR for GFF-supported activities.
- Follow-up meeting to clarify the HMIS/LMIS integration and provide training to private partners.
- Strengthen coordination mechanisms through focal points from medical associations and private health networks.
- MoHD to map grievance redress mechanisms and share guidance on FP service codes of conduct.
- All partners were encouraged to share any additional feedback via email within a week.

8. Closing Remarks

The meeting was closed with appreciation to all participants. MoHD and PSI representatives thanked stakeholders for their valuable insights and reaffirmed their commitment to inclusive and collaborative FP service delivery in Somaliland.

**ANNEX 11: MINUTES VIRTUAL STAKEHOLDER CONSULTATIONS ON THE
E&S INSTRUMENTS FOR THE DAMAL CAAFIMAAD PROJECT, 3RD
FEBRUARY 2021**

A. Objective: to get input and suggestions on improving the social and environmental instruments for Damal Caafimaad Project including stakeholder engagement, GM, labour and security procedures and the GBV action plan

B. Participants: representatives of disadvantaged and vulnerable groups and different NGOs working in the health sector in targeted regions of Nugaal (Puntland), Bay and Bakool (South West), and Hiraan (Hirshabelle).

C. Agenda

Time	Session	Lead
9-9.15	Opening and introduction to Damal Caafimaad Project	Nur Ali Mohamud, Director Planning, Ministry of Health
9.15-10.15	Social risks, Stakeholder Engagement Plan and Labour Management Procedures, Security management framework	Abass Kassim, social specialist, World Bank
10.15-10.30	Health break	
10.30-11	GBV action plan	Shair Luli/Verena Phips, GBV specialists, World Bank
11-11.30	Environmental risks and mitigation measures	Abdi Zeila Dubow, environmental specialist, World Bank
11.30-12.30	Discussion on social and environmental risks and mitigation measures	Nur Ali Mohamud, Director Planning, Ministry of Health Vanessa Sigrid Tilstone, Social Specialist, World Bank

D. Table of Participants

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Non-state actors		
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E. Environmental and Social concerns raised and suggested mitigation measures

Environmental and Social Risks	Mitigation measures
Concern about public private partnerships is problematic, as services are not free, this not accessible to the poor	The focus will be strengthening private providers through regulations, not as the form of implementation. Given around 80% population use private health providers they need to be regulated. This is being done as part of the project.
Exclusion of marginalized and minority communities (including persons living with disabilities) in consultations as well as beneficiary of the services offered under the project.	Special effort will be made to reach all communities regardless of their background and status both in consultation and in beneficiary. Varying forms of communication to reach a range of people including those who may have hearing, visual or intellectual impairments needs to be considered.

Environmental and Social Risks	Mitigation measures
	Grievance and feedback procedures should also be accessible in various forms and accessible to persons with disabilities, women and children.
It would be useful to establish a civil society advisory group for the project who would advise on transparency and accountability in the project.	Transparency and accountability will be promoted as part of the project including via the SEP. There will be annual stakeholder meetings including of CSOs to feedback on the project
Concern that RCRF social specialists will be asked to support this project as well as RCRF	Separate social specialists will be employed, but the two projects need to work in synergy and learn from each other
How to address resistance of the community for child spacing and condom use	Child spacing is a more accepted term by the community and awareness raising its importance will be carried out
Confidentiality on reporting GBV-related cases	Confidentiality of reporting GBV cases will be guaranteed for victims. This is well explained in the GBV action plan. All healthcare workers providing these services will be trained.
Need to harmonize medical waste management both of health facilities and pharmacies	Medical waste management will be improved as part of the project for health facilities, however the project is not working with pharmacies.
Concern over management of medical waste, especially disposal of placenta in health facilities	Incinerators will be installed in health facilities and consideration will be made of culturally appropriate ways of placenta disposal, which will be addressed in medical waste management plan.
Promotion of occupational health and safety	Training will be conducted on OHS issues for all health staff

ANNEX 12: STAKEHOLDERS CONSULTATION MEETING & MINUTES FOR PROJECT AF - 27 JUNE 2023

A. Participants

This was a virtual meeting coordinated by the PCIU team from the Federal Ministry of Health (FMOH) and conducted via Zoom platform. It was attended by 34 participants as shown in Table A10-1 below, and included health practitioners, INGOs, Academia, Women led organizations, CSOs, other WB financed projects, FMOH departments, PCIU, PMT from state level, in addition to WB representatives.

The meeting was chaired by– PCIU Senior Programme Coordinator at the FMOH and presentations done by the respective Safeguards experts from the Ministry. The Project Coordinator made presentation on the overall project and the Additional Finance components, followed by presentations on expected E&S issues by Ministry’s E&S specialists, documents been required and prepared to manage such risks and impacts, as well as the importance of collecting inputs from Project’s stakeholders. WB senior social development suggested that points should mainly focus on possible concerns and interests of project’s beneficiaries (people-centered), aiming for informing the preparation of Project’s AF updated documents, and collecting recommendations, accordingly.

Table A10-1: List of participants

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B. Objectives

- To receive key stakeholders' input into proposed framework for management of the project-level E&S risks and impacts.
- To assess the new E&S risks of the AF components, with the possibility for including new mitigation measures.
- To Strengthen positive impacts and outcomes of the Somalia DC project, and additionally financed components in particular.

The presentations made during the meeting included an introduction to the Environment and Social Framework (ESF) that was adopted by the World Bank in October 2018 as a means to better manage project environmental and social risks. It was noted that six out of the 10 Environmental and Social Standards (ESSs) are relevant to the project. These are:

ESS 1: Assessment and Management of Environmental and Social Risks and Impacts

ESS 2: Labor and Working Conditions

ESS 3: Resource Efficiency and Pollution Prevention and Management

ESS 4: Community Health and Safety

ESS 6: Biodiversity Conservation and Sustainable Management of Living Natural Resources

ESS 10: Stakeholder Engagement and Information Disclosure

It was noted also that the World Bank requires that all Bank funded projects consider the potential E&S risks and impacts that a project may generate. The Federal Ministry of Health (MoH) is obliged to ensure that negative E&S risks and impacts are avoided, minimized, managed and mitigated. The meeting was therefore called for that meeting, as part of ESS 10 requirements on stakeholder consultation.

The team presented an overview of the parent project as well as the additional finance component to the participants prior to sharing the project’s ESS instruments.

C. Project instruments

The E&S team introduced 4 key instruments for the project (as presented in Table A10-2 below): Stakeholder Engagement Plan (SEP); Environmental and Social Management Framework (ESMF), Labor Management Procedures (LMP) and the Sexual Exploitation, Abuse and Harassment (SEAH) Prevention and Response Plan.

Table A10-2: Key project instruments, purpose and key issues for consideration

Instrument	Purpose	Key issues for consideration
<p>SEP – Presented by Acting social safeguard specialist for DC project</p>	<ol style="list-style-type: none"> 1. Outlines a plan for continuous stakeholder engagement throughout the project at all levels including with: <i>disadvantaged and hard to reach groups: women, IDPs, pastoralists, and minority groups</i> etc. 2. Behavior change communication strategy to address especially for priority groups. 3. Stakeholder feedback surveys: TPM, Communication effectiveness 4. Grievance Redress Mechanisms (GRM): accessible, trusted, functional and confidential. 5. Complaints: focal points at facility sites. 6. Separate channels for reporting incidents through GRM: project, direct workers, and GBV/SEAH cases. 7. Disclosure: All key documents with Somali summary will be publicly disclosed on MoF/H and WB websites 	<ol style="list-style-type: none"> 1. What is working so far to promote service delivery among priority groups in hard-to-reach areas as well as DC target regions? 2. How best to overcome challenges particularly among hard-to-reach and disadvantaged groups including: minority groups: women, IDPs, nomadic pastoralists. Are different approaches needed in different FMS ? 3. How best to get stakeholder feedback on project implementation at FGS and FMS levels? 4. Who and how can complaints be received and resolved impartially and confidentially, including from workers and regarding sexual harassment, exploitation and abuse: <ol style="list-style-type: none"> a) During the DC service delivering campaigns? b) At FMS and FGS level?
<p>ESMF – Presented by environmental safeguard specialist for DC project</p>	<ol style="list-style-type: none"> 1. Outlines all E&S risks and mitigation measures and provides an overview of all instruments. 2. Policy environment and institutional framework. 3. Roles and responsibilities – MOH, WHO, UNICEF, NGOs/contractors. 4. Capacity assessments of FGS MOH partners, orientation and training plan 5. Staffing – FGS: environment, social and GBV specialists. 6. incident reporting 7. Medical waste and infection control plan for the vaccination program 8. SEAH Prevention and Response Action Plan 9. Monitoring and reporting – who will monitor and report E&S issues. 	<ol style="list-style-type: none"> 1. What are the potential risks from implementing this project? 2. What measures should be put in place to ensure that the identified risks are addressed and mitigated? 3. What measures should be put in place to specifically address vulnerable, minority and disadvantaged groups (pastoralists, nomadic populations, female teachers, learners with disabilities, etc.) and people in marginalized areas (remote, poor rural and urban areas)? 4. How should the disclosure of existing grievance redress mechanism (GRM) and feedback be made more effective in order to reach all stakeholders? What other structures/systems are operational in the country for seeking grievance redress?

Instrument	Purpose	Key issues for consideration
LMP – Presented by Acting social safeguard specialist for DC project	<ol style="list-style-type: none"> 1. All workers involved with delivering the project: <ul style="list-style-type: none"> • Prevention of <i>forced and child</i> (under 18) labor; • Occupational health and safety concerns including security protocols and protection from GBV and infectious diseases; • Need: training including security personnel, code of conduct and access to project GRM, GBV/SEA/SH 2. Direct workers: PCIU staff & contracted workers: <ol style="list-style-type: none"> a. Promote <i>fair treatment, non-discrimination</i> & equal opportunity. b. Measures to <i>prevent and address harassment, intimidation, and/or exploitation.</i> d. Provide <i>accessible means to raise workplace concerns/ grievance</i> redress including GBV/SH – <i>confidential and non-retaliation</i> 	<ol style="list-style-type: none"> 1. Responsibilities for workers involved in service delivery from NGOs, private sector for security, CoCs, training on OHS requirements and monitor all damal caafimaad health facility targets . How is it being done now? 2. Do all teams have adequate PPE? Are they paid on time, for overtime, CoC’s, awareness on complaints mechanism? 3. How good are the procedures for entry into health care facilities, including minimizing visitors and undergoing strict checks before entering?
SEAH Plan Presented by GBV specialist for DC project	<ol style="list-style-type: none"> 1. Define and reinforce GBV/SEAH requirements in procurement processes and contracts 2. Review the Implement Agencies’ capacity to prevent and respond to GBV/SEAH 3. Inform project stakeholders about GBV/SEA risks Establish GBV/SEAH sensitive channels for reporting in the GM. 	<ol style="list-style-type: none"> 1. Are there additional risks that have been left out and might exacerbate the risks of GBV/SEAH within the DC project? 2. What additional mitigation measures can be put in place to prevent SEA/SH Be put in place to address GBV/SEAH allegations in the DC project?

The key environmental social and GBV/SEAH risks (presented in Table A10-3 below) have been identified but the list needs to be reviewed and refined based on the local understanding of the issues.

Table A10-3: Key environment and social risks

#	Theme	Risks
1.	Environment	<ul style="list-style-type: none"> • Community health and safety risks, medical waste (incl. contaminated waste), hazardous use and disposal of disinfectants, masks, and gloves, and the burden of untreated waste, Occupational Health and Safety (OHS) risks involving medical workers assigned to this project at implementation, such as risks of disease transmission • Additional risks from the use of fossil fuels (including diesel) for provision of off-grid power to refrigerate vaccines – risks of exudates from fuel containers and subsequent contamination of soil systems and groundwater resources. • Environmental risks and their mitigation measures will be articulated in the ESMF, including an Infection Prevention and Control – Waste Management Plan (IPC-WMP) for the project, as well as in area-specific Environmental and Social Management Plans (ESMPs).

#	Theme	Risks
2.	Social	<ul style="list-style-type: none"> • Conflicts • Lack of inclusion: urban focus, lack of inclusion of minority groups, IDPs, women, lack of reach of information e.g. some minority groups may not use mainstream media or have access or literacy e.g. women, IDPs etc. • Security risks: targeting e.g. by AS, lack of community buy-in • Labour risks: long hours, delayed remuneration; nepotism • Grievance mechanism: no trusted, accessible mechanisms, and fear of retribution
3.	GBV/SEAH	<ul style="list-style-type: none"> • Potential abuse of power and sexual exploitation in labor practices • High risks related to limitations on mobility during service delivery rollout. • Unequal gender and power relations can exacerbate the risks of GBV in HCF. • Misinformation or lack of information throughout the project's components can lead to harm and violence towards the communities. • Services delivery shortages and rationing might contribute to increased risks of sexual abuse and harassment

D. Discussion

The issues presented and raised during the discussion and responded to are summarized in the following Table A10-4.

Table A10-4: Issues raised and responses

Theme	Issue	Response
GBV/SEAH	<ul style="list-style-type: none"> • Social risks includes: There is existing sexual harassment in the workplace but mostly is unreported due to fear of losing the job or not having full information about the reporting 	<p>Mitigation measures: provide more awareness rising on the key government staff about SEAH GRM reporting mechanism, availability and accessibility with maintenance confidentiality and all project workers should get CoC orientation and should sign the project COC.</p> <ul style="list-style-type: none"> • Continuation of GBV/SEAH risks and Mitigation measures. • The project will conduct GBV service mapping and Clinical Management of Rape assessment in Nationwide.
GRM	<ul style="list-style-type: none"> • Inclusion of all relevant complains • How do states mobilize? Are states aware the GRM? 	<ul style="list-style-type: none"> • Updating the necessary GRM complains in line with positive and negative complains. • The states aware GRM mechanism and received orientation and now planning to establish GRM methods at state level. • The PCIU and PMT will conduct/continue mass community awareness raising of the GRM reporting mechanism available to educate the community and beneficiaries.

Theme	Issue	Response
Environmental Risks/MWMP.	<ul style="list-style-type: none"> • Regarding managing project risk Any mitigation measures about floods in Damal Cafimaad project areas, like Hiiraan regions, as we all know that the riverine villages in the country has experiences recurrent floods and it has resulted in the destruction of homes, livelihoods, crops, roads, water and sanitation infrastructure and also access to essential health and nutrition services are challenging during the floods. • Although there is a waste management plan – the participants wanted to know more information. • Do the projects have experience in environmental and social impact assessments? 	<ul style="list-style-type: none"> • DC project have CERC component for emergencies. • Health facility environmental management emergency responses plan as Draft document, the main objective is to identify /determines the level of the exposure. • the capacity to deal with the exposures at facility level, • Finally we Do not only focus on floods but all kinds of exposures example Fire outbreaks and so on. • Based on waste management procedures across the country most of the cold chain wastes will be used via integrated waste management approaches i.e. reuse, reduce and recycle. However there are other principles used by UN agencies i.e. SOPs in terms of waste management. • Of course DC safeguard together with WB safeguard developed a document called ESIA.
Occupational health and Safety	It was noted that the Occupational health and safety guidelines were developed but still at draft stage, as well as to follow up on the existing Child safeguard policy.	DC project to follow up on the exiting child safeguard policy. Under the Contractors ESMP there will be provisions for child protection.
Interacting with the stakeholders and suggestions points	<ul style="list-style-type: none"> • Also one of the social risks may be lack or in adequate public participation.-Mitigation measures: the project should ensure that measures are out in place to identify and reach for disadvantaged groups and rural population with project information. • There were suggestions by the stakeholders to have more stakeholder engagement that are physical. • Regular technical meetings that are periodic with set timelines – monthly, quarterly and extra among the FGs and FMS and key implementing partners. • Creating early warning signals as flood prevention mechanism. • To follow up the national disability agency i.e., national disability act, inclusion of PWD. • Disclose of all updated and translated documents into the ministry of website. • Ensuring the adaptation and implementation of WB safeguard compliances. 	

ANNEX 13: INCLUSION PLAN

A. Introduction

The project will give special consideration to disadvantaged groups, which include: minority castes and groups;⁶⁸ IDPs; people who live in remote rural areas or areas characterized by violence that are bereft of social services and amenities; nomadic pastoralist communities; PWDs; and female headed households including vulnerable orphans and unaccompanied minors.

The Contractors' E&S assessment and management plans will identify and address barriers to disadvantaged and vulnerable groups participating in and benefiting from project services. Measures will be included in the contractors' SEPs and community health outreach strategies as well as via training of service providers and health staff on the need to promote inclusion and diversity in staffing. Physical measures, such as ramps and rails in health facilities will be considered as well as means of ensuring that information is presented in accessible formats including sign language and braille. The project will ensure access to separate and culturally appropriate facilities for males and females, particularly for GBV/SEAH and child spacing services, culturally appropriate placenta pits and confidentiality of patient information and GMs.

There are social, economic and physical barriers that prevent disadvantaged and vulnerable individuals and groups from participating in projects, which include lack of financial resources, inaccessibility of meeting venues, social stigma, lack of awareness and/or poor consultation. For instance, PWDs are often not effectively engaged in consultations due to lack of access, social stigma and cultural beliefs that ensure they not prioritized in health service delivery due to their limited productivity in society. Women with disabilities, for instance, have continued to have less access to child spacing services due to stigma, limited access and poor perception of service providers about their sexuality. In this regard, the project will deploy viable strategies to engage targeted communities and other stakeholders to overcome social stigma and promote inclusion.

In view of the risk of clannism, nepotism and elite capture and potential exclusion of disadvantaged and vulnerable groups, the social safeguards team at the FGS and FMS MoHs will ensure that the implementing partners put measures in place to reach areas where disadvantaged and vulnerable groups live. They will also promote inclusion in project consultations and access to services. There will be a need to be deliberate in ensuring that men are involved in consultations and all the other aspects related to access to health service access.

B. Engaging disadvantaged and vulnerable groups

The project will promote inclusion of disadvantaged and vulnerable groups by ensuring their involvement in consultations in the sub-project design and the development of the ESMPs. This will include ensuring that health facilities are accessible to people with physical disabilities (e.g. having ramps and rails where appropriate) and training health staff and community health committees on their role of providing services without discrimination. The health facilities will also record PWDs in the health information tools and

⁶⁸This shall include all groups falling outside the big four clans and not genealogically associated with them in a specific district or geographical area including the ethnic, occupational groups.

share the reports with the PCIU for monitoring and response where necessary. In addition, efforts will be made to promote diversity in staffing (see LMP). In addition, community health committees will have diverse representation including disadvantaged and vulnerable individuals and groups.

Community and Health worker training will emphasize non-discrimination and access to health for all including disadvantaged and vulnerable groups. Special effort will be made to ensure that healthcare staff are trained and sensitized on inclusion of disadvantaged and vulnerable groups including minorities and PWDs as well as age and associated healthcare needs. CoCs, ethical guidelines and procedures for health staff will be established to support safe and appropriate provision of healthcare including right to impartial needs-based healthcare, and procedures for obtaining informed consent for services. In addition, healthcare staff will be made aware of the increased risk of sexual violence faced by people with disabilities (women and girls, but also boys and men) and train them in the safe identification and care of PWDs who have experienced sexual violence, while respecting confidentiality. Social barriers affecting access to information and services for these groups, such as discrimination and stigma, will be identified and addressed.

Stakeholder and community engagement will be key in the sensitization of community level structures and means by which complaints and grievances related to the project will be received, handled and addressed. The understanding is that communities understand their own vulnerabilities compared to external actors and the engagement of local structures is most effective in such projects where administrative capacity is limited.

The participation of disadvantaged and vulnerable groups in the selection, design and implementation of project activities will largely determine the success of this Inclusion Plan. Where adverse impacts are likely, the PCIU and the State PMTs will undertake prior and informed consultations with the likely affected communities and those who work with and/or are knowledgeable of the local development issues and concerns. The primary objectives will be to:

- a. Understand the operational structures in the respective communities;
- b. Seek input/feedback to avoid or minimize the potential adverse impacts associated with the planned interventions; and
- c. Identify culturally appropriate impact mitigation measures.

Consultations will be carried out broadly in two stages. First, prior to the commencement of any project activity, the implementing agency will arrange for consultations with community leaders, community health committees and representatives of disadvantaged and vulnerable groups about the need for, and the probable positive and negative impacts associated with the project activities as part of the development of the ESMPs. Second, there will be continuous stakeholder engagement that will ensure the active involvement of disadvantaged and vulnerable groups as part of the contractors' SEP and monitoring.

The implementing entity will:

- a) Facilitate broad participation of disadvantaged and vulnerable individuals and groups with adequate gender and generational representation, community elders/leaders, religious leaders, and CBOs;
- b) Provide the disadvantaged and vulnerable individuals and groups with all relevant information about the project including on potential adverse impacts;
- c) Ensure communication methods are appropriate given the low level of literacy, local dialects and communication challenges for PWDs;

- d) Organize and conduct the consultations in forms that ensure free expression of their views and preferences;
- e) Document details of all consultation meetings with disadvantaged and vulnerable individuals and groups on their perceptions of project activities and the associated impacts, especially the adverse ones;
- f) Share any input/feedback offered by the target populations; and
- g) Provide an account of the conditions agreed with the people consulted.

Once the disadvantaged and vulnerable individuals and groups are identified in the project area, the provisions in this Inclusion Plan will ensure mitigation measures of any adverse impacts of the project are implemented in a timely manner. The project should ensure benefits to the disadvantaged and vulnerable by ascertaining that they are consulted, have accessible and trusted GM to channel the complaints they might have on the project.

To help ensure that the process does not marginalize men, women and other vulnerable groups, representation for these groups will be required in the grievance committee (GC) tasked to resolve grievances/complaints at the community level.

The following issues will be addressed during the implementation stage of the project:

- a) Provision of an effective mechanism for monitoring implementation of the Inclusion Plan by the PCIU and PMTs, social safeguards team and contracted NGOs;
- b) Involve suitably experienced CBOs/NGOs to address the disadvantaged and vulnerable groups through developing and implementing targeted action plans that are issue focused (e.g. on access to health services for women in remote areas);
- c) Ensuring appropriate budgetary allocation of resources for the contractors' Inclusion Plans as part of the contractors' ESMPs; and
- d) Provision of technical assistance for sustaining the activities addressing the needs of the disadvantaged and vulnerable individuals and groups.

ANNEX 14: GBV ACTION PLAN

A. Introduction

The project intends to improve quality, scope, and access to the Essential Package of Health (and nutrition) Services (EPHS) through resource mapping to support the development of an EPHS Somalia’s health needs. There are four proposed areas to be supported under the project: Expanding the coverage of prioritized EPHS in selected regions, developing government stewardship capacities to enhance service delivery, Project Management, M&E, Knowledge Management, and Learning, and Contingency Emergency Response Component (CERC).

The FGS MoH and FMS MOHs will implement the proposed project. The FGS MOH will provide overall health sector stewardship, including regulatory oversight and monitoring of state-level service delivery implementation. Besides, the FGS MOH will manage service delivery contracts for most states. In states where the FGS operates the service delivery contract, the FMS will monitor and supervise contract implementation, managing relevant safeguard instruments with oversight from the FGS MoH.

This GBV Action Plan details the necessary operational measures and protocols that will be put in place to address Gender based violence (GBV), sexual exploitation and abuse and sexual harassment (SEAH) related to the health project and how they will be integrated over the life of the project. This includes, how to address any SEAH allegations that may arise and procedures for preventing and responding to GBV/SEAH. The Action Plan details how allegations of SEAH will be handled (investigation procedures) and disciplinary action for violation of the Code of Conduct (CoC) by workers.

B. Definition of terms

The Inter-Agency Standing Committee (IASC) defines gender-based violence as “an umbrella term for any harmful act that is perpetrated against a person’s will, and that is based on socially ascribed (gender) differences between males and females. GBV broadly encompasses physical, sexual, economic, psychological/emotional abuse/violence including threats and coercion, and harmful practices occurring between individuals, within families and in the community at large. These include sexual violence, domestic or intimate partner violence, trafficking, forced and/or early marriage, and other traditional practices that cause harm.

The United Nations defines sexual exploitation as “any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another”. Sexual abuse on the other hand is “the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.” SEA is therefore a form of gender-based violence and generally refers to acts perpetrated against beneficiaries of a project by staff, contractors, consultants, workers and Partners.

Sexual harassment is defined as any unwelcome sexual advance, request for sexual favour, verbal or physical conduct or gesture of a sexual nature, or any other behaviour of a sexual nature that might reasonably be expected or be perceived to cause offense or humiliation to another, when such conduct interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment. It occurs between personnel/staff and involves any unwelcome sexual advance or unwanted verbal or physical conduct of a sexual nature.

C. Why Should the Health Sector Address Gender-Based Violence?

Gender-based violence has adverse consequences on women's sexual and reproductive health. The experience of gender-based violence has also been linked to increased risk of gynaecological disorders,⁶⁹ unsafe abortion, pregnancy complications,⁷⁰ miscarriage, low birth weight,⁷¹ and pelvic inflammatory disease. Abuse, primarily physical and sexual violence, can limit a woman's ability to negotiate on the use of contraception, putting them at a higher risk for unintended pregnancies and sexually transmitted infections (STIs), including HIV. Childhood sexual abuse has been associated with risky behaviours such as drug and alcohol use, more sexual partners and lower contraceptive use.⁷²

Gender-based violence has been identified as a significant cause of disability and death among women. Epidemiological evidence indicates that among women of reproductive age, intimate partner violence alone is a major cause of disability and mortality throughout the world.⁷³ Gender-based violence has profound, negative consequences for women's physical and emotional health, ranging from emotional distress, bodily injury, and chronic pain to deadly outcomes such as suicide and homicide. It is a risk factor for many physical, mental, and sexual health problems.

Healthcare workers and in particular female health workers may face GBV risks, especially those working in more remote areas with little supervision. At the same time, health care workers may put women at risk if they are uninformed or unprepared. Health professionals who breach patient confidentiality, respond poorly to the disclosure of violence, blame victims, or fail to offer support where needed can put women's safety, well-being, and their lives at risk.⁷⁴ For instance, providers can cause further harm by:

- Expressing negative attitudes to women who are survivors of physical or sexual abuse, such as rape.
- Discussing woman's injuries in a consultation room which can be overheard by a potentially violent spouse standing outside.
- Breach confidentiality by sharing information about pregnancy, abortion, STIs, HIV, or sexual abuse with another family member without the woman's consent.
- Providing inappropriate medical support by missing out on the reasons behind a repetitive, sexually transmitted infection.

D. Country Contextual Risks

Gender-based violence (GBV) affects 1 in 3 women in their lifetime. Most recent global estimates suggest that 35% of women worldwide have experienced physical and sexual intimate partner violence (IPV) or non-partner violence. Over 200 million girls and women are estimated to have undergone Female Genital Mutilation.⁷⁵

⁶⁹ Campbell J et al. "Health consequences of intimate partner violence." *The Lancet*, 359(9314):1331-1336, 2002.

⁷⁰ Heise L, Ellsberg M, Gottemoeller M. "Ending Violence Against Women." *Population Reports*, Volume XXVII, Number 4, Series L, Number 11, 1999.

⁷¹ Murphy C et al. "Abuse: a risk factor for low birth weight? A systemic review and meta-analysis." *Canadian Medical Association Journal*, 164(11):1567-1572, 2001.

⁷² Walker et al. "Adult health status of women HMO members with histories of childhood abuse and neglect." *American Journal of Medicine*, 107.4: 332-339, 1999.

⁷³ Krug E et al, eds. *World Report on Violence and Health*. Geneva: World Health Organization, 2002.

⁷⁴ Bott S et al. "Improving the health sector responses to Gender Based Violence." Resource manual for health care professionals in developing countries.

⁷⁵ International Alert/CISP (2015) *The Complexity of Sexual and Gender-Based Violence: Insights from Mogadishu and South Central Somalia*, International Alert, Nairobi.

Available evidence indicates GBV is common in the lives of women and girls across the life course in Somalia, with some forms of GBV endemic. FGM/C has in the past been near universally practiced. Intimate partner violence and sexual violence, the most prevalent types of GBV globally, are commonplace in Somali women and girls' lives. Some forms of GBV are normative in Somalia, including FGM/C, child marriage and some intimate partner violence behaviours.⁷⁶ Other normative forms of GBV in Somalia include cultural practices of abduction and forced marriage and widow inheritance.⁷⁷ The extent to which each type of GBV is practiced and normative varies across regions of the country, and there are indications of apparent shifts in beliefs and attitudes that support FGM/C, child marriage and intimate partner violence within Somalia.

Sexual violence, along with other violence, is said to have become normalized in Somalia. This apparent normalization appears to be the result of sustained exposure to elevated levels of sexual violence over past decades compounded by the lack of national and community-level communication, discussion and dialogue about sexual violence and other forms of GBV.⁷⁸ This combination of high levels of exposure and low levels of public and private discourse have created an environment which not only enables violence against women and girls to continue, but also curbs national and community-level awareness, commitment and action to do something about it.

A growing body of epidemiological evidence demonstrates that gender-based violence can cause or contribute to a host of health problems among women. These range from the immediate health effects of physical and sexual violence, including injury and infection, to long-term health impacts of substance use, depression or anxiety, poor pregnancy outcomes such as low birth weight) and increased rates of abortion among survivors of violence.⁷⁹

Evidence indicates that health service delivery for sexual assault survivors is inadequate in Somalia. There is a lack of a trained medical workforce, inadequate infrastructure and supply of essential post-rape care equipment and drugs. For example, a study of 779 health centres across Somalia revealed that only 25 percent had the necessary drugs to treat sexually transmitted infections and fewer than 18 percent had the capacity to provide counselling and testing for HIV.⁸⁰

Sexual exploitation and abuse of children and women by people in positions of authority and power are reportedly common as elsewhere, linked to poverty, insecurity and impunity.⁸¹ Although data are limited, there is evidence of high levels of sexual exploitation and abuse by a range of perpetrators, including domestic and foreign security forces and by civilians.⁸² Anecdotal evidence from humanitarian and development agencies indicate that sexual exploitation and abuse is a largely unreported and significant problem in the country.

While there has been commitment by the Federal Government of Somalia to reducing overall maternal mortality rate across the country by no less than 25% by 2030 through training and employment of additional midwives, there is need to accelerate progress towards achieving universal access to quality sexual and reproductive health services for all.

⁷⁶ Ibid.

⁷⁷ Norwegian Country of Origin Information Centre (2018) Somalia: Marriage and divorce, Landinfo, Oslo.

⁷⁸ International Alert/CISP (2015).

⁷⁹ Wirtz A.L, Perrin N.A., Desgroppes A. et al (2018) Lifetime prevalence, correlates and health consequences of gender-based violence victimisation and perpetration among men and women in Somalia', *BMJ Glob Health* 2018;3.

⁸⁰ GBV Sub-Cluster Strategy 2018-2020.

- There is existing sexual harassment in the workplace but mostly is unreported due to fear of losing the job or not having full information about the reporting

E. Identified Project-related GBV Risks

This project's identified risks include gender relations between staff (direct and contracted workers) and service delivery modalities. At the same time, the survivors and even the perpetrators of the GBV/SEAH could be the project staff, individuals in the family, and the community at large. The project-related risks are substantial and are as follows:

- **Potential abuse of power and sexual exploitation in labour practices:** The recruitment process can distort power relations and lead to opportunities for abuse. Hiring and employment practices that seek to increase the number of women can also expose them to incidents of sexual exploitation, harassment, or violence. Additionally, unequal gender norms and harmful beliefs run the risk of creating hostile environments for female workers. In cases where female workers have less time for traditional gender-related work such as childcare, this can also lead to a potential increase in IPV.
- **Female Health workers may face high risks related to limitations on their mobility during outreach or supervision,** leading to potential exposure to GBV/SEAH when implementing FHW duties. For example, traveling long distances to reach communities and/or service sites work sites can increase targeting, exploitation and harm from non-partner individuals, including armed groups/forces/individuals.
- **Limited or incomplete training of personnel,** as well as a lack of competent survivor-centred primary, secondary and tertiary services can increase risk of harm. Other risks include violence or death for survivors of GBV, women, girls and other groups (such as people with disabilities and people of minority ethnic/tribal groups). Survivors of GBV who choose to seek services and disclose their experience be it in a primary health care setting, to FHWs or at designated clinical management of rape services may experience more violence and harm by providers or health personnel who do not observe survivor-centred principles – namely safety, confidentiality, non-discrimination, and informed consent – or who do not abide by safe and ethical operating procedures for referrals to specialized services.
- **Lack of appropriate rooms for private consultation and examination to ensure the privacy and safety of survivors seeking care can break confidentiality or breaks in considerations for a survivor's safety and choices** could lead to a slew of consequences including retaliation by perpetrator(s), intimate partners or family members, social isolation, targeted physical attack and death.
- **The inability to recognize or respond appropriately to the signs of trauma from survivors** can lead first responders such as FHWs to inadvertently exacerbate stigma, trauma, and/or survivors' ability to access safe appropriate services.
- **Limited or lack of essential supplies and drugs of treatment of infections and management of rape** could put the survivors at further risks. Survivors of violence who seek services at the health facilities where there are no drugs and limited referral services could further harm their health and physical safety.
- **Community conflict resolution approaches** can lead to more harm against survivors who report GBV/SEAH experiences. Community or social governance resolution processes might reinforce gender inequality. Through pushing for resolutions that widen inequalities, are not survivor-centred, and may lead to impunity and more harm to a survivor, for example through marriage to a perpetrator, re-victimization or other consequences.

F. Existing Risk Management Systems/gaps

Regulations and Policies

The health workforce deployment and procedures developed in 2019 to help Somali Federal Government through the Ministry of Health to train, employ, deploy and retain an adequately skilled health workforce that is well motivated to offer quality services to the general public and people living in Somalia.

The policy guides on staff appointments, performance management, staff training and development, and grievance and disciplinary handling procedures mechanisms. On matters of disciplining and dealing with misconduct, there is a need to develop mechanisms to address specifically SEAH, including a GM with separate channels to manage GBV related complaints and the procedure for disciplinary actions on matters on GBV/SEAH which does not appear in the policy.

The code of conduct for the Federal government of Somalia sets the values, standards of behaviour and rights and responsibilities of all staff. The Code of Ethics has been developed to set out the framework within which all civil servants will work and the core values and standards of behaviour they are expected to uphold. It is clear that the CoC developed emphasizes on supporting a positive working environment by observing the FGS civil service policy on harassment, sexual harassment and bullying. There is a need for staff capacity development to include regular orientation to understand better the ethical requirements related to their work and operations. The development of simplified information, education, and communication materials translated in different Somali dialects can be facilitated to enhance the uptake of the COC content in all the project locations.

The clinical management of rape protocol

Developed in 2015 by the Ministry of Health at the Federal level aims at creating an enabling environment for the provision of equitable access to standardized and quality Clinical Management of Rape services. It also covers legal response and Psychosocial Support throughout Somalia. This protocol also guides on quality assurance, procedures for coordination, service delivery, including necessary supplies to be stocked and overall framework on the standardized CMR training and continuous capacity building of health personnel.

Therefore, the project needs to look into the potential risks emanating due to limited training of personnel, inadequate or lack of supplies, and drugs in health facilities where CMR services are needed. Also, lack of private rooms for consultations and understanding of the survivor-centred approach, and providing care for all by enabling environment free from GBV and SEAH. If not well managed, these factors can lead to further harm to the workers and community members.

The project will put in place the necessary mechanisms to address SEAH. The proposed mitigation measures as per the risk level in the current project is as follows:

- GBV requirements and expectations included in the procurement process, including essential supplies and drugs for health and nutrition and the signing of the Code of Conduct by all the project staff to cultivate an environment free from GBV and SEAH.
- Materials developed for stakeholders providing information, education, and communication to indicate that the project and/area is a GBV free zone as well as provide information on GBV response services (such as hotline numbers and where to seek services when needed).
- Utilizing the GM developed and being implemented under the RCRF project with a separate channel to manage GBV-related complaints integrated into the GM to enable reporting in a safe, confidential survivor-centric manner.

- Mapping out GBV health response services and protocols in project areas to ensure the availability of services, including adequate medical supply kits such as post rape treatment kits.

GBV ACTION PLAN

#	Objective:	To reduce the risks of GBV/SEAH and enhance health response services for GBV survivors					
	Activity to Address GBV/ SEAH risk	Steps to be taken	Timelines	Institutional Focal Point	Collaborating actors/relevant ministries	Output indicators	Estimated Budgets (USD) 2021-2025
1.	Define and reinforce GBV/SEAH requirements in procurement processes and contracts						
a)	Incorporate GBV/SEAH/Requirements and expectations in the any standard bidding documents, as well as contractor and consultants’ contracts (see annex 8 for sample contract for contractors).	Ensure that GBV/SEAH issues are incorporated in all bidding documents and contracts signed by contractors and consultants	Before project activities begin.	MOH-FGS	MOH-FMS World Bank	GBV/SEAH standards in procurement/contract document	N/A
b)	Codes of Conduct signed and understood by project management team, consultants, CSOs/NGOs service providers and private sector network	Define the requirements to be included in the CoC which addresses GBV/SEAH Review CoC for provisions/clauses that guard against GBV/SEAH Have CoCs signed by all staffs Train all project-related staff on the behavior obligations under the CoCs. Display CoC in project sites and translated into the local language(s)	Before project activities begin	MOH -FGS	MOH-FMS	Percentage of workers that have signed a CoC (target 100 percent)	The training of the staff on CoC will be conducted by the GBV specialist with support from WB
2.	Review the IA’s capacity to prevent and respond to GBV/SEAH;						
a)	Recruit GBV specialist to support the project and supervise the implementation of the GBV action plan	Recruitment of GBV specialist	Within the first 3 months of project effectiveness	MOH -FGS	WB	Qualified and competent GBV staffs recruited	120,000

#	Objective:	To reduce the risks of GBV/SEAH and enhance health response services for GBV survivors					
	Activity to Address GBV/ SEAH risk	Steps to be taken	Timelines	Institutional Focal Point	Collaborating actors/relevant ministries	Output indicators	Estimated Budgets (USD) 2021-2025
b)	Develop and train frontline health workers & other non-clinical staff including security guards, receptionist on GBV basic concepts including on referral pathway, Psychological first aid etc.	Develop a training plan Develop training materials/ content using global/national standards, human rights and survivor centred approaches Conduct training for project staff	Within the first 3 months of project effectiveness Retraining during project implementation	MOH -FGS	MOH-FMS, PMTs (Project Management teams) , PCIT (Project Coordination and Implementation Team) and WB	Number of trainings conducted for project staff Number of health staff and frontline workers who have received orientation on the GBV referral pathway and are able to refer survivors to appropriate care.	319,500
c)	Develop M&E programme	Develop a comprehensive M&E plan to monitor GBV action plan implementation Promotion of high-level commitment on monitoring the implementation of GBV Action Plan in order to support efforts to provide multi-sectoral support to GBV survivors. Monitor GBV action plan	Maintained throughout Project implementation	GBV/SEAH Specialist-MOH-FGS	MOH- FMS	M&E framework in place	N/A
3.	Inform project stakeholders about GBV/SEAH risks						
a)	Establish partnerships with key stakeholders	Identify and officially inform the stakeholders on the components of the projects and project-related risks of GBV/SEAH Develop interview/ facilitation guides	Within the first 3 months of project effectiveness	MOH -FGS	MOH- FMS	Number and types of stakeholders engaged	N/A

#	Objective:	To reduce the risks of GBV/SEAH and enhance health response services for GBV survivors					
	Activity to Address GBV/ SEAH risk	Steps to be taken	Timelines	Institutional Focal Point	Collaborating actors/relevant ministries	Output indicators	Estimated Budgets (USD) 2021-2025
		Conduct stakeholder meetings/FGDs Conduct regular SEAH safety audits Prepare field visit reports	Maintained throughout Project implementation .				
b)	Identify, train and establish GBV Focal points in each health facility and community (Female health workers)	Establish trained, dedicated and committed GBV focal points in each health facility with clear responsibilities related to the care of survivors (e.g., clinical care (CMR), mental health and psychosocial support and referral etc.) Identify and train-where feasible-female doctors and nurses to provide support for survivors of GBV since most survivors are women and have female health practitioners may facilitate disclosure and access to appropriate care.	Within the first 3 months of project effectiveness Maintained throughout Project implementation .	MOH -FGS	MOH- FMS	Number of GBV focal points identified and trained	Cost covered under the training of health personnel)
c)	Develop relevant IEC materials for community engagements within the community and in the health facilities and nutrition centres	Develop relevant GBV IEC materials that targets everyone without discrimination and are easy to comprehend. IEC materials to include information on GBV response services (such as hotline and where to get help).	Within the first 6 months of project effectiveness Maintained throughout Project	MOH -FGS	MOH- FMS	Number and type of GBV/SEAH IEC material developed	30,000

#	Objective:	To reduce the risks of GBV/SEAH and enhance health response services for GBV survivors					
	Activity to Address GBV/ SEAH risk	Steps to be taken	Timelines	Institutional Focal Point	Collaborating actors/relevant ministries	Output indicators	Estimated Budgets (USD) 2021-2025
		Print out medical charts with pictogram and information on how to better access services Integrate GBV issues into IYCF and mobilization sessions Develop GBV /SEAH information guide integrated into the health materials for female health workers outreach teams.	implementation .				
4. Mapping of service delivery for GBV/SEAH prevention and response							
a)	Develop and or/update a multisectoral GBV/SEAH referral pathway(s)	On the basis of mapped GBV/SEAH prevention and response service providers, develop/update a GBV/SEAH referral list of preferred service providers. Identify key gaps where remedial measures may be required (e.g., training staff on psychosocial first aid) Disseminate the referral pathway/list to stakeholders including other service providers such as legal, psychosocial etc.	Within the first 3 months of project effectiveness Maintained throughout Project implementation.	MOH -FGS	MOH- FMS	Referral pathway developed/updated Number/type of GBV/SEAH preventive and response services available.	N/A
b)	Conduct CMR capacity assessment in key health facilities	Using the existing CMR protocol conduct regular audits	Within the first 3 months of	MOH -FGS	MOH- FMS,	Number of sites with health facilities that	60,000

#	Objective:	To reduce the risks of GBV/SEAH and enhance health response services for GBV survivors					
	Activity to Address GBV/ SEAH risk	Steps to be taken	Timelines	Institutional Focal Point	Collaborating actors/relevant ministries	Output indicators	Estimated Budgets (USD) 2021-2025
		through CMR checklist to identify gaps Identify gaps and remedial action on the provision of post rape treatment kits-this will facilitate effective response for the GBV survivors who come to these health centers. Ensure steady supplies of CMR in all key health facilities with CMR capacity	project effectiveness Maintained throughout Project implementation.		WB GBV specialist/Consultant CSOs/NGOs service providers and private sector network	can provide CMR services Number of health facility with the post rape treatment kits CMR supplies available	
5.	GBV/SEAH sensitive channels for reporting in GM						
a)	Review GM for specific GBV/SEAH procedures	Building from the RCRF project, regular update reporting pathways that include support systems and accountability mechanisms including how to handle SEAH allegations properly Evaluate the effectiveness of the anonymous and confidential tracking system used by female health workers developed under the RCRF project	Within the first 3 months of project effectiveness	MOH -FGS	MOH- FMS,	GM with GBV/SEAH procedure integrated In the GM	N/A

#	Objective:	To reduce the risks of GBV/SEAH and enhance health response services for GBV survivors					
	Activity to Address GBV/ SEAH risk	Steps to be taken	Timelines	Institutional Focal Point	Collaborating actors/relevant ministries	Output indicators	Estimated Budgets (USD) 2021-2025
b.	Identify and train GM operators and GBV/SEAH social focal points within the GM, who will be responsible for GBV/SEAH cases and referrals as defined in the referral pathway.	Identify and select GBV/SEAH focal persons within the GM to manage GBV/SEAH related complaints Clarify the role of the GM operators and social focal points in GBV/SEAH as referral points Train the social focal points and all GM operators on GBV/SEAH basics, survivor-centred approach and the referral pathways	Within the first 6 months of project effectiveness Retraining during project implementation.	MOH -FGS	MOH- FMS,	GM operators and GBV social focal points identified and trained	17,460
c)	Review GM reports/logs for GBV/SEAH sensitivity	Review logs for GBV/SEAH documentation to ensure it follows standards for documenting GBV/SEAH cases Identify and review culturally appropriate community-based reporting mechanism to facilitate reporting.	During project implementation.	MOH-FGS	MOH- FMS,	Number of GBV/SEAH cases documented Number of referrals of SEAH incidents to the project GM/ by other service providers	N/A
	TOTAL BUDGET						546,960

ANNEX 15: TOR FOR FMS SOCIAL/GBV SPECIALISTS

A. Background

The social risk is rated as substantial taking into account the following key social risks and impacts: (i) potential exclusion of disadvantaged groups from project benefits and elite capture; and (ii) potential risks of increased social tension in the community (for example, on how services are delivered, or siting of services); (iii) conflict and security risks for project workers, patients and the community; (iv) labour risks including OHS risks, sexual exploitation and abuse, sexual harassment, and other forms of gender-based violence (GBV) that may occur in recruitment or retention of skilled or unskilled female workers and the delivery of services; (v) contextual risks of operating in a conflict zone and complex social context where effective and inclusive community consultations, stakeholder engagement, and community participation and safety of staff is challenging, and developing effective and trusted *GMs* due to difficulty in accessing rural areas, and the collective nature of traditional complaints handling.

Social risks will be mitigated through the implementation and adaptation of the Social Management Framework which will include procedures on how to mitigate barriers and promote social acceptability of project interventions among vulnerable and marginalised groups as well as for the CERC, and includes a GBV action plan will identify actions to prevent GBV among staff and patients and ensure a separate, survivor-centric and confidential GM and procedures for dealing with cases and provision of services for survivors. A Stakeholder Engagement Plan outlines procedure to identify key stakeholders including representatives of disadvantaged group members to ensure inclusive and transparent consultation processes for input and feedback on the project throughout the project cycle. an and a functional GM. Labour management procedures (LMP) will outline fair treatment, non-discrimination and equal opportunity of project workers and define separate workers' grievance procedures. Security Management Framework and project, regional and area SecMPs will ensure that security measures are in place for staff and patients and that any armed personnel are sufficiently trained and monitored, to ensure they conduct themselves appropriately.

During project implementation, area specific social management and stakeholder engagement plans will be developed for implementing partners, contractors and other entities as appropriate.

B. Scope of Work

Reporting to the Project Manager at the FMS PMT at the state Ministry of Health, the Social and GBV Specialist is responsible for ensuring the implementation of the social instruments and GBV action plan at FMS level. They will provide technical support to the IPs in the preparation of social safeguard documentation and monitoring/reporting on social safeguards implementation, as well as provide guidance on preventing and responding to Sexual Exploitation and Abuse and Workplace Sexual Harassment in the Project. This includes: (i) Monitor compliance with social safeguards and develop social impact assessments incorporating all E&S requirements); (ii) Procure technical assistance to conduct social screening (as needed); (iii) set up GM(s), including GBV-sensitive mechanisms; (iv) Ensure that the design and evaluation of the Project reflects a gender-sensitive approach and gender-responsive measures; (v) Sensitize Government staff to the GBV risks and raise the awareness of the community on GBV in a culturally appropriate manner; (vi) map GBV service providers and identify/develop GBV Referral Pathways; (vii) ensure implementation and monitoring or GBV risk mitigation measures as articulated under the GBV action plan); and (v) Monitor the use and effectiveness of the Project GM(s).

The Social/GBV Specialist is expected to perform the following tasks:

- Ensure all social instruments are implemented at FMS level either directly or via contractors;
- Ensuring inclusive and genuine stakeholder engagement and a robust, trusted and functional GM that is accessible to all communities, workers and stakeholders;
- Provide quarterly reports to the FMS PM and FGS senior social specialists and GBV specialists on the implementation of all safeguards instruments and functioning of the GM;
- Support the PMT in identifying and addressing the risks of GBV, in particular, SEA and Workplace SH by identifying and implementing appropriate GBV prevention and mitigation measures;
- Put in place monitoring and evaluation plan for activities relating to the prevention and management of GBV cases, and contribute to monitoring and evaluation of the GBV elements of the environmental and social safeguard documents prepared within the framework of the project;
- Support the PMT in responding to any identified GBV incidents, ensure that effective monitoring and evaluation mechanisms are in place to report on such incidents and incorporate lessons into the approach, as appropriate;
- Develop and conduct relevant capacity building and training activities for government counterparts, including social safeguard specialist, PCIU staff and other relevant partners at FGS and FMS levels; and
- Provide recommendations and costing for the implementation of community awareness raising activities that include the risk of SEA related to the project, the code of conduct for workers, the GM and the ways in which the community members can safely report concerns.

C. Duration of assignment

The Social and GBV Specialist will be engaged on a full-time basis and is expected to commence the assignment on [DATE] for an initial period of 12 months, with a trial period of 3 months. The contract is renewable annually subject to satisfactory performance for the entire project period.

Engagement can cover a period of four years subject to project need and annual performance review with an intermediate performance evaluation in the first three months of services rendered. Terms of Reference, and detailed work plan with agreed targets will be used as the basis to evaluate performance. The recruitment of the Social/ GBV Specialist should follow the World Bank's procurement guidelines.

D. Reporting

The Social and GBV Specialist will report to the GBV Specialist and Social Safeguards Specialist of the PCIU in the Federal Ministry of Health and work in close collaboration with a wide range of stakeholders including the project-affected communities, contractor/s, other GBV service providers, as well as the World Bank's Project and Safeguard team, as needed.

E. Qualifications and Experience

The Social and GBV Specialist will possess the following qualifications:

- A degree in sociology, anthropology or community development, or gender;
- 5 years' community development experience in Somalia, preferably in different regions of FGS including promoting gender and vulnerable and marginalised groups inclusion, conflict mitigation, labour management, participatory approaches and feedback mechanisms;
- Excellent English and Somali written and verbal skills;
- Excellent understanding and commitment to social inclusion, conflict mitigation, labour management, gender and GBV, stakeholder engagement and participatory development;
- Familiarity with the World Bank's Environmental and social framework and commitment and passion to develop skills in social risk management;

- Strong interpersonal skills and the capacity to apply a survivor-centered approach to support, guide, listen, assess, plan and follow up on services and survivor support;
- Operational experience at country/regional level in the implementation of programming related to violence against women and children, sexual exploitation and abuse, GBV, gender, and child protection; and
- Experience in delivering gender-sensitization trainings to a wide range of audience including in challenging environments.

ANNEX 16: TOR OF SENIOR ENVIRONMENTAL SPECIALIST FGS

A. Background

The environmental risk is rated as substantial, taking into account the following key risks and impacts: (i) potential environmental degradation during construction and rehabilitation of health facilities, including soil erosion, waste generation, and water contamination; (ii) poor management of healthcare waste, including risks of infection, pollution, and unsafe incineration practices; (iii) occupational health and safety (OHS) risks to project workers due to exposure to hazardous materials, medical waste, and unsafe working conditions; (iv) community health and safety risks related to emissions, waste disposal, and construction activities in populated areas; and (v) cumulative environmental impacts and climate-related risks such as drought, flooding, or heat stress affecting project sustainability. Environmental risks will be mitigated through the preparation and implementation of site-specific Environmental and Social Management Plans (ESMPs) developed by contractors in line with the project’s Environmental and Social Framework (ESF) instruments. These ESMPs will incorporate the Infection Control and Waste Management Plan (ICWMP), Occupational Health and Safety Management Plan (OHSMP), and site-specific mitigation measures for waste handling, emissions control, and resource efficiency.

B. Scope of Work

Reporting to the Senior Health Programme Coordinator in the Project Coordination and Implementation Unit at the Federal Ministry of Health in Mogadishu, the Senior Environmental Safeguards Specialist is responsible for providing oversight and technical support to the PCIUs in the preparation of environmental safeguards documentation and monitoring and reporting on environmental safeguards implementation. This includes: (i) Monitoring compliance with environmental safeguards and reviewing environmental impact assessments incorporating requirements for environmental mitigation of risks and impacts); (ii) Procuring technical assistance to conduct environmental screening and scoping of project activities; (iii) Supervising the working of the established project grievance redress mechanism(s) at the FMS level; (iv) Monitoring the use and effectiveness of the Project grievance redress mechanism(s); and (v) Providing oversight and leadership to the conduct of work by the FMS Environmental Specialists.

The Senior Environmental Safeguards Specialist is expected to perform the following tasks:

- Familiarization with the Environmental and Social Framework (ESF) of the World Bank
- Familiarization with project documents including Environmental Management Framework (EMF), Environmental and Social Commitment Plan (ESCP) and the Infection Control and Waste Management Plan (ICWMP) for the project
- Identify all environmental risks and mitigation measures as per the World Bank’s Environmental and Social Framework and ensure they are incorporated into the environmental safeguards instruments and oversee their preparation. Environmental safeguards instruments will include: the Environmental Management Framework including a EMF for CERC activities, a Stakeholder Engagement Framework, Labour Management Procedures, an Environmental and Social Commitment Plan, Security Management Procedures, developed by consultants experienced in these areas and employed by the Federal Ministry of Health, as well as the Infection Control and Waste Management Plan
- Provide technical support to the PCIU and to the FMS PMT part-time Environmental Specialists in: (i) Screening, scoping and assessing the environmental risks and impacts of the proposed project activities; (ii) Reviewing mitigation and enhancement measures for environmental risks and

impacts proposed by the PMTs; and (iii) Providing guidelines/instruments to the PCIU and FMS PMTs in the preparation of safeguards documents in compliance with World Bank safeguards policies; and (iv) Monitoring implementation of environmental safeguards and assessing the efficacy of mitigation measures, in compliance with World Bank safeguard policies and international best practices

- Provide technical oversight to consultants and part-time Environmental Specialists at the PMT in the preparation of environmental safeguard instruments, including site-specific Environmental and Social Assessment and Management Plans (ESAMPs) and ICWMPs
- Ensure that the legal and binding commitments for the prudent management of project-level environmental risks and impacts, as enumerated in the project’s Environmental and Social Commitment Plan, are implemented

In undertaking the assignment, the Senior Environmental Safeguards Specialist will work closely and collaborate with the Technical Team of the World Bank, the PCIU, PMTs, relevant line Ministries and Agencies, and the Federal and State Ministries of Health.

C. DURATION OF ASSIGNMENT

The PCIU Environmental Safeguards Specialist will be engaged on a full-time basis and is expected to commence the assignment on [DATE] for an initial period of 12 months, with a trial period of 6 months. The contract is renewable annually subject to satisfactory performance.

Engagement can cover a period of four years subject to project need and annual performance review with an intermediate performance evaluation in the first three months of services rendered. Terms of Reference, and detailed work plan with agreed targets will be used as the basis to evaluate performance.

The recruitment of the Senior Environmental Safeguards Specialist should follow the World Bank’s and government’s procurement guidelines.

D. QUALIFICATIONS

The PCIU Environmental Safeguards Specialist will possess the following qualifications:

- Advanced degree in Public Health, Environmental Science, Natural Resources Management, Waste Management, Ecology or other relevant fields
- Minimum of 7 years relevant professional work experience in environmental impact assessments, environmental audits, legal and policy review, and formulation of project action plans for environmental safeguard management in projects financed by international donor agencies (preferably the World Bank)
- Conversant with relevant national and state environmental laws
- Knowledge and experience of ICT-based Office applications and tools (word processing, spreadsheets and data processing, PowerPoint)
- Knowledge and experience of World Bank’s Environmental and Social Framework and operations and the specific context of Somalia or in fragile and conflict situations considered an asset
- Excellent analytical, communication, writing, presentation/facilitation and editorial skills in English; Somali language skills an asset
- Ability to collaborate effectively with other team members, contribute productively to the team’s

work and output and demonstrate respect for different points of view

- Ability to work independently and with little to no supervision, ability to plan and effectively manage complex, long-term projects
- Having research, risk assessment monitoring and innovation capacity related to environmental science.

ANNEX 17: TOR FOR FGS GBV SPECIALIST

A. Background

The GBV risk rating for this project is considered substantial due to risks sexual exploitation and abuse, sexual harassment, and other forms of gender-based violence (GBV) that may occur in recruitment or retention of skilled or unskilled female workers and the delivery of both health services; (v) contextual risks of operating in a conflict zone and complex social context where effective and inclusive community consultations, monitoring, and developing effective and trusted GMs are challenging.

A GBV action plan has been prepared and a GBV advisor at FGS level is needed to ensure its implementation at all levels.

B. Scope of Work

Reporting to the Senior Project Coordinator in the Project Coordination and Implementation Unit at the Federal Ministry of Health, the Gender-Based Violence Specialist is responsible for providing technical support to the PCIU on the implementation of Gender-Based Violence prevention and response recommendations under the Project, building on global best practice on addressing the risk of GBV. This includes, among other responsibilities: (i) Reviewing and updating GBV risks during project implementation in the project; (ii) GBV service provider mapping; (iii) Sensitization of the project stakeholders to the potential GBV risks; and monitoring implementation of the full suite of mitigation measures throughout project implementation.

The Gender-Based Violence Specialist is expected to perform the following tasks, among others:

- Review of project-related GBV risks, including in particular risks of sexual exploitation and abuse and sexual harassment, and updating of risk mitigation strategies for the project;
- Contribute to monitoring and evaluation of the GBV risk management elements of the environmental and social safeguard instruments prepared within the framework of the project, in particular all activities outlined within the GBV prevention and response plan;
- Contribute to development of terms of reference for the recruitment of GBV consultants or NGOs who may be hired to support the implementation of GBV prevention and response activities;
- Collaborate with the other experts of the PCIU, in particular the environmental and social safeguard specialists, within the framework of their activities;
- Participate in periodic project coordination meetings and, if necessary, on site, in order to collect feedback from relevant actors on the implementation of the GM, in order to be able to adapt the mechanism using lessons learned;
- Develop and conduct relevant capacity building and training activities for government counterparts, including social safeguard specialist, PCIU staff and other relevant partners at FGS and FMS levels.
- Support development of reporting and response protocols for management of GBV cases should they arise during project implementation;
- Put in place monitoring and evaluation plan for activities relating to the and management of GBV cases;
- Support the monitoring of indicators relating to the functioning of the GM, in particular concerning the reporting and follow-up of GBV complaints related to the project;
- Evaluate project activities to assess the adequacy with national and World Bank requirements in terms of prevention and management of GBV cases;
- Analyse key gaps between achievements and targets and make any appropriate recommendations to improve performance in terms of prevention and management of GBV cases;

- Contribute to the preparation of annual action plans, drafting of periodic project reports and ensure that GBV aspects are adequately taken into account in said reports.
- Support implementation of community awareness raising activities that include the risk of SEA related to the project, the code of conduct for workers, the GM and the ways in which the community members can safely report concerns; and
- Other key tasks related to GBV risk identification and management that may arise during the assignment.

In undertaking the assignment, the GBV Specialist will work closely and collaborate with the Technical Team of the World Bank, the PCIU, PMTs, relevant line Ministries and Agencies, and the Federal and State Ministries of Health.

C. Duration of assignment

The Gender-Based Violence Specialist will be engaged on a full-time basis and is expected to commence the assignment on [DATE] for an initial period of 12 months, with a trial period of 3 months. The contract is renewable annually subject to satisfactory performance.

Engagement can cover a period of four years subject to project need and annual performance review with an intermediate performance evaluation in the first three months of services rendered. Terms of Reference, and detailed work plan with agreed targets will be used as the basis to evaluate performance. The recruitment of the GBV Specialist should follow the World Bank's procurement guidelines.

D. Reporting

The GBV Specialist will report to the Senior Project Coordinator of the PCIU in the Federal Ministry of Health and work in close collaboration with the FMS PMT's Social/ GBV specialists and liaise with the World Bank social safeguards specialist.

E. Qualification and Experience

The Gender-Based Violence Specialist will possess the following qualifications:

- Advanced degree in relevant social sciences (Gender, International Development, International Relations and/or related areas);
- Minimum of 7 years relevant professional work experience at national and international levels in development field, with a focus on GBV prevention and response activities and conducting awareness campaigns on women's rights, gender equality, GBV, and / or reproductive health;
- Knowledge of the guiding and ethical principles that govern work with survivors of GBV and good practices in the implementation of activities to prevent and address GBV;
- Operational experience at country/regional level in the implementation of programming related to violence against women and children, sexual exploitation and abuse, GBV, gender, and child protection;
- Experience in delivering gender-sensitization trainings to a wide range of audience including in challenging environments; and
- Experience in data collection and analysis on GBV.

ANNEX 18: TOR OF SENIOR SOCIAL SPECIALIST FGS

A. Background

The project social risk is rated as substantial taking into account the following key social risks and impacts: (i) potential exclusion of disadvantaged groups from project benefits and elite capture; and (ii) potential risks of increased social tension in the community (for example, on how services are delivered, or siting of services); (iii) conflict and security risks for project workers, patients and the community; (iv) labour risks including OHS risks, sexual exploitation and abuse, sexual harassment, and other forms of gender-based violence (GBV) that may occur in recruitment or retention of skilled or unskilled female workers and the delivery of services; (v) contextual risks of operating in a conflict zone and complex social context where effective and inclusive community consultations, stakeholder engagement, and community participation and safety of staff is challenging, and developing effective and trusted GMs due to difficulty in accessing rural areas, and the collective nature of traditional complaints handling.

Social risks will be mitigated through the implementation of E&S management plans which will be developed by the contractors in line with the E&S instruments. The plans will include mechanisms to mitigate barriers and promote social acceptability of project interventions among disadvantaged and vulnerable groups. It will include a GBV action plan, which will identify actions to prevent GBV/SEAH among staff and patients and ensure a separate, survivor-centric and confidential GM and procedures for dealing with cases and provision of services for survivors. A Stakeholder Engagement Plan outlines procedures to identify key stakeholders including representatives of disadvantaged and vulnerable groups to ensure inclusive and transparent consultation processes for input and feedback on the project throughout the project cycle. an and a functional GM. An inclusion plan outlines measures to ensure that disadvantaged groups are not excluded. Labour management procedures (LMP) will outline fair treatment, non-discrimination and equal opportunity of project workers and define separate workers' grievance procedures. SecMPs will ensure that security measures are in place for staff and patients and that any armed personnel are sufficiently trained and monitored, to ensure they conduct themselves appropriately. During project implementation, area specific social management and stakeholder engagement plans will be developed for implementing partners, contractors and other entities as appropriate.

B. Scope of Work

Under the supervision of the senior health programme coordinator of the PCIU and FGS MOH, the senior social safeguards specialist will be the main focal point for the implementation of the social instruments for the Damal Caafimaad and will provide capacity building support and guidance to the social and GBV specialists on social risk management (SRM) at FMS level.

The senior social safeguards specialist will oversee the implementation of the Social Management Framework, Stakeholder Engagement Plan, and Labour Management Procedures, and the GM for the project, as well as review and monitor the implementing partner ESMPs. They will provide guidance, technical and capacity building support on SRM throughout the PCIU and the Program Management Teams (PMT) at the MoH, as well as the social specialists at FMS MoH, the implementing partners and other contractors. They will promote collaboration and coordination with social specialists in the RCRF and SCRP projects as well as other projects supporting the roll out and implementation of the revised EPHS framework across the country.

The senior social safeguards specialist will be responsible for ensuring inclusive and genuine stakeholder engagement and a project wide GM that is accessible to all communities, workers and stakeholders and

ensure synergy with the component on citizen engagement and feedback. They will provide leadership on social risk management and identify synergies and promote coordination across government partners and other agencies.

More generally, the senior social specialist will be responsible to ensure that all social risks and impacts are monitored and the mitigated and social safeguards instruments and the ESCP are implemented on time and reported on every quarter.

C. Deliverables

1. Develop mechanisms, modalities and timelines and ensure timely implementation of the safeguard's instruments and ESCP.
2. Ensure all social risk management measures are integrated into the POM, project guidance, TORs, contracts, reporting and monitoring mechanisms.
3. Review EOIs, RFP and contractors' social assessment and management plans;
4. Promote understanding of social context and risk management guide studies/reviews as necessary.
5. Orient shortlisted contractors on social risk management requirements;
6. Build the capacity of all social specialists at FMS level, implementing partners and contractors and promote synergy in approaches and coordination across government and World Bank funded projects.
7. Lead capacity assessment for social risk management capacities and update the capacity building plan.
8. Ensure summaries of the social instruments are translated into Somali and disseminated to all stakeholders in accessible ways.
9. Ensure that all social risks associated with the project are identified, monitored and mitigated.
10. Promote inclusivity, transparency and gender equity throughout the project.
11. Develop and ensure the functioning of a GM for the project that is accessible to all stakeholders including community members served by the projects especially disadvantaged and vulnerable groups.
12. Monitor and address challenges with implementation of social risk management plans.
13. Receive, log and process complaints about the project at FGS level in conjunction with the project manager and members of the PCIU.
14. Provide quarterly reports to the PM and the WB social safeguards specialist on the implementation of all safeguards instruments and functioning of the GM.

D. Reporting

The senior social safeguards specialist will report to the Senior Health Programme Coordinator of the Damal Caafimaad PCIU, and work in close collaboration with the GBV advisor, the environmental specialist, the communication officer, security advisor and M&E officer and procurement and other colleagues within the PCIU and FMS social specialists. They will liaise closely with the RCRF and SCRP social specialists and will seek technical support as required from the World Bank social safeguards specialists.

E. Qualifications and Experience

The specialist/officer will have the following qualifications and experience:

- A degree in sociology, social science, anthropology or community development, or gender;
- At minimum, seven (7) years community development experience in Somalia, in target regions of FGS, preferably in health project implementation, including at least some experience of each of: promoting gender and disadvantaged and vulnerable groups inclusion, conflict mitigation, labour management, participatory approaches and feedback mechanisms;

- Excellent English and Somali written and verbal skills;
- Familiarity with the World Bank’s environmental and social framework and commitment and passion to develop their and other skills in social risk management;
- Excellent understanding and commitment to social inclusion, conflict mitigation, labour management, gender and GBV, stakeholder engagement and participatory development;
- Experience of training and capacity building of others in the above fields;
- Hard working, proactive and solutions oriented.

ANNEX 19: TOR FOR A CONTRACTOR’S E&S ASSESSMENT & MANAGEMENT PLAN (ESMP)

A. Introduction and Project Description:⁸³

Give a short description of the project

B. Purpose

Indicate the objectives and the project activities, the activities that may cause environmental and social negative impacts and needing adequate mitigation measures. Please refer to the overall project documents including: Stakeholder engagement plan, inclusion plan, GBV action plan, Environmental and social management frameworks including the GBV action plan, the labor management procedures, the security management framework and the project level and regional Security Management Plans. Please ensure there is a section on each of the above showing how the recommendations are being planned given the contractor and regional specificities including how they will be included for any sub-contractors.

C. Tasks

The Contractors ESMP should cover:

- Potential environmental and social impacts resulting from project activities, based on ground level assessment and analysis;
- Proposed mitigation measures;
- Institutional responsibilities for implementation;
- Monitoring indicators;
- Institutional responsibilities for monitoring and implementation of mitigation measures;
- Costs of activities;
- Calendar of implementation; and
- Capacity needs.

The C-ESMP results and the proposed mitigation measures should be discussed with relevant stakeholders, NGOs, CBOs and community representatives including representatives of disadvantaged groups, local administration and other organizations involved in the project activities. Recommendations from these public consultations should be included in the final ESMP.

D. Format

- Cover page
- Table of Contents
- List of Abbreviations, Acronyms and Units
- Introduction
- Project Site Description and Process
- Applicable standards: including World Banks Operational Performance Standards. Country Standards, Other funding partner standards, other international standards, if appropriate (ISO, WMO, WHO and so on) and other elements of good international practice. If there are specific international standards or practices that need to be met, these should be listed

⁸³ This be further developed at start of project implementation. It should be updated based upon standard list of impacts/risks and standard EHSMP – which will provide a more complete description of all EHS areas/issues/topics.

- Assessment of environmental and social impacts and mitigation measures for project activities;
- Costed Plan within timing and responsibilities outlined, including:
 - Regional specific Stakeholder engagement plan, inclusion plan, GBV action plan, and Labour management plan; area specific SecMPs;
 - Monitoring indicators
 - ESMP training requirements, if any.

E. Timescale

The contractor will produce the final ESMP one week after receiving consolidated comments from the World Bank, relevant Country institutions

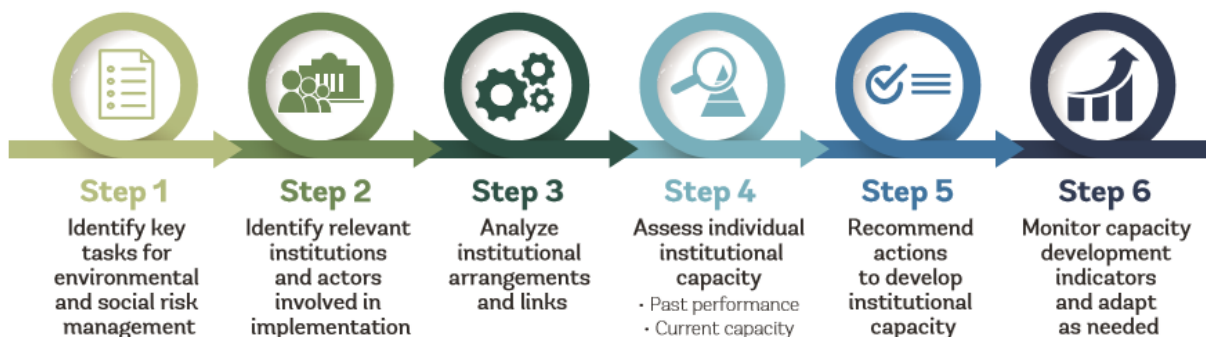
F. Deliverables

Draft and Final ESMP (soft copy only)

ANNEX 20: DRAFT TOR FOR E&S CAPACITY ASSESSMENT

Capacity assessment at the project-level consists of six steps (Figure A18-1). To produce a concise, practical, and project-focused assessment, Steps 2-5 focus on the list of key tasks identified in Step 1. Step 6 concerns measuring progress of capacity development activities and adjusting as needed based on evidence.

Figure A18-1. Six steps for project-level capacity assessment



Step 1 focuses on identifying tasks that are required to avoid, mitigate, or manage significant E&S risks and impacts based on the nature and context of the project.

Steps 2 and 3 provide a framework for mapping the institutions involved in project implementation. Institutional mapping identifies the institutions and major actors involved in implementing the E&S risk management tasks identified in Step 1 and describes their respective roles and responsibilities. These steps are to be carried out for each of the specific E&S risk management tasks for the project, as identified in Step 1.

Box 2. Typical institutions and actors responsible for project development and implementation

- **Project primary implementers:** Project Coordination and Implementation Unit (PCIU), Program Management Unit (PMU), and central and local government entities (ministries or other departments with supporting roles).
- **Contractors and subcontractors:** Contracted or subcontracted suppliers of construction and other project-related services
- **Affected people and other stakeholders:** Influencers, other decision makers, entities that are affected by outcomes, and entities or individuals that can affect the outcome of an operation.
- **Development partners:** Multilateral development banks (MDBs), bilateral donors, and Multi-donor

Table A20-1. Example of a matrix for analyzing the roles of institutions and actors for project-level tasks

Key Task					
	PCIU	PMT	Implementing partners	Sub contractors	Third party monitors
Supervision	X	X	X		X
Enforcement	X	X			
Contractor management	X		x		
Implementation	x	x	x	x	
Monitoring and reporting	X	x	x	x	X
Training and other capacity development	X	X	X		
Adaptive management	X	x	X		
Information disclosure	X	X	X		

X indicates a role in implementation of the task

Step 3 assesses the overall governance structure for a project—the institutions involved and the nature of the operational links among them. The analysis at this stage identifies potential issues that could undermine project implementation and provides recommendations for improving the project’s institutional governance structure. This step of the assessment focuses on: (i) clarifying the respective mandated roles and accountabilities of the institutions identified in Step 2; (ii) identifying any gaps, areas of overlap, excessive fragmentation of responsibilities, potential redundancies or conflicts, etc., as indicated in Box 3; and (iii) evaluating the effectiveness of necessary lines of communication and coordination mechanisms among the institutions.

Box 3. Key questions to assess institutional roles and responsibilities

Is there a clear governance structure for this task?

- If the responsibility for implementation of a given task is shared among two or more institutions, what are the lines of communication and coordination mechanisms among the institutions involved, if any?
- If there are areas of overlap in roles and responsibilities, are these likely to lead to conflict, redundancy, inefficiency, etc.?
- If there are gaps, that is, tasks that are not clearly the responsibility of any institution, what agreement is in place to fill them, if any?
- Where there seems to be excessive fragmentation of responsibility, which could lead to confusion or inefficiency, can the structure be simplified or unified?
- Are there any other potential issues related to the governance structure for this task?

Step 4 divides the assessment of individual institutions’ capacity to carry out their specific E&S risk management tasks into two parts: (1) assessment of past performance and (2) assessment of current

capacity considering future responsibilities. Some aspects of an institution’s capacity—such as level of commitment to implement its policies, effectiveness of institutional and individual incentives, and ability to adapt to changing circumstances—can only be meaningfully evaluated based on its track record in similar situations. Newer institutions will not have a track record by which to demonstrate this capacity, so the assessment must rely on evaluating the current established systems and available resources.

Step 4.1: Assess past performance of contractors

An institution’s past performance should be evaluated both in the context of implementing previous or current projects financed by the Bank or by other development partners with similar E&S policies and standards, and when implementing activities under national laws and systems. This is particularly important for tasks where national requirements differ significantly from Bank requirements, since it can be particularly challenging for individuals and institutions to adhere to the Bank’s requirements in such cases. Key aspects to consider are compliance and enforcement, monitoring, stakeholder engagement, and documentation and recordkeeping.

Box 4 provides guiding questions for assessing an institution’s capacity and commitment to implement the E&S risk management tasks for which it will be responsible, based on its track record.

Box 4. Questions to assess whether an institution is able and committed to implement its E&S risk management tasks

Can you provide documentation and other evidence that this institution ...?

- has performed this task before?
- has a system for monitoring and assessing performance?
- has a track record of compliance with relevant national or regional regulation?
- has a track record of compliance with Bank safeguards or ESF and/or other MDBs policies, as relevant?
- regularly applies a system for quality management?
- takes E&S information from the ESA process and monitoring into account when making decisions and taking actions?
- effectively manages the E&S performance of contractors, including contractor selection, routine supervision, quality control and corrective actions?
- has systems in place for institutional learning and improvement, learning lessons from past mistakes and experiences?
- is able to hire staff and/or recruit consultants in a reasonable timeframe, and to retain well-qualified and high-performing staff?

Step 4.2: Assess current capacity of institution

The assessment considers four elements of institutional capacity that are relevant for E&S risk management: external enabling environment; organizational arrangements; human resources; and budget, equipment, and means. The list in Table A18-2 recognizes that some factors affecting institutional performance may be external to the institution itself (enabling environment), and that the systems for managing human, financial, and material resources can be as important as the scale and availability of the resources themselves.

Table A18-2. Elements and sub-elements of individual institutional capacity

Element	Sub-element
External enabling environment	Government policies
	Laws and regulations
	Institutional incentives

Element	Sub-element
	Mandate
	National-level commitment
Organizational policy, structure, procedure, and culture	Institutional Policies and Procedures
	Reporting lines and span of control
	Quality assurance and control systems
	Transparency measures
	Institutional-level commitment
	Stakeholder engagement
	Appropriate staff incentives
Human resources	Technical skills and soft skills
	Job descriptions
	Turnover and recruiting times
	ESS2 requirements (human resource policies)
Budget, equipment, and means	Amount, control over allocation, availability, and process of budgets
	Budgetary projections
	Management systems
	Transportation, equipment and supplies
	Information technology infrastructure and databases

Table 5 provides specific guiding questions and examples for assessing these elements and sub-elements of institutional capacity. The questions and responses should be considered as they relate to the specific E&S risk management tasks for which the institution will be responsible.

Step 5 uses the previous analytical steps to identify specific needs and actions for capacity development that may be required to enable individual institutions (and the project’s institutional structure as a whole) to fulfil their roles.

Formulate recommendations as concrete operational actions. Include the actions in the ESMP with specific capacity development measures and related responsibilities, outcomes, budgets, timelines, and indicators that are necessary for successful implementation. These measures should be referenced where relevant in the ESCP, with indicators for monitoring progress and adaptive management.

Step 6 embeds precise capacity development measures and results monitoring in the capacity development activity, to evaluate progress and make timely adjustments as needed. Further, tracking and documenting outputs and outcomes will contribute to knowledge for developing project-level borrower capacity in the future.

Typical tasks for project-level E&S risk management ⁸⁴

ESS 1 Environmental and Social Assessments

⁸⁴ The tasks and specific responsibilities listed here are intended as examples only. They are drawn from the ESS but they are not intended to be an exhaustive indication of all requirements found in the relevant ESS. Other tasks and requirements should be identified for the needs of specific operations.

Task	Specific responsibilities
Assess, manage and monitor the environmental and social risks and impacts of the project throughout the project life cycle	<p>Conducts environmental and social assessments considering elements of international good practice, including:</p> <ul style="list-style-type: none"> - In-line with mitigation hierarchy - proportionality, - comprehensive approach (social and environment); - alternatives assessment; - consider direct, indirect, and cumulative impacts; - consultations and disclosure of information - monitoring and reporting
Environmental and social assessment	<p>Assess the environmental and social risks and impacts of the project throughout the project life cycle</p> <hr/> <p>Understands and can apply EHSGs of the WBG</p> <hr/> <p>Considers social risks in a comprehensive manner and in accordance with elements of ESS 1</p> <hr/> <p>Proposes and implements differentiated measures so that adverse impacts do not fall disproportionately on the disadvantaged or vulnerable, and they are not disadvantaged in sharing any development benefits and opportunities resulting from the project</p> <hr/> <p>Can identify and assess the potential environmental and social risks and impacts of Associated Facilities</p> <hr/> <p>As appropriate, recruit and hire independent experts for high risk projects</p> <hr/> <p>Considers risk and impacts associated with the primary suppliers</p> <hr/> <p>Consider potentially significant project-related transboundary and global risks and impacts</p>
Environmental and Social Commitment Plan (ESCP)	<p>Implements the measures and actions identified in the ESCP in accordance with the timeframes specified, and can review the status of implementation of the ESCP as part of its monitoring and reporting</p> <hr/> <p>Can carry out, as appropriate, additional assessments and stakeholder engagement in accordance with the ESSs, and propose changes, for approval by the Bank, to the ESCP where project context or activities change</p>
Project monitoring and reporting	<p>Monitors the environmental and social performance of the project in accordance with the legal agreement (including the ESCP)</p> <hr/> <p>Engages stakeholders and third parties, such as independent experts, local communities or NGOs, to complement or verify its own monitoring activities</p> <hr/> <p>Provide regular reports as set out in the ESCP to the Bank of the results of the monitoring</p> <hr/> <p>Identify any necessary corrective and preventive actions, and will incorporate these in an amended ESCP or the relevant management tool</p>
Stakeholder engagement and	<p>Engage with, and provide sufficient information to stakeholders throughout the life cycle of the project, in a manner appropriate to the nature of their interests and the potential environmental and social risks and impacts of the project</p>

Task	Specific responsibilities
information disclosure	Provide information on risks and impacts associated with project changes and consult with project-affected parties as to how these risks and impacts will be mitigated
Management of contractors	Assesses the environmental and social risks and impacts associated with project contractors
	Ascertain that contractors engaged under the project are legitimate and reliable enterprises, and have knowledge and skills to perform their project tasks in accordance with their contractual commitments
	Incorporate all relevant aspects of the ESCP into tender documents
	Ensure contractors apply the relevant aspects of the ESCP and the relevant management tools, and including appropriate and effective non-compliance remedies
	Monitor contractor compliance with their contractual commitments
	Require contractors to have equivalent arrangements with their sub-contractors

ESS 2 Labour and Working Conditions

Task	Specific responsibilities
Working conditions	Develop written labor management codes, adopt facility or industry labor standards and practices and disseminate to project workers
	Implementation of terms and conditions of labor for eligible workers in line with ESS 2 requirements
	Ensure decisions on hiring and labor are non-discriminatory
	Monitor, supervise and assess compliance with labor codes
Protecting the workforce	Establish and enforce provision on child labor and minimum work age
	Establish practices and procedures to ensure not use of forced labor
	Provide adequate training and safety measures for project workers including community workers
	Monitor and enforce regulations and practices
Grievance Mechanisms	Develop and implement grievance measures for all project workers
	Inform and disseminate information on worker rights and obligations
Protections for community workers	Assess whether project labor is or will be provided on a voluntary basis as an outcome of individual or community agreement
	Prepare labor management procedures for community workers used in project
	Assess risk of child or forced labor where community labor is contributed to project activities
	Provide training on workplace safety

Task	Specific responsibilities
Occupational Health and Safety measures	Assess existing OHS measures against criteria listed in ESS
	Prepare OHS plan or similar policy for project workers
	Implement OHS plans and measures
	Establish mechanisms for workers to raise complaints, concerns, recommendations for improved safety practices
	Establish and implement measures for monitoring, supervising and enforcing agreed plans and measures
Primary Supply Workers	Identify labor risks associated with project primary suppliers
	Set out rules and responsibilities of primary suppliers to ensure compliance with policy principles
	Require primary supplier to comply with safety and labor requirements
	Monitor, supervise and enforce agreements reached with primary suppliers
Community Exposure to Health Issues	Identify and implement measures to avoid or minimize transmission of communicable diseases that may be associated with the influx of temporary or permanent project labor
	Establish project management plans to avoid or minimize community exposure to water-borne, water-based, water-related, and vector-borne diseases, and communicable and non-communicable diseases
Emergency Preparedness Planning	Identify and implement measures to prevent or minimize adverse impacts from emergency situations
	Establish emergency preparedness plans including institutional responsibilities, evacuation plans, communications strategies, housing and other logistical support
	Prepare and implement Risk Hazard Assessments (RHA) and Emergency Response Plans (ERP)
	Establish coordination and communication mechanisms for implementing emergency response plans
Management and Safety of Hazardous Materials	Develop operational management plans for hazardous materials in-line with policy objectives, national requirements and/or GIIP
	Assess direct project risks from use, transport, storage, disposal of hazardous materials
	Supervise and enforce entities responsible for executing management plans
Management of Security Personnel	Assess overall security risks from contracted security personnel inside and outside of project facilities or surrounding development sites
	Establish project security operations policies in line with ESS 4, national legal requirements and/or GIIP
	Conduct thorough verification screening and evaluation of personnel and/or security firms retained for security services. Including investigations of any past abuses by personnel or firms

ESS 10 Stakeholder Engagement

Task	Specific responsibilities
Engagement during project preparation	Identify and analyze project stakeholders
	Prepare stakeholder engagement plan
	Disclose project information
	Conduct meaningful consultations
Engagement during project implementation and external reporting	Engage with, and provide information to, project-affected parties and other interested parties throughout the life cycle of the project
	Conduct stakeholder engagement in accordance with the SEP, and build upon the channels of communication and engagement already established with stakeholders
	If there are significant changes to the project that result in additional risks and impacts provide information on such risks and impacts and consult with project-affected parties as to how these risks and impacts will be mitigated
Grievance mechanism	Establish effective grievance redress mechanisms
	Respond to concerns and grievances of project-affected parties related to the environmental and social performance of the project in a timely manner
	Handle grievance in a culturally appropriate manner: be discreet, objective, sensitive and responsive to the needs and concerns of the project-affected parties
Organizational capacity and commitment	Define clear roles, responsibilities and authority as well as designate specific personnel to be responsible for the implementation and monitoring of stakeholder engagement activities and compliance