FEDERAL REPUBLIC OF SOMALIA

MINISTRY OF HEALTH & HUMAN SERVICES (MOH)

Additional Financing Four for Improving Healthcare Services in Somalia Project ("Damal Caafimaad") (P178876)

STAKEHOLDER ENGAGEMENT PLAN (SEP)

UPDATED APRIL 2026

Table of Contents

Contents

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS:

AF	Additional Financing
EPHS	Essential Package of Health Services
ESCP	Environmental and Social Commitment Plan
ESF	Environmental and Social Framework
ESMP	Environmental and Social Management Plan
FMoH	Federal Ministry of Health
FMS	Federal Member States
FP	Family Planning
GBV	Gender-Based Violence
GFF	Global Financing Facility
GRM	Grievance Redress Mechanism
HMIS	Health Management Information System
IVR	Interactive Voice Response
KIIs	Key Informant Interviews
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organization
PCIU	Project Coordination and Implementation Unit
PFM	Public Financial Management
PMT	Project Management Team
SDD	Solar Direct Drive
SEP	Stakeholder Engagement Plan
UNOPS	United Nations Office for Project Services
WB	World Bank
WHO	World Health Organization

1. INTRODUCTION

1. Somalia's health indicators remain among the worst in the world, with an average life expectancy of fifty-six years. These indicators lag behind those in the WHO AFRO and selected comparable Fragility, Conflict, and Violence (FCV) impacted countries in Africa. Somalia suffers from high levels of mortality especially among children, underlined by stunting, high fertility, high maternal mortality, low school enrollment, and limited public and private sector financial protection mechanisms. The country's high poverty rates further compound low human capital as poverty limits opportunities for people to access basic services, exacerbating poor education and health outcome. In addition, the country is faced with the impacts of cyclical floods and droughts, together with protracted and ongoing armed conflict that has internally displaced more than 4.1 million people according to UNOCHA. The interlinkages between climate and environmental change, cyclical drought, poverty, fragility, severe food insecurity, conflict, and the global COVID-19 crisis further strained the already-fragile healthcare system.

2. **"Improving Healthcare Services in Somalia Project",** also known as **"*Damal Caafimaad",*** is expected to run from May 2021 to June 2026 in selected geographical areas in Somalia with an overarching Project Development Objective (PDO) to "*improve the coverage of essential health and nutrition services in project areas and strengthen stewardship capacity of Ministries of Health*." The project seeks to scale up high-impact health services across the population in project target regions and develop the Federal and State Ministries' of Health capacity to act as stewards of the health sector, effectively governing and building core functions that will enable the Government to lead and manage the sector. The criterion for geographic selection is based on objective measures, 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 (SHDS), and current partner support.

3. The project also seeks to strengthen the capacity of Ministries of Health at the Federal levels in order to enhance quality health service delivery across the country. The Damal Caafimaad Project is the first project of a similar size and scale in which the Government will have the central role in procuring and monitoring the activities of service delivery organizations. The project will specifically develop the capacity of the Ministries of Health in contract management and broader public financial management (PFM), health information and management systems (HMIS), support to the private sector service providers and networks, organizational capacity development, and support to regulatory reforms. In addition, the project also seeks to support the day-to-day management of the implementation through development of a monitoring and evaluation (M&E) framework and coordination mechanisms and will possibly provide an emergency fund for epidemics and outbreaks during the project implementation period through a Contingency Emergency Response Component (CERC).

4. The Damal Caafimaad project was approved on June 28, 2021, and became effective on December 30, 2021. The Project envelope of US$104.25 million comprises a US$75.0 million grant from the International Development Association (IDA-D8620), a US$25.0 million grant from the GFF (TF-B5820), and a US$4.25 million grant (AF, D862-SO) from the Green Climate Fund. The latter was approved on April 2, 2024. Furthermore, the Project was restructured on April 30, 2025, extending its closing date from May 30, 2025, to June 30, 2026. However, following another restructuring the project closing date was extended to December 31, 2026.

5. The fourth Additional Financing (AF) of US$15 million will support the Government of Somalia in responding to a severe drought-induced humanitarian crisis. Financed through the IDA Crisis Response Window Early Response Financing (CRW-ERF), the AF will fund the procurement and delivery of critical nutrition and health supplies including Ready-to-Use Therapeutic Food (RUTF), therapeutic milk, Small Quantity Lipid-Based

Nutrient Supplements (SQ-LNS), vaccines, and emergency health commodities targeting children under five in affected project districts.
Somalia is facing a rapidly deteriorating food security situation, driven by the failure of the 2025 Gu' rainy season (April–June) and the October–December Deyr rains. As of September 2025, 4.4 million people nearly 4.4 million people are experiencing acute food insecurity (IPC Phase 3+), with 921,000 in emergency conditions (IPC Phase 4). An estimated 1.85 million children under five are projected to suffer from acute malnutrition in 2026, including 421,000 cases of Severe Acute Malnutrition (SAM), which carries very high mortality risk. Compounding this, the drought has worsened water scarcity, driven up costs for trucked water, and triggered localized outbreaks of cholera, measles, and diphtheria. The crisis is most acute in districts supported under the Damal Caafimaad project including Baidoa, Burhakaba, Jalalaqsi, and Diinsor as well as IDP settlements in Mogadishu and Baidoa, where acute malnutrition rates exceed the emergency threshold of 15 percent. Shrinking humanitarian financing further threatens the continuity of essential health services.

6. The AF will sustain and scale up the Government's health sector response by amending existing project contracts to supply emergency nutrition and health commodities to supported facilities, while intensifying targeting of the most vulnerable households. To address food insecurity more comprehensively, the Damal Caafimaad project will collaborate with the BOOST-YOU project (P507443) to roll out Co-Responsibility Cash Transfers in target districts. Using the Universal Social Registry (USR) as a targeting platform, BOOST-YOU will identify and enroll eligible households particularly pregnant women and mothers of young children and link cash transfers to the use of health and nutrition services. This joint approach will combine acute malnutrition treatment under Damal Caafimaad with improved household food security under BOOST-YOU, creating a mutually reinforcing response to the ongoing crisis

7. The project had previously processed three AFs. The first AF was from the Green Climate Fund (GCF) Cooling Facility in the amount of US$4.25 million approved on April 2, 2025, with the aim of strengthening cold chain capacity by procuring and installing climate friendly cooling equipment and appliances, specifically solar direct refrigerators. The second AF, approved on October 1, 2025, in the amount of US$5.0 million from the Global Financing Facility (GFF) Multi-Sectoral Challenge Fund for Improving Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH-N) was aimed at scaling up the uptake of modern contraceptive methods using private providers. The third AF, approved on December, 31, 2025, to continue provision of essential health services through contracted non-governmental organizations (NGOs) in project supported regions and to renovate and equip six hospitals as well as construct the national cold chain storage facility.

8. Effective stakeholder engagement management for the Damal Caafimaad project (and the AF) requires a comprehensive approach that includes ongoing communication, listening, and collaboration. This updated Stakeholder Engagement Plan (SEP) will cover activities under both the parent project and the AF 1, 2 3 and 4 interventions. It outlines how different stakeholders will be engaged throughout the project cycle and provides mechanisms for their feedback to be used to improve project implementation. The SEP entails the identification and analysis of key stakeholders (including disadvantaged groups), their characteristics and interests, and the methods of communication, engagement, and consultation that are appropriate for different groups of stakeholders. The SEP outlines the type of information to be provided to and collected from different groups to facilitate their meaningful engagement in identifying, monitoring, and mitigating E&S risks associated with project implementation. This SEP update also integrates the AF 4 stakeholders including UNOPS, the implementing agency for the 6 regional hospitals and cold chain facility. The SEP revision includes targeted engagement strategies for couples, community leaders, male gatekeepers, and religious figures, and ensures that all stakeholders are meaningfully included in risk mitigation and information disclosure processes under ESS1, ESS2, ESS4, and ESS10.

9. The SEP is an iterative strategy that is reviewed and updated periodically as a result of the feedback and information gleaned from the regular engagements on the project. After each substantial engagement, the government will summarize key feedback and share it with relevant project teams and contractors to incorporate as appropriate to improve project performance. Stakeholders will be notified of the responses to their feedback and/or grievances. The Project Implementation and Coordination Unit (PCIU) at the FGS Ministry of Health (MoH) and the Project Management Team (PMT) at the FMS MoH level will keep updated documentation on the engagements with stakeholders and the actions taken as a result of the feedback received.

2. PROJECT DESCRIPTION

7. In alignment with the PDO to *"improve the coverage of essential health and nutrition services in project areas and strengthen stewardship capacity of Ministries of Health,"* the parent Project and Additional Financing (AF 1, 2 3 and 4) will support the delivery of a package of health services to beneficiaries, which includes procurement of health commodities (including medicines), construction of six hospitals and national cold chain facility, minor renovations and repairs of existing health centres, procurement of key equipment including provision of solar power generation and green cooling equipment, and development of policies and mechanisms that would regulate safer disposal of obsolete cold chain equipment, as well as developing capacity of the regional level to manage health service delivery including support for HMIS, and supportive supervision. Delivery of prioritized, essential health services will result in improved quality and availability of health services, followed by uptake of quality health services. In the long term, improved coverage of quality health services will lead to improved health outcomes among Project beneficiaries. The proposed AF will allow the Government of Somalia to respond to the ongoing drought by primarily addressing acute and severe malnutrition situations - procuring and delivering Ready-to-Use Therapeutic Food (RUTF), therapeutic milk, Small Quantity Lipid-Based Nutrient Supplements (SQ-LNS), and emergency health supplies such as vaccines to under-5 children in affected project districts.

8. In addition, the Damal Caafimaad project aims to respond to the institutional, operational, and technical capacity needs in Somalia's Ministries of Health (MoHs). At the request of the Federal Ministry of Health (FMoH), this project will strengthen the FMoH public financial management capacity (PFM) in fiduciary and contract management in the short, medium and long-term. Short-term activities will be supported during project preparation using WB executed financing, and longer-term activities will help build credible PFM systems in Somalia's MoHs in a consistent and phased approach. The FP initiative expands the EPHS with a dedicated family planning service line, offering short and long contraceptive methods free of charge through private providers.

9. The Project has four components as described in the sections below:

(i) **Component 1:** Expanding the coverage of high-impact health and nutrition services in select geographic areas.
(ii) **Component 2:** Strengthening Government's stewardship to enhance service delivery.
(iii) **Component 3:** Project Management and Knowledge Management and Learning.
(iv) **Component 4:** Contingency Emergency Response Component (CERC).
(v) A new component (**Essential Nutrition and Emergency Health Supplies**) will be added under the project (US$15 million). Its objective is to ensure the timely, reliable, and uninterrupted availability of essential nutrition, immunization, and emergency health supplies across high-priority districts.

10. The AF will support effective treatment and prevention of severe acute malnutrition; strengthen routine immunization and outbreak preparedness by bolstering stocks of critical vaccines; and enhance emergency health readiness through the strategic pre-positioning of cholera kits and essential outbreak response supplies in the country, improving the capacity of frontline facilities to respond rapidly in high-priority districts.

11. **For treatment and prevention of SAM in priority districts the AF will support procurement and distribution of** (a) 120,000 cartons of Ready to Use Therapeutic Food (RUTF) to treat 150,000 children (6–59 months) in line with Integrated Management of Acute Malnutrition (IMAM) guidelines; (b) 800 cartons of F-100 and 2,400 cartons of F-75 to treat 15,000 children with SAM complications; and (c) 45,000 Small-Quantity Lipid-based Nutrient Supplements (SQLNS) supplements for children 6–23 months to prevent deterioration into acute malnutrition in drought affected districts.

12. **To bolster vaccine stocks and prevent outbreaks of immunizable diseases, the AF will procure and distribute vaccines** [Measles, Bacillus Calmette-Guérin (BCG), Bivalent Oral Poliomyelitis Vaccine (bOPV), Tetanus and Diphtheria (Td)], and supplies to support routine and supplementary immunization activities targeting 1,206,242 children under five years of age, including 150,000 children under one year of age in priority districts giving priority to project supported districts while extending support to additional districts with surges of cases of vaccine preventable diseases.

13. **To enhance emergency response capacity**, the AF will support the pre-positioning of emergency and outbreak response supplies (Interagency Emergency Health Kits (IEHK) and AWD) across 21 high-priority districts to ensure timely response for 1.98 million people in need. These measures will enable rapid deployment during outbreaks and reduce delays in response. It is envisaged that the AF will avail the appropriate The **proposed** financing amounts by components are highlighted in Table 1.

Table 1: Original Project and Proposed AF3 Financing Amounts by Component

Component	Original Project, AF1, AF2 and AF3 (US$ M)				AF4 (US$ M)	Total (US$ M)
	IDA amount	GFF amount	GCF amount	Original Total	IDA AF	Total
Component 1: Expanding the coverage of high-impact health and nutrition services in select geographic areas (FGS)	71.00	23.50	4.00	98.50	0.00	98.50
Component 2: Strengthening Government's stewardship to enhance service delivery	3.30	5.00	0.00	8.30	0.00	8.30
Component 3: Project management, knowledge management and learning	10.20	0.00	0.25	10.45	0.00	10.45
Component 4: CERC	0.00	0.00	0.00	0.00	0.00	0.00
Component 5: Continuity of essential health services	9.00	0.00	0.00	9.00	0.00	9.00
Project Activities in Somaliland	9.50	1.50	0.00	11.00	0.00	11.00
Component 6 (New): Essential Nutrition and Emergency Health Supplies	0.00	0.00	0.00	0.00	15.00	
TOTAL	103.00	30.00	4.25	137.25	15.00	152.25

14. **Component 2:** Strengthening Government's stewardship to enhance service delivery will support both the Federal and FMS levels in the following technical areas: (i) HMIS and data use; (ii) PFM/contract management/health financing; (iii) private sector development and regulatory reforms; and (iv) organizational development. The activities will be implemented under four sub-components.

15. **Component 3:** Project Management and 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.

16. Under component 3, AF 1 provided additional US$0.25 million increasing the component cost from

US$6.00 million to US$6.25 million. The AF1 also financed technical assistance to improve the policy environment for climate friendly cold chain and power. Specifically, the support focused 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.

17. **Component 4:** Contingency Emergency Response Component (CERC) – This component is a zero cost component known as a Contingency Emergency Component (CERC). It will provide immediate surge funding in the event of a public health emergency, such as a disease outbreak and 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.

18. **Component 5: Continuity of essential health services (US$9.0 million).** This component was introduced during the processing of AF 3 and is being implemented by UNOPS. It finances the completion of the civil works activities that were started under the Somalia COVID-19 Emergency Vaccination Project, and the implementation of the climate emergency hospital response team's capacity building.

19. **Component 6 (New): Essential Nutrition and Emergency Health Supplies:** This is a new component whose objective is to ensure the timely, reliable, and uninterrupted availability of essential nutrition, immunization, and emergency health supplies across high-priority districts. It will support effective treatment and prevention of severe acute malnutrition (SAM); strengthen routine immunization and outbreak preparedness by bolstering stocks of critical vaccines; and enhance emergency health readiness through the strategic pre-positioning of cholera kits and essential outbreak response supplies in the country, improving the capacity of frontline facilities to respond rapidly in high-priority districts.

20. A summary of the project was developed in standard Somali language and published on the FGS Ministry of Health website.

Aim of the Stakeholder Engagement Plan

21. The overall objective of this SEP is to define a program for stakeholder engagement, including public information dissemination and feedback mechanisms including via the project grievance mechanisms, throughout the entire project cycle. It outlines the ways in which the project will communicate with stakeholders and includes a mechanism by which people can raise concerns, provide feedback, or make complaints about the project and any activities related to the project. For Damal Caafimaad Project stakeholder engagement is key to communicating the principles of prioritization *of* essential health and nutrition services in project areas and strengthen stewardship capacity of Ministries of Health, reaching out to disadvantaged and vulnerable groups, overcoming demand-side barriers to access and creating accountability against misallocation, discrimination and corruption.

3. STAKEHOLDER IDENTIFICATION AND ANALYSIS

22. The parent project and AF 1, 2 and 3 continue to engage a large and diverse array of stakeholders during planning and implementation. The FGS and the participating FMS/BRA are responsible for project implementation and management, together with contracted implementation partners, who will implement the services delivery programs and construction of six regional hospitals and national cold chain facility, minor renovations and repairs of existing health centres in public health facilities throughout the selected regions, in partnership with local organizations. Non-state stakeholders such as community leaders, citizens who benefit from the services provided, health workers, disadvantaged and vulnerable groups and their representatives/advocates, etc. are involved regularly through the life of the project. Additional diverse groups such as private sector health service providers, international NGOs working in the health sector, and civil society groups, are engaged as appropriate, especially during discussions related to the environmental and social risks and impacts associated with the project interventions. Relationships with existing non-government actors, including UN agencies, NGOs, and private sector organizations, have been established and, in some cases, enhanced to ensure the project leverages the activities of the agencies within the health sector in Somalia. Special consideration has been taken to ensure that women, youth, minority groups, elderly and persons living with disabilities (PWDs) are represented among the stakeholder groups. Various other stakeholders such as religious leaders, clan elders and opinion leaders who may influence the perceptions to increase essential health and nutrition services and involvement of women in the project have also been actively engaged. Particularly frontline workers who can act as role models for others as well as older people (over 50 years) and people with co-morbidities. AF 2 introduced the GFF supported FP initiative under the Project with the stakeholder landscape expanding to include private health service providers.

23. For the purposes of effective and tailored engagement, stakeholders of the proposed project(s) can be divided into the following core categories:

- **Affected Parties** – persons, groups and other entities within the Project Area of Influence (PAI) that are directly influenced (actually or potentially) by the project and/or have been identified as most susceptible to change associated with the project, and who need to be closely engaged in identifying impacts and their significance, as well as in decision-making on mitigation and management measures.
- **Other Interested Parties** – individuals/groups/entities that may not experience direct impacts from the Project but who consider or perceive their interests as being affected by the project and/or who could affect the project and the process of its implementation in some way; and
- **Vulnerable Groups** – persons who may be disproportionately impacted or further disadvantaged by the project(s) as compared with any other groups due to their vulnerable status and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project.

Table 2 Stakeholders Identified and Analysed

Stakeholder Category	Stakeholder Group	Stakeholders	Relevance to Project	Needs	Mode of Consultation
Primary	Community	Community leaders- religious leaders clan elders and opinion leaders,	The community elders, religious leaders and/or traditional health providers can promote positive opinion towards services and articulate issues and	To learn about the project's activities and to have a platform to advise on social risks management and mitigation.	Public consultation with the general public as part of state level and Federal Level Consultation and Engagement Meetings.

Stakeholder Category	Stakeholder Group	Stakeholders	Relevance to Project	Needs	Mode of Consultation
			amplify the voices of those who may be otherwise hard to reach or not empowered to raise issues. Given the role of religion in Somalia religious leaders can be important agents of change if engaged meaningfully.		
			• Children under five suffering from malnutrition • Pregnant and lactating women • Caregivers and mothers • Internally Displaced Persons (IDPs) and drought-affected communities		
		Community and community groups or community health committee	Somali citizens who reside in the project locations. Their views about the potential environmental and social risks are essential in identifying and mitigating those risks. Their feedback about the project implementation is crucial to the overall success of the project	To be consulted and be informed about the potential environmental and social risks of the project - in order to address and mitigate, as much as possible. To contribute their feedback and concerns about the implementation of the project.	FGD, KII, Round table meetings with the community health committee Implementing Partners will be responsible on this with oversight by PMT/PCIU.
		Communities living and working immediately around the construction sites of the six hospitals and the National Cold Chain Facility.	Directly affected by construction and rehabilitation activities—exposed to potential noise, dust, traffic disruption, and safety concerns. They will also benefit from improved access to upgraded healthcare services once facilities are operational	To be consulted and informed about potential E&S risks and mitigation measures and Inform on construction timelines, temporary impacts, OHS risks, and access to the project GM. To contribute feedback and	Public consultations /dialogue forums-FGD, KII, Round table meetings with community health committees. Implementing partner will be responsible for conducting this with oversight by PCIU/PMT

Stakeholder Category	Stakeholder Group	Stakeholders	Relevance to Project	Needs	Mode of Consultation
				concerns about implementation- They will also learn about GRM channels to share their concerns and complaints	
		Urban community residents in Mogadishu, Kismayo, Garowe, and Hargeisa Male Engagement (husbands and religious/cultural figures who influence women's access to FP).	Family Planning users as part of AF 2	Besides Family Planning Efforts.	PSI will engage them by media, radio broadcast and telephone. They are engaging through trusted people, traditional leaders and women group
		Disadvantaged and vulnerable groups (women, youth)	Disadvantaged groups and particularly from women themselves who are the main beneficiaries of the project. Provision of quality healthcare service for all members of the society (i.e., women and children, and Vulnerable and Marginalized Groups (VMGs)) will lead to a healthy and prosperous population. Persons with disabilities	PSI will have FGD to understand their family planning needs and other health service needs. To learn about GRM channels to share their concerns and complaints.	Focus group discussion These will be engaged at community level (by Partners) and State and Federal Level by the PMT/PCIU.
		Minority groups (Bantu, Bravenese, Rerhamar, Bajuni, Eyle, Galgala, Tumal, Yibir and Gaboye.), IDPs and nomads	Minority groups should be meaningfully consulted to ensure their voices are heard and their specific needs are addressed. Efforts must be made to avoid any form of discrimination, and they have the right to equitable access to services.	Make efforts to ensure their specific concerns and perspectives are captured during stakeholder engagement processes. While they are part of the larger population, we recognize their unique needs	Conduct ad-hoc consultations engage them separately where possible in addition to broader consultations with primary and vulnerable groups.

Stakeholder Category	Stakeholder Group	Stakeholders	Relevance to Project	Needs	Mode of Consultation
				To about GRM channels to share their concerns and complaints	
	Health workers	Public Service Providers Private Service Providers- Private health clinics Construction workers, contractors, and UNOPS field staff	People and companies who will benefit from project-related employment (i.e., health workers, consultants, suppliers, contractors, private businesses in the health sector). These people ensure the provision of inclusive, accessible and quality services for all, ensuring that their human rights and dignity are respected	To be consulted and be informed about the potential environmental and social risks of the project - in order to address and mitigate them. To contribute their feedback and concerns about the implementation of the project.	KII, FGD, workshops, monthly meetings with implementing partners and health committee as part of state level and Federal Level Consultation and Engagement Meetings.
		Construction workers, contractors, and UNOPS field staff	Directly involved in AF3 civil works; critical for ensuring compliance with Labor Management Procedures (LMP), Occupational Health and Safety (OHS) standards, and the Code of Conduct (CoC).	Safe working conditions, adherence to CoC, fair and timely wages, access to worker GRM, and continuous safety orientation.	Regular coordination meetings, OHS and Code of Conduct (CoC) orientations, toolbox talks, training workshops, and awareness sessions on workers' rights and responsibilities
		Private health clinics are contracted health care facilities to deliver FP services.	These actors while previously underrepresented in stakeholder analysis, are now directly involved in service delivery and play a critical role in increasing access of health services, especially in urban areas.	They need targeted orientation, establishment of facility-level focal points, and simplified communication strategies in Somali tailored to address misconceptions.	Establish health committees they will be consulted under the PSI engagement plan
		Traditional health providers e.g., traditional birth attendants or healers.	May benefit from linkages with expanded coverage of high-impact health and nutrition services, e.g., antenatal visits and	To be consulted and engaged in the project - in order to support its outcomes.	Implementing partners and directly through PMTs

Stakeholder Category	Stakeholder Group	Stakeholders	Relevance to Project	Needs	Mode of Consultation
			improved nutrition and care of expectant mothers and		
	Project implementors	The Project Implementation and Coordination Unit (PCIU) at the FGS Ministry of Health (MoH) and the Project Management Team (PMT) at the FMS MoH level	These ministries are integral to the overall success of the project at all stages and are crucial to the establishment of the physical, technical, legal and regulatory framework of the project as well as providing human resources. As a result of the project activities, the capacities of the ministries of health (both levels of the federation) will be strengthened. The ministries' feedback and cooperation throughout the project cycle is crucial to the overall success of the project.	To be consulted and be informed about the potential environmental and social risks of the project – in order to address and mitigate them. To respond and act on the feedback/ suggestions provided by other stakeholders about existing risks. To create an easily accessible communications channels for other stakeholders to air their views. To address the grievances of other stakeholders.	Bi-weekly meetings, Workshops, and quarterly meetings, Bi-weekly security community of practicing training (COP)
Secondary Stakeholders	INGOs	UN agencies- UNICEF, UNOPS, Population Services International (PSI)	Development partners will have a convenient platform to provide technical advice and financial assistance and performance standards for service provision in the health sector. Engagement with these groups can improve coordination and avoid duplication of duties.	To learn about the project's activities, share information, lessons learned, and explore opportunities to maximize impact with similar projects.	Workshops,
	CSOs, NGOs	working in the health sector	Civil society organizations especially those which work closely with disadvantaged groups in the focus regions of the	To learn about the project's activities and to have a platform to advise on social risks management and mitigation.	Workshops

Stakeholder Category	Stakeholder Group	Stakeholders	Relevance to Project	Needs	Mode of Consultation
			project, are often able to articulate issues and amplify the voices of those who may be otherwise hard to reach or not empowered to raise issues and are often well informed about lessons learnt and good practice in particular contexts.		
	Other Government Institutions / Ministries	Implementing projects in the country such as social services and construction related interventions	The engagement with other line ministries will enhance coordination efforts among the government institution and innovate multi-sectoral approach and maximize our collective social and economic development in the country	Project share their working areas and expertise, explore areas for complementarity and standardization	Workshops

24. Engagement approaches for private clinics and FP-specific audiences include orientation workshops on the ESF, focused group discussions with FP clients (especially women and girls), and use of IVR systems to collect anonymous feedback on service quality. Community dialogues involving elders and women's associations are recommended to address socio-cultural sensitivities related to contraceptive uptake. Digital channels (e.g., WhatsApp groups or radio broadcasts) are also suitable for broader public information campaigns.

25. While public MoH entities and NGOs remain primary decision-makers, private providers are increasingly influential as service delivery agents. Religious leaders and influential elders also hold considerable sway over community acceptance of FP services.

3.1. Stakeholder Engagement

26. A number of stakeholder consultations have been conducted both virtually and in person, engaging a wide range of stakeholders at the federal, state levels, the communities and the NGOs .The government will continue to promote genuine stakeholder engagement to build mutual trust, foster transparent communication with both the project beneficiaries and other stakeholders, and ensure social and environment risks are identified and mitigated. In Somalia, consistent and meaningful dialogue with stakeholders is critical to maximize opportunities for the project's success, enhance project acceptance and ownership and improve the social contract between the government and its citizens and promote security.

27. The SEP and the citizen engagement platform will continue to be implemented in such a way as to leverage

the stakeholder engagements to further the goals of monitoring E&S risks while also setting mutual expectations, clarifying the extent of the government's commitments and resources, and obtaining feedback on activities. Lastly, the SEP includes a grievance mechanism (GM), with clear and transparent procedures, to allow for the implementing partners and different levels of MoH to act upon complaints and suggestions for improvements in a timely mannerPrevious Summary of stakeholder engagement done during project preparation.

28. No additional consultations were conducted for the SEP at this stage. Nevertheless, as the SEP is considered a living document, ongoing consultations will take place throughout the implementation of the AF. These efforts will ensure that stakeholders are kept informed regarding new activities, related risks and impacts, and any modifications to implementation arrangements or the grievance mechanism.

29. However, the most recent stakeholder consultation meeting, held on August 19, 2025, brought together about 100 participants who included Federal and State Ministries, UN agencies, NGOs, civil society, IDPs, minority groups and persons with disabilities (PWDs) women-led organizations, and community health committees to review progress on the Damal Caafimaad and COVID-19 Emergency Vaccination projects. Achievements were substantial, demonstrating significant expansion and resilience in Somalia's health system. The session reviewed project progress, safeguards performance, and lessons learned. Stakeholders acknowledged substantial gains in service delivery, workforce gender balance, and integration of Environmental and Social Safeguards (ESF), GBV/SEA-SH prevention, and grievance redress systems. They recommended stronger inclusion of persons with disabilities (PWDs) and internally displaced persons (IDPs), deeper community accountability through Community Health Committees (CHCs), and partnerships with local CSOs and the private sector to ensure sustainability. The meeting concluded that while the health sector is on a transformative path, the key to sustained success lies in addressing inclusivity and sustainability. Stakeholders agreed on five critical Recommendations for the way forward: 1) Strengthen the inclusion of PWDs and IDPs in service and employment; 2) Deepen accountability and local ownership by empowering Community Health Committees (CHCs); 3) Scale up GBV prevention and ensure survivor-centred, disability-inclusive services; 4) Enhance sustainability by forging stronger partnerships with local civil society and the private sector; and 5) Rapidly roll out digital platforms, such as the new GRM Portal, to improve transparency and efficiency in accountability. In addition, during the preparation of the ESMPs for the construction of the six hospitals, consultations were held with details of these consultations provided in Annex 1. The summary is presented in Table 3.

Table 3: Consultations held during the preparation of the ESMPs

Date	Meeting Purpose	Summary	Participants
06 June 2024	Design team mission to visit the site and to agree on the requirements for Forlanini Hospital and the cold chain facility	The design team detailed discussion on the requirements of the hospital, the priorities of the hospital, the location of the site for the priorities, preparatory works and the need for expedited implementation of the cold chain facility. The UNOPS team expressed the need for prompt review and approval of the requests related to the design that will be submitted to the MoH and the hospital.	Ministry of Health (1) Forlanini Hospital Personnel (6) PCIU (1) UNOPS (6)
July 2024	Design team and the stakeholders meeting to agree ESMP and design process of the sub-project on Bosaso Hospital	The design team met with the PCIU Project Coordinator among other key stakeholders to discuss on Environmental and social risks connected to the demolition and construction, including construction waste and its disposal	Bosaso Hospital (4) Community members (12)
02 July 2024	Design team and the stakeholders meeting to agree on the	The design team proposed designs for the new sections of the hospital, the architectural plans, highlighting key areas such as the emergency	MOH (1) UNOPS (3) Community member (12)

Date	Meeting Purpose	Summary	Participants
	requirements for Dhusamareeb Hospital	department, triage, inpatient services, kitchen, police rooms, standard operation theatre, waiting areas, cafeteria, and ample parking facilities. Each section was shown through detailed drawings, giving stakeholders a comprehensive view of the planned facilities.	
08 July 2024	Kismayo Hospital Stakeholders meeting to agree on the requirements for Jowhar Hospital	The design team detailed discussion on the requirements of the hospital, the priorities of the hospital, the location of the site, proposed rehabilitation and reconstruction and the proposed phases. This includes implementations under phase 1 comprising new Accident and emergency unit, Operation theatre, Intensive Care Unit, renovation of OPD, x-ray room and pharmacy, external works and relocation of external services, and demolition of existing buildings to construct new ones.	Kismayo General Hospital (6) -Ministry of Health (4) UNOPS (5)
14 July 2024	Design team and the stakeholders meeting to agree on the requirements for Baidoa Hospital	The design team detailed the proposed rehabilitation and reconstruction and the proposed phases and the zoning of the existing hospital and future expansions.	Ministry of Health (3) Baidoa Referral Hospital (2) UNOPS (6)
17 July 2024	Design team and the stakeholders meeting to agree on the requirements for Jowhar Hospital	The design team detailed the requirements of the hospital, the priorities of the hospital, the location of the site for the priorities, preparatory works that can be done in parallel while the design proceeds were discussed. The hospital authorities mentioned the priority is the emergency unit and operating theater.	UNOPS (2) Director General, Hirshabelle MoH Jowhar Hospital (4)
10 December 2024	ESMP review Forlanini Hospital Asbestos Removal and disposal	The bidders are required to include Asbestos removal specialist certified with asbestos abatement training program with experience in managing asbestos removal in projects that involve demolition in compliance with the Environmental and Social Management Plan (ESMP)	PCIU (4 members) Forlanini Hospital Personnel (4 members) UNOPS (1 member))

30. Engagement in the project design and the planned activities, and implementation arrangements have been carried out with relevant government agencies, development partners and non-government project-affected stakeholders. As part of the development of the SEP, and the Environmental and Social Management Framework (ESMF), a series of consultations were carried out with a diverse set of stakeholders including government staff, health workers, civil society and NGO staff, including 39 individuals, 6 of whom were women under the parent project. For the purposes of introducing the new components under AF 1, and further discussing views and concerns, a follow-on stakeholder consultation was held on June 27, 2023. The consultations provided valuable insights on potential E&S risks and mitigation measures related to the implementation of the parent & AF "Damal Caafimaad" project as indicated in Annexes 1 & 2. Due to the COVID-19 pandemic, early engagements of the parent project were done virtually with stakeholders in the confirmed regions, however, additional consultations will continue in the remaining regions, either virtual or in-person, as the global health emergency has been declared over by WHO on May 5, 2023.

31. The parent project is effective, but the implementation of the project components is still at early stages

and thus there has been little stakeholder engagement undertaken. The project's grievance redress mechanism is in place and operational. The MoH has published the GRM on their website and is in the process of starting stakeholder engagement to ensure that avenues for grievance logging and the process of management of grievances have been shared with all relevant stakeholders. The GRM for the parent project will be applicable to the AF 1, 2 and 3 activities.

32. During implementation of the parent project the following consultations and sensitizations have been conducted

Table 4: Previous Project consultations under Damal Caafimaad (parent Project & the AF 1)

No	Date	Subject of consultations	Attendance
1.	June 27, 2023	- Receiving key stakeholders' input into proposed framework for management of the project-level E&S risks and impacts. - Assessing the new E&S risks of the AF components, with the possibility for including new mitigation measures. - Strengthening positive impacts and outcomes of the Somalia DC project, and additionally financed components in particular.	Attended by 34 participants (as shown in Annex 3), 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.
2.	Preparation: Dec. 14, 2020; Jan. 2021	Expert discussions on a variety of risks and impacts, which included: - False perceptions about the Project, prioritization among vulnerable and marginalized groups, elite capture, socio-cultural beliefs, community acceptance/ ownership and participation, clan and government tensions, and environmental risks, including improper disposal of syringes and used equipment, as well as medical waste, among others. - Exclusion, security, labor issues, OHS, GBV, and access to GM.	Representatives of local and international organizations, in addition to PM and E&S team at the FMoH. See Annex 1.
3.	February 3, 2021	- Collecting 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.	Representatives of disadvantaged and vulnerable groups and different NGOs working in the health sector in targeted regions of Nugaal (Puntland), Bay and Bakool (Southwest), and Hiraan and Middle Shabelle (Hirshabelle).

Table 5: Issues raised and responses made during consultations of the AF 1 in June 27, 2023

NO	*Issue*	*Response*
1	- Social risks include existing sexual harassment in the workplace but mostly it is unreported due to either fearing loss of the jobs or not	- Mitigation measures would include: providing more awareness by key government staff about GRM reporting on SEAH issues, the availability and accessibility of such mechanism, with the confidentiality of complainants being maintained all the way.

NO	Issue	Response
	having full information about the reporting procedures.	Additionally, all project workers should get CoC orientation and should sign the project COC accordingly. - The GBV/SEAH risks and Mitigation measures will be managed throughout the project (incl. AF) lifecycle. - The project will conduct GBV service mapping and assess Clinical Management of Rape nationwide.
2	- Inclusion of all relevant complaints. How are states being mobilized on Project GRM? Have beneficiaries at the participating states level been made aware of the GRM?	- GRM design already allows for receiving both negative and positive notes related to the Project. The GRM system is adaptive and can be updated to accommodate all types of complaints concerning the Project. - The participating states have been made aware of the Project GRM mechanism and have already received the required orientation. The Project is continuously planning to establish appropriate GRM channels at the state level. - For the sake of educating the community and beneficiaries, the PCIU and PMT will conduct community awareness raising campaigns on the available GRM reporting mechanisms.
3	- Regarding managing project risk Any mitigation measures about floods in Damal Cafimaad project areas, like Hiiraan and Middle shabelle 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 presented in the Project's ESMF,– the participants wanted to know more about waste generated by the different the project components. Do the Project teams have enough experience in environmental and social impact assessments?	- The DC project has already included a Contingency Emergency Response Component (CERC), which can be activated upon occurrence of emergencies, such as in case of floods. - The targeted Health Facilities have started drafting site- specific Emergency Response Plans (ERPs), with the aim of identifying the level of exposure to environmental disasters, and possible measures to be taken. - The capacity to deal with emergency exposures at the facility level has been improved. - Finally, we Do not only focus on floods but all kinds of exposures example Fire outbreaks and so on. - Most of the cold chain waste will be used via integrated waste management approaches i.e. reuse, reduce and recycle. However, UN agencies operating in the country (WHO in particular) have contributed to formulating Standard Operating Procedures (SOPs) to manage waste generated in HCFs. The team will continue using these SOPs given they are in line with the waste management plan introduced through the Project's ESMF, and been updated to accommodate other types of waste, where necessary. Yes, the Project team at the MoH side has appropriate expertise to manage E&S issues. For instance, the DC E&S safeguards team has collaborated with WB E&S safeguards team to get ESMF developed and adopted for the Project and AF, including other E&S instruments.
4	It was noted that the Occupational health and safety guidelines concerning child labor have been drafted for the project already, however, the project team should have followed up on the existing Child safeguard policies available in the country.	- The DC project teams will follow up on the exiting child safeguard policies and ensure protection measures provided at the most stringent level. - Additionally, under the Contractors ESMP there will be enough provisions for child protection.
5	<u>Additional notes:</u>	
	- Also, one of the social risks may be lack of adequate public participation. Mitigation measures conveyed in this	

NO	Issue	Response
	regard included: ensuring that measures for identifying and reaching out to disadvantaged groups and rural populations are in place. - There were suggestions by the stakeholders to have more stakeholder engagement that are physical. - The need to have regular technical meetings that are periodic with pre-set timelines – i.e., monthly, quarterly. These meetings would aim at increasing engagement of stakeholders at the FGS and FMS levels, as well as ensuring enough participation of key implementing partners. SEP will be updated to increase participation frequency. - Creating early warning signals against flood and putting preventive measures are essential to the Project. The Project will invest in emergency response planning, including utilizing existing systems and improving HCFs' capacity for preparedness. - Following up with the national disability agency i.e., according to the national disability act, as well as inclusion of PWD are essential to the Project. The Project will ensure enough participation of PWD. The Project team has already developed an "Inclusion Plan" that will be adopted and updated throughout the Project lifecycle. - All updated and translated documents should be disclosed through the Ministry's official website. - Adaptation and implementation of WB E&S safeguards and ensuring compliance is essential to the Project.	

33. In June 17 and 18, 2025, the project implementation team held consultations with private sector health service providers and PSI on the AF 2 activities i.e. Family Planning (FP) initiative supported by GFF challenge fund. The consultations focused on understanding their capacity, coordination structure and ability to align with E&S risk management under the project in Somalia and Somaliland.

Table 6: Private Sector consultations under Damal Caafimaad the Additional Financing 2

Subject of consultations	Attendance
-Stakeholder consultation with private FP service providers to align implementation with ESF. Discussed community awareness, misinformation, lack of internal GRMs, absence of CoC and coordination with PCIU, PMTs, and PSI.	45 participants including private clinics representations, experts in FP outreach, FMOH, MoH, PCIU, and FMS PMTs, and project E&S specialist in Somalia. See Annex 1
-Stakeholder consultation with private FP service providers to align implementation with ESF. Discussed community awareness, misinformation, lack of internal GRMs, absence of CoC and coordination with PCIU, PMTs, and PSI.	19 participants including private clinics representations, experts in FP outreach, FMOH, MoH, PCIU, and FMS PMTs, and project E&S specialist in Somaliland. See Annex 2

The consultations focused on understanding their capacity, coordination structure and ability to align with E&S risk management under the project in Somalia and Somaliland.

Table 7: Summary of the key risks raised and potential mitigation measures

Aspect	Key Risk	Mitigation Measures
Perception about the project and its implementation	-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 MoH officials have an 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	The procurement process should be conducted in a transparent manner and due diligence followed. -The ministries should remain focused on 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.

Aspect	Key Risk	Mitigation Measures
	number of 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 employment and contracts. - Socio-cultural beliefs about medicines and vaccines within communities is however common in remote areas. For example, people may be discouraged from using conventional medicine and instead encouraged to seek traditional medicines.	-Contracting employees from the local areas and improving their capacity because they understand the dynamics of the areas.
	Community acceptance/ownership and participation: Acceptance of the project by the communities in the implementation areas. The communities need to understand the project components very well before implementation.	- Social risks can be minimized if all clans and communities are consulted about the project equally. - Proper consultation with the key stakeholders, community members and local administration in order to avoid exclusion of certain groups.
	Challenges: -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. -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. - Role of gate keepers in implementation – they often play an intermediary role between the IDPs and the services providers. ***Environmental risks*** - disposal of syringes, injections and other equipment cause risks to the communities. There is no proper mechanism to dispose medical equipment.	-Review security risks in the target areas. - Conduct proper security analysis and prior site visit before the target locations are chosen. - Community representation should be increased especially women. - Recruitment of medical professionals from local communities. - Awareness raising conducted by experienced women regarding misperceptions of vaccines - Proper disposal mechanism for health equipment such as incineration. -Selection of proper sites for health facilities (always avoid flood-prone areas).

Aspect	Key Risk	Mitigation Measures
Exclusion during project implementation	- There could be exclusion of certain groups such as minority groups, IDPs and people living with disabilities 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 family planning 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 the community, but they are most often treated as an external group. IDPs are not in most cases considered to be part of the communities.	- Proper consultation with these communities, and awareness to the communities regarding their rights to be part of the project. - 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. - Establish health centers in IDP populated areas/districts.
Labor- related risks	- Non-compliance of Somali labor laws are expected during the project implementation. For example, recruitment of workers may be flawed due to nepotism and elite capture. - Somali labor 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 likely. -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 pay for project workers. Some employees are paid incentives while others are paid salaries.	- Advocacy groups should be established to counter flawed processes. - Monitoring of labour laws - Equal payment for project workers depending on the qualifications and experience.
Security issues and conflict	- 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. - No security threats in Puntland.	- 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	- Some health facilities are associated with certain clans; therefore, some clans (especially minority groups) may not feel comfortable	- Awareness raising on services for all. -Put policies in place to stop the influence of clans in recruitment of health workers and

Aspect	Key Risk	Mitigation Measures
	seeking medical assistance from it. This is because these medical facilities are dominated by certain clans.	initiate elimination of discriminatory behavior in recruitment processes.
Grievance Mechanism	- Grievance feedback mechanisms do exist, but people are not confident using them 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). - People do not use suggestion boxes due to the high illiteracy level. It is better for them to call and air their grievances (Puntland state).	Toll-free numbers are established, and the calls are managed by an external actor, the people may be comfortable conveying their grievances. - Contract a third party to manage GRM on behalf of the MoH. -Conduct forums/meetings at the community level regarding the implementation of the project.
Gender-based violence (GBV)	- 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.	-Awareness raising about the consequences of the GBV in workplaces.
Occupational health and safety	- AS do not mostly target/attack health facilities. - If proper security analysis 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 may witness violence and injuries and death at workplace. - Most health workers do not have PPEs and are not able to protect themselves from infectious diseases.	-Put security measures in place. 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	Stakeholder engagement can be conducted through meetings, community fora and bilateral meetings with elders and community influencers.	- 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,

Aspect	Key Risk	Mitigation Measures
		especially during peak hours.
Recommendations	- Proper implementation of the project and engagement of a wide range of stakeholders throughout the implementation process.	-Close monitoring by 3rd party and World Bank

34. The project's implementing partners will carry out consultations and dissemination of information about services throughout the region, at community and at regional levels via FM radio and social media. The consultation process needs to be culturally appropriate, non-discriminatory and gender sensitive and reach disadvantaged and vulnerable groups. It needs to ensure that all groups whose lives might be affected by the project are properly consulted to verify and assess the significance of social risks and that all affected groups are provided the opportunity to participate in the development of mitigation measures.

35. Since PSI already has GRM channels in place as part of the project, they will also utilize these channels within the private sector facilities. PSI will continue to monitor grievances through their established mechanisms and report to MoH using the existing reporting procedures currently in place.

36. **Socio-cultural beliefs**

- Since responsibility for household decisions mostly resides with men, women often have to seek their husbands' permission before they seek medical assistance at health centers, thus it is important to ensure that men understand the importance of healthcare services for women and children and trust the service provision, including by ensuring that female medical workers are an option and women are treated in a secure and culturally sensitive environment.
- Men tend not to be engaged in health interventions since the focus tends to be on women. There is however evidence that male involvement leads to better and sustained health outcomes as opposed to focusing only on women. The project will need to deliberately focus on men as key stakeholders.
- Clan structures and cultural practices are believed to have a major impact on the utilization of formal healthcare services. Most communities in Somalia have high regard for traditional medicine (use of herbal medicinal products) due to its perceived value over conventional medicines. This has affected the popularity and the use of conventional medicines in many parts of Somalia. The traditional birth attendants continue to play a critical role in maternal and child health in the country.
- There is particular stigma associated with family planning, vaccination and GBV services and strong cultural beliefs around FGM/C, which need to be carefully promoted by engaging with key influencers including elders, religious leaders and community influencers for men and women.

37. The discussions with the stakeholders under the RCRF program, which supports the Female Health Worker program and is being built into this project, provided a nuanced understanding of the potential social risks identified. Below are some of the key takeaways from the discussions:

- There was consensus amongst those consulted that the biggest limitation to providing services to under-served communities is lack of access due either to insecurity or poor infrastructure. The government and humanitarian/development partners use data to determine locations for support and to coordinate to ensure limited gaps when possible.
- While there is always the potential that women may be subject to GBV/SEAH, whether as direct beneficiaries or recipients of services, most stakeholders felt that the primary challenge facing women is

SEAH within the workplace. The potential for SEAH exists because most of the lower skilled workers such as FHWs are recruited from the lower economic rankings, therefore, they are in dire need of their salaries and would not be willing to do anything to jeopardize their income.

3.2. Summary of project stakeholder engagement tools and techniques

38. Stakeholder engagement will continue to be tailored to the most effective mechanisms to reach the identified stakeholder groups, namely affected parties, other interested parties and disadvantaged and vulnerable individuals or groups. This will be led by the implementing partners supported and monitored by the social specialists within the Program Management Teams (PMTs) in the participating FMS and social specialist at the FGS level Project Coordination and Implementation Unit (PCIU). At the community-level, implementing partners will build a coalition of change agents and community monitors, or work with existing structures by adopting various communication and participatory methods designed to inform, consult, involve, collaborate or empower. These will include mechanisms to engage disadvantaged and vulnerable groups such as IDPs, minority groups and clans, women, and people living in remote communities including nomadic pastoralists.

39. Monitoring is being carried out via social media and mobile phone apps, on the quality of services and the functionality of health centers as well as via the health staff by the MoH and complemented by a third-party monitoring (TPM) agent.

40. Due to obstacles in participation of disadvantaged and vulnerable groups, the implementing partners will continue to collaborate with organizations who advocate for equitable services to ensure their views are taken into consideration and their issues addressed. To expand the audience for public information campaigns, the project utilizes strategic communication measures depending on the audience, for example FM radio, social media and TV discussions. In addition, periodic community feedback surveys will be carried out to get feedback on all services provided by the project and an understanding of whether there is awareness on the GM and whether it is trusted. These feedback mechanisms could include virtual Geo-enabled monitoring tools which have already been introduced to the other World Bank supported projects.

41. Meaningful stakeholder engagement depends on timely, accessible, and easily understood information. Making available project-related information as early as possible in the project cycle and in a manner, format, and language appropriate for each stakeholder group is important. Table 6 indicates the methods for stakeholder engagement and information disclosure. Formats to present information may include presentations, non-technical summaries, project leaflets, diagrams, posters and pamphlets, where possible sent by mobile phone as well as physically depending on accessibility and stakeholder needs.

42. Table 8 presents the different ways through which the stakeholders are being consulted and kept informed on the project progress.

Table 8: Future Consultation processes

No	Stakeholder	Mode of Engagement	Frequency	Purpose	Responsibility
1	Somali citizens, such as community members who will benefit from the healthcare services (i.e., mothers, children, pregnant women, IDPs and nomads, people living with disabilities and other disadvantaged and	Public fora using approaches such as community conversations or dialogue forums, including in-person meeting. -Messages through phones and social media	At initiation of services, quarterly, monthly, and as needed throughout the project implementation.	• To educate communities on the project's goals and activities. To collect views on social risks and how they could be managed, or their management could be improved. Provide	PCIU/PMTs and Social and GBV safeguards Specialist at FGS and focal points at FMS levels.

No	Stakeholder	Mode of Engagement	Frequency	Purpose	Responsibility
	vulnerable groups including those living within the hospitals and cold chain facility construction sites.	platforms (e.g., WhatsApp). -Community feedback surveys. GRM Portal		dialogue opportunities where citizens have access to and engage with government representatives and other stakeholders. • Collect feedback from the target communities to understand their concerns, issues and perceptions of the overall project implementation.	
2	People and companies who will benefit from project-related employment (i.e., health workers, consultants, NGOs private businesses in the health sector, power and cooling equipment suppliers).	• Regular meetings to review progress of project implementation to report effectiveness and challenges. • Workshops with technical officers. • WhatsApp groups formed to share information.	Quarterly, monthly, and as needed.	• To provide timely access to information, data, documents, and other relevant project information • Learn about any issues related to OHS, GBV/SEAH. • Solicit feedback on project implementation. • To increase understanding and support GBV/SEAH	Supervisors and social safeguards officers at FGS and FMS levels.
3	The MoH and FMS line ministries, departments and government agencies directly supported by the project (i.e. ministries of health at both levels of the federation).	Series of high-level and technical engagement, meeting and working sessions with technical ministry counterparts. All-day workshop with technical officers.	Quarterly, monthly, and as needed	• Project reviews including social risks and how they are being managed • Seeking clearance to implement the project components • Raise awareness of key provisions to provide a protective environment free from GBV/SEAH. • Review GM monitoring processes. • To promote shared responsibility and partnership.	PCIU/PMTs and Social safeguards officers at FGS and focal points at FMS levels.

No	Stakeholder	Mode of Engagement	Frequency	Purpose	Responsibility
4	International NGOs and bilateral donor agencies.	Discussion in meetings: sector, public and focal. These meetings / assemblies are to stimulate collaboration and get feedback. This could be achieved through existing technical working groups such as development partners group on health e.g. the health cluster coordination group Regional/FMS health coordination working groups	During project formulation and implementation.	• Sharing of information, reviews, clearance and seeking support. • To solicit guidance and feedback on project effectiveness and social risk management. • Learning and building on ongoing work by various partners and creating synergy and avoiding duplication of efforts.	PCIU/PMTs and Social safeguards officers at FGS and focal points at FMS levels.
5	Civil society organizations (i.e. women and youth groups) and direct and indirect representatives of disadvantaged and vulnerable groups.	Discussion in meetings: sector, public and focal. These meetings / assemblies are to stimulate collaboration and get feedback.	During project formulation and implementation (quarterly, monthly, and as needed)	• Learning and building on ongoing work by various partners and creating synergy and avoiding duplication of efforts • Strengthening local capacities as first responders.	PCIU/PMTs and Social safeguards officers at FGS and focal points at FMS levels.
6	The disadvantaged and vulnerable groups including the poorest communities, IDPs, minority groups and clans, people living in remote rural areas and people living with disabilities.	• Public meetings using approaches such as community conversations or dialogue fora. • Using local FM radio stations, meetings and local community communication structures for more coverage	At launch. Quarterly, monthly, and as needed throughout implementation.	• To educate communities on the project's goals and activities. • Collect views on social risks and how they could be managed or how their management could be improved. • Provide dialogue opportunities where citizens have access to and engage with government representatives and other stakeholders. • Supporting the communities to understand their rights to access quality	PCIU/PMTs and Social safeguards officers at FGS and focal points at FMS levels.

No	Stakeholder	Mode of Engagement	Frequency	Purpose	Responsibility
				health services and demand for services and accountability. • To share the available GBV services • To educate on SEA-SH Risks, mitigation measures and how to report SEA Allegation within 24 hours.	
7.	Private FP Service Providers	• Technical meetings, phone consultations, E&S training workshops, community forums.	Monthly/Quarterly	• To align with project and E&S compliance. • Collect feedback on FP implementation risks and needs. • Raise awareness on CoC, GM, and OHS	PCIU, PMTs, PSI

4. INCLUSION PLAN

4.1. Introduction

43. The project will carry out targeted stakeholder engagement with vulnerable and disadvantaged groups and individuals which include minority castes and groups[1], IDPs, people who live in remote rural areas or areas characterized by violence that are bereft of social services and amenities, nomadic pastoralist communities, People with Disabilities (PWDs), and female headed households including vulnerable orphans and unaccompanied minors to understand their concerns/needs in terms of accessing information, medical facilities and services and other challenges in these communities. Special attention will be paid to engage with women as intermediaries. The details of strategies that will be adopted to effectively engage and communicate to vulnerable group will be considered during project implementation. Implementing partners will develop plans for inclusive stakeholder engagement and feedback as part of their initial project wide implementing plans which will be submitted periodically for review by the PCIU and approved by the Bank.

44. 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.

45. 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 are not prioritized in health service delivery due to their limited productivity in society. Women with disabilities, for instance, continue 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.

46. 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 and women are involved in consultations and all the other aspects related to access to health services.

47. 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 share the reports

[1] This 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. The minority groups in Somalia include, among others, Bantu, Bravenese, Rer- hamar, Bajuni, Eyle, Galgala, Tumal, Yibir and Gaboye. These groups continue to live in conditions of great poverty and suffer numerous forms of discrimination and exclusion.

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.

48. The inclusion plan was expanded to accommodate the Family Planning (FP) sub-component introduced through Additional Financing 2(AF 2). The project will ensure inclusive access to voluntary and informed FP services by targeting underserved urban populations in Mogadishu, Kismayo, Garowe, and Hargeisa. Special focus will be placed on marginalized groups such as married girls and women, people with disabilities, internally displaced persons (IDPs), minority clans, and individuals in conservative communities where FP remains stigmatized. The project will address social barriers such as spousal consent requirements, misinformation, and cultural sensitivities by involving male gatekeepers, elders, and religious leaders in sensitization campaigns. Private health providers contracted for FP delivery will be oriented on inclusive service provision and community engagement, with a requirement to designate focal points for grievance management and ensure gender-sensitive and accessible services. Culturally appropriate communication strategies (e.g., Somali-language messaging, IVR, and radio) and physical accessibility features (e.g., privacy, ramps, separate consultation areas) will be mainstreamed. Community health workers and facility staff will receive training on ethical, non-discriminatory FP service delivery, and will be supported to address stigma and enhance equitable access for all, especially vulnerable women and girls.

49. Community health workers 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.

50. 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.

51. 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.

52. Consultations will be carried out broadly in two stages. First, prior to the commencement of any project activity, the implementing agency will arrange 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.

53. The implementing entity will:

- Facilitate broad participation of disadvantaged and vulnerable individuals and groups with adequate gender and generational representation, community elders/leaders, religious leaders, and Civil Based Organizations (CBOs);
- Provide the disadvantaged and vulnerable individuals and groups with all relevant information about the project including on potential adverse impacts;
- Ensure communication methods are appropriate given the low level of literacy, local dialects and communication challenges for PWDs;
- Organize and conduct the consultations in forms that ensure free expression of their views and preferences;
- 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;
- Share any input/feedback offered by the target populations; and
- Provide an account of the conditions agreed with the people consulted.

54. 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.

55. 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.

56. 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 disadvantaged and vulnerable individuals and groups.

5. RESOURCES AND RESPONSIBILITIES

57. The project is being implemented by the Project Coordination and Implementation Unit (PCIU) at the FGS Ministry of Health, and the Project Management Teams (PMTs) at the FMS level. The FGS MoH has overall project management responsibility, coordinating overall project implementation. It is also responsible for knowledge management, capacity strengthening, monitoring, and evaluation of project activities, procurement, contract management, and technical implementation support to the FMS line ministry. The project implementation at the federal level is led by a Senior Project Coordinator and supported by the following specialists: Contract Management/M&E Specialists, Procurement Specialist, Public Financial Management Specialist, Environmental Specialist, Social Specialist, GBV specialist, Security Specialist and Communication Specialist, and other supporting staff. In the long term, the Federal MoH PCIU aims to serve as the coordination and management unit for development partner financing and activities in the health sector.

58. In each of the participating federal member states, there is a Project Management Team (PMT), situated at the FMS MoH, who are primarily responsible for project management at the state 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. The PMT is led by a Project Manager in all FMSs, as well as Safeguard Specialists (one full-time Social/ GBV Specialist, and one full-time Environmental Safeguards Specialist) in FMS with project activities only. Overall, the Senior Project Coordinator of FGS and Project Manager in each FMS coordinate efforts within their respective governments, as well as between the FGS and the FMS. A Social and GBV Specialist are assigned in the participating FMS level and the NGO implementing partners to oversee the implementation of the social instruments and receive, log and follow up resolution of complaints. The implementing partner will have the requisite social and environmental expertise to implement the project.

59. At the contractor level, it is envisaged that a social specialist is assigned to handle day-to-day interactions with the beneficiary communities and report back to PCIU/PMTs on cross cutting issues. The specialist would serve as a focal point and should be tasked with preparation and implementation of site-specific SEP, including planning community outreach programmes, and facilitating grievance redressal arrangements.

60. The implementation and monitoring of this SEP is undertaken by the PCIU. The direct responsibility of its implementation is designated to the Social Specialist within the FGS Ministry of Health. The Social Specialist and Communication Specialist works with other ministry-level and state-level social safeguards officers to ensure that lessons are learnt from other projects, that the objectives of the plans are met and with the appropriate allocation of the necessary resources for its implementation. Adequate budget for stakeholder engagement will be allocated from the overall project cost, which will include cost for organizing meetings, workshops and training, hiring of staff, field visits, translation and printing of relevant materials, and operating GMs. Reports on stakeholder engagement and a summary of grievances will be received by the FGS Social Specialist and implementing partners every three months.

6. GRIEVANCE MECHANISM

6.1. Introduction

61. The parent project's grievance mechanism is in place and is operational. The project has developed a comprehensive GRM protocol and established functioning grievance channels at the PCIU, PMT, and service provider levels. These include emails, phone numbers, and in-person reporting options. Designated focal persons have been identified at all levels to ensure the timely and effective handling of complaints. A Grievance Redress Committee (GRC) is in place at both FGS and FMS levels to review and address raised issues. A standardized GRM grievance log is also being used to document, track, and follow up on all complaints. To strengthen the GRM system, the project has recently developed the Citizen Engagement Centre (CEC) which features a dedicated GRM portal, easily accessible via the short number 9444. Staff training and official launch of the same to ensure broad public awareness and encourage maximum utilization of these platforms by all stakeholders was undertaken in August 2025. Building capacity for GRM focal points at facility and NGO levels is also needed to improve documentation, follow-up and tracking. Gender-Based Violence/Sexual Exploitation and Abuse (GBV/SEAH) cases are handled separately to ensure confidentiality and application of a survivor-centered approach.

62. There is potential that the project may have some unintended consequences e.g., risk of further exacerbating existing exclusion patterns or tensions between groups who feel they are under/misrepresented and undermine trust between citizens and government if transparency, equity and appropriate citizen engagement is not fostered. A Grievance Mechanism (GM) has been developed to enable the effective resolution of any grievances of the project stakeholders, including civil servants and communities where the health services will be provided. The GRM channels include emails, phone numbers, and in-person reporting options. Designated focal persons have been identified at all levels to ensure the timely and effective handling of complaints. A Grievance Redress Committee (GRC) is in place at both FGS and FMS levels to review and address raised issues. A standardized GRM grievance log is also being used to document, track, and follow up on all complaints. The project GRM is operational. During the period between January and November 2025, the nature of the cases is mainly related to recruitment issues such as, nepotism, falsified qualifications, salary delays, and the quality of health services. A total of 69 complaints were received, of these 65 were resolved, while 4 cases remain pending with actions for resolution. The GRM did not have a toll-free line, therefore, to strengthen the GRM system, the project has recently developed the Citizen Engagement Centre (CEC) which features a dedicated GRM portal, easily accessible via a toll-free line number 9444. Staff training and official launch of the same to ensure broad public awareness and encourage maximum utilization of these platforms by all stakeholders was undertaken in August 2025.

63. There are confidential, appropriate mechanisms to deal with complaints regarding sexual harassment, exploitation and abuse as provided for in the GBV Action Plan. There are also separate worker grievance mechanism for the use of all direct and contracted workers to raise employment-related concerns, in line with the provisions of ESS2. The project has put measures in place to ensure that this worker grievance mechanism is easily accessible to all project workers. Social focal persons within the implementing partners have been trained in grievance handling and resolution, including confidentiality requirements and whistle blower protection. With the introduction of new service areas such as FP under AF2, grievances may also arise around service eligibility, perceived cultural and religious sensitivity. Special care will be taken to address such concerns through community-informed and confidential feedback channels.

64. For the **'Damal Caafimaad'** project, the FGS MoH has the responsibility to resolve all issues related to the parent Project and AF 1, 2 and 3 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 is 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 is 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.

65. A Grievance Committee (GC) has been established at both levels of the Federation consisting of the project coordinator, and relevant staff, with the Social Specialist acting as the secretary to the meeting and taking minutes and conducting following up the grievance resolution process for the parent project and will also manage grievances under the AF. The GC will meet 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 will 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.

6.2. Objective and types of GM

66. 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.

67. 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.
- Disputes around FP eligibility or access.
- Perceptions of coercion or miscommunication in FP service delivery.
- Sensitivity around use of FP by unmarried girls or without spousal consent.
- Incorrect or harmful FP product administration
- Unclarity in who selects the FP method (provider vs. client)
- IPV

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

6.3. Building Awareness on GM

69. The FGS MoH PCIU has briefed all its staff, and the staff of the line ministries at FMS level, on the GM procedures and formats to be used including reporting and resolution. A public awareness campaign will be conducted to inform all communities and staff on the mechanism. A one pager has been developed in both English and Somali languages and posted in the MoH website. 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. The grievance one pager is provided in Annex 9. FP-related grievance awareness will be strengthened through targeted community messaging using gender- and culturally sensitive materials. Messaging will clarify client rights, choice of method, and availability of recourse through the GM, particularly addressing fears of marital or community backlash.

70. The project will aim to address grievances through using the steps shown in Table 9 and indicative timelines.

Table 9: 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

6.4. Grievance Management Process

71. 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 1):

- 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;
- Document the experience for future reference. Ensure private healthcare FP focal persons and community health volunteers are trained; and
- Ensure confidentiality and referral pathways for FP complaints are understood by all GM focal points.

Table 10: Examples of Anticipated FP Related Grievances

Category	Sample Grievance	Suggested Response Path
Method Selection problem	"Health workers chose for me my FP method without proper explanation"	Inform provider retraining; offer counselling; re-educate clients on choice.
Social Repercussions	"My husband threatened me because I took FP"	Confidential support
Cultural Sensitivity	"Unmarried girls/women receiving FP; our elders are angry"	Engage elders in awareness sessions; explain eligibility criteria; ensure community dialogue mechanisms.
Service cost	"I was told FP is free, but was charged"	Clarify procurement source, clarify what is free what is not free, track cost-related grievances.
Adverse side effects	"My wife got sick after implant"	Refer to clinical quality team, introduce

		medical follow-up protocol in GM pathway.
Skills of Providers	"The nurse seemed unsure and gave wrong information"	Inform health management for refresher training; include complaint in FP training feedback.

Since PSI already has GRM channels in place as part of the project, they will also utilize these channels within the private sector facilities. PSI will continue to monitor grievances through their established mechanisms and report to the project team using the existing project's reporting procedures currently in place.

The private sector will address complaints and challenges and need to report to PSI and PSI will report to the PCIU, relevant staff will be required to sign the Project Code of Conduct. Additionally, PSI, PCIU, and the PMT established and managed their respective GRM channels.

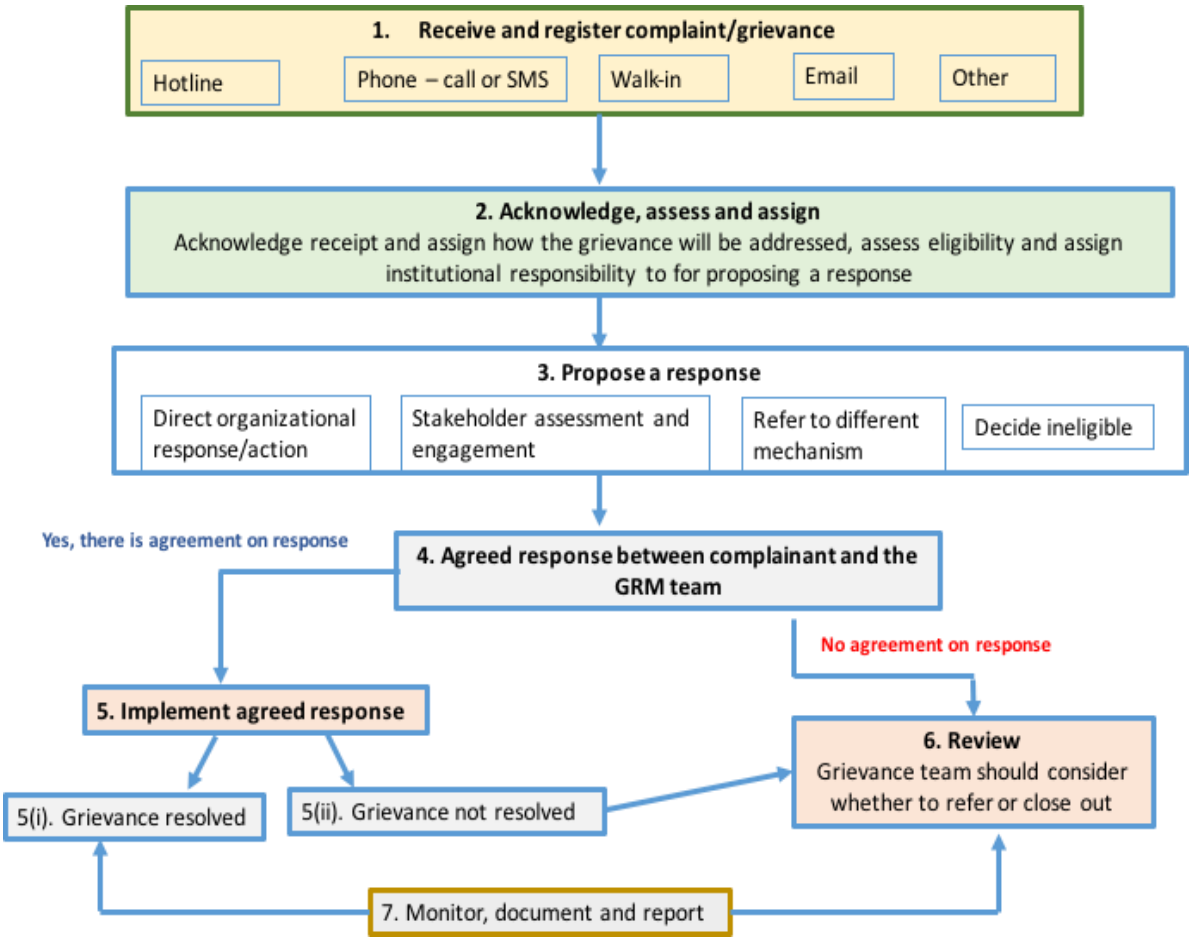

Figure 1: Structure of Grievance Mechanism

6.5. Grievances Related to GBV/SEAH

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

73. 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).

74. Where such a case is reported to the GM, actions undertaken will ensure confidentiality, safety and survivor-centered 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 in 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.

75. In consultation with the FGS MoH and relevant community stakeholders, separate channels and protocols for reporting and addressing allegations of GBV/SEAH have been 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.

76. Family Planning service rollout may pose GBV/SEAH risks such as coercion, spousal violence, or exploitation of young girls. The GM will monitor trends closely and ensure survivor-centered responses are in place for complaints potentially arising from FP provision or access. The complaints can be presented in person, email or by letter to:

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

77. The PCIU that will manage the AF have been trained on Gender Based Violence/Sexual Exploitation Abuse and Sexual Harassment and have all signed Code of Ethical Conducts (CoCs).

6.6. AF 3 SEA-SH Prevention and response

78. To ensure zero tolerance for Sexual Exploitation, Abuse, and Harassment (SEA/SH) during the construction and operational phases of the six regional hospitals and the national cold-chain facility under AF3, the following are being undertaken.

a) Policy and Framework Integration

- The SEA/SH Accountability and Response Framework developed under the Damal Caafimaad Project will be fully applied to all civil works and supervision contracts.
- All contractors, subcontractors, and UNOPS field personnel are required to adopt and implement the Code of Conduct (CoC) covering SEA/SH, signed by all workers before deployment.
- The ESMP and Labor Management Procedures (LMP) includes site-specific SEA/SH mitigation actions, including supervision checklists and worker sensitization protocols.

b) Prevention Measures

- Mandatory SEA/SH orientation and toolbox talks for all construction workers, security staff, and supervisors before site access and periodically during implementation.
- Display posters and signboards in Somali and English at all construction sites highlighting prohibited behaviors, reporting pathways, and GRM contact information (including hotline 9444).
- Strengthen collaboration with local women's organizations and GBV service providers for community awareness on available support and confidential reporting.
- Establish safe and gender-segregated facilities (latrines, changing rooms, and resting areas) for male and female workers.

- Reinforce worker–community interface protocols to minimize risks of exploitation and harassment of women and girls near construction sites.

c) Reporting and Response Mechanism

- Immediate reporting of SEA/SH allegations within 24 hours to the PCIU SEA/SH focal person and onward referral through the established survivor-centered referral pathway.
- Maintain survivor confidentiality and informed consent at all stages of case management.
- Ensure survivors' access to medical, psychosocial, and legal assistance through pre-identified service providers.

6.7. World Bank's Grievance Service

79. 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.

80. **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

81. 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.

7. MONITORING AND REPORTING

82. The overarching implementation and monitoring of the stakeholder engagement plan is the responsibility of the PCIU, particularly the social safeguards specialist assisted by the communication officer. The responsibility at FMS level is with the FMS PMT. Implementing partners are responsible for stakeholder engagement and the GM within their regions as outlined as part of their Environmental and Social Assessment and Management plan submitted with their bidding documents. The Project Coordinator of the project will ensure that the objectives of the plans are met and successful implementation of the plan by the allocation of the necessary resources for its implementation and ensure synergy and community feedback with the third-party monitor.

83. During the implementation of the AF, the FGS Ministry of Health through the PCIU will collect baseline data, using both quantitative and qualitative methods and report on the following indicators:

a. Number of project beneficiaries, government agencies, international NGOs (including bilateral donor agencies), civil society organizations, private sector and other stakeholder groups that have been involved in consultations on the project implementation and feedback on a quarterly basis. Means of verification: minutes and reports of consultations disaggregated according to gender, group and region.

b. Number of engagements (e.g. meetings, workshops, consultations, participants' sex and age in disaggregated form) with stakeholders during the project implementation phase (on an annual basis). Means of verification: Minutes Reports and other documentation of stakeholder engagement plan.

c. Percentage of stakeholders who rate as satisfactory the level at which their views and concerns are taken into account by the project (disaggregated by sex and disadvantaged group in each area). The responsible party for measuring this indicator is MOH PCIU when they conduct the Mid-Term and Terminal Evaluation, and the third-party monitor when they collect beneficiary feedback). Means of verification: impact and satisfactory assessments as part of project evaluation.

d. The PCIU Social and GBV Specialists, in coordination with UNOPS and PMTs, will:
    - Conduct **monthly supervision and spot-checks** at construction sites.
    - Include SEA/SH indicators in the **E&S monitoring framework** (e.g., % of workers trained, number of community awareness sessions, number of cases reported/resolved).

84. The project performance assessed through monitoring activities will be reported back to stakeholders during stakeholder meetings, and disclosure of monitoring outcomes and engagement with the community maintenance committee in each project district. The lessons learned through monitoring will also contribute to the design of future subprojects and be shared with their stakeholders.

8. DISCLOSURE OF PROJECT DOCUMENTS

85. Table 11 outlines what information should be disclosed on the project and how.

Table 11: Project information disclosure

Disclosure of project documents			
Project stage	**Target stakeholders**	**List of information to be disclosed**	**Methods and timing proposed**
Before bidding process	Project beneficiaries (community members) and the general public.	Updated LMP, SEP, ESMF and project GRM in Somali.	WB and MoH website Stakeholder consultation meetings at FGS and FMS level.
Before sub-project implementation	Project beneficiaries (community members) and the general public	Area/subproject specific Environmental and social assessment and management plans (ESAMPs) including plans for implementation of SEP, ESMF including MWMP, GBV action plan, and LMP.	MoH website FMS and regional consultation meetings and community consultation meetings with all groups including VMGs.
Annual	Key stakeholders and project beneficiaries at FGS and FMS level including VMGs or their representatives.	Annual report on progress and lessons learnt, complaints resolution and feedback.	MoH website, FGS and FMS stakeholder consultation meetings.

9. INDICATIVE BUDGET, SUMMARY ACTIONS AND TIMELINES

86. Table 12 presents the estimated budget for implementing the SEP. It is anticipated that this budget will be reviewed and adjusted based on the parent and AF 1, 2 and 3 project engagement needs.

Table 12: Estimated budget for implementing the SEP

Stakeholder Engagement Activities	Timeline	Q-ty/per years (months)	Unit Cost, USD per year	No. of years	Total cost (USD)
GM toll free hotlines 1 FGS	Before sub-project implementation	6 months	2000	2 quarters	4,000
Communication materials (leaflets, posters on project and GM, GM forms, registers in Somali)	Before sub-project implementation	6 months	1500	2 Quarters	3,000
Training of all staff and contractors on GM	Before sub-project implementation	6 Months	10,000	Once	10,000
6 stakeholder consultation and feedback meeting (FGS level) by January 2026 then engagement meetings at FGS and FMS levels by May 2026	Before sub-project implementation	Once a year	10,000 for the FMS and 35000 for the FGS	8	95,000
FM radio press conferences and call ins (one at FGS and FMS level)	Before sub-project implementation	Once a year	2000	7	14,000
Monitoring visits by FGS and FMS social officers	Once component activities start	Per quarter	5,000	2 times (FGS) and 2 times for each FMS = 14	70,000
Annual stakeholder feedback survey (call Centre) through the Citizen Engagement Centre	By April 2026	Per year	10000	Once	10,000
PSI to conduct engagement of the private sector	Before sub-project implementation	*TBC*	TBC	TBC	*TBC*
Subtotal					**159,000**
Contingency 5%					**7,950**
Total					**166,950**

Table 13: Calendar of Stakeholder Engagement Process

Engagement type	*Level*	*Objective*	*Time*	*Responsible*
Consultation Meeting	*FGS*	*To introduce new changes, risks and mitigation measures for the 3 additional financing, collect feedback and input to validate and approval*	*December 2025 / January 2026*	*PCIU Environmental and Social/GBV Safeguard Specialists*
Regular engagement meetings	*FGS* *FMS*	*Provide progress implementation information and collect feedback from stakeholders*	*April 2026* *June 2026*	*PCIU Environmental and Social/GBV Safeguard Specialists*
Develop / update communication materials and dissemination	*FGS*	*To standardize information; awarenes activities by safeguard team towards E&S and GRM*	*January 2026*	*PCIU Environmental and Social/GBV Safeguard Specialist and Communication Specialists*
Refresher training to contractors	*FGS*	*Train to contractors on E&S in general and specifically Stakeholder/community engagement meetings*	*January 2026*	*PCIU Environmental and Social/GBV Safeguard Specialists*
Radio Press Conference	*FGS* *FMS*	*Increase awareness on E&S, Stakeholder Engagement and GRM to the wider public*	*February 2026*	*PCIU/PMT Environmental and Social/GBV Safeguard Specialists*
Conduct Monitoring Visits	*FGS* *FMS*	*Conduct spot checks and monitoring visits to the service delivery sites, Contractor offices and community – to collect monitoring data using standardized checklist*	*February 2026* *May 2026*	*PCIU/PMT Environmental and Social /GBV Safeguard Specialists*

ANNEXES

Consultations Held on 19–20 August 2025

In August 2025, the Project Coordination and Implementation Unit (PCIU) of the Federal Ministry of Health conducted two major stakeholder consultation events in Mogadishu to strengthen inclusive engagement, transparency, and accountability under the Damal Caafimaad and Somalia COVID-19 Emergency Vaccination Projects.

19 August 2025 – National Stakeholder Consultation Meeting
A high-level consultation brought together over 100 participants, including representatives from Federal and State Ministries of Health, UN agencies, NGOs, women-led organizations, civil society, Community Health Committees (CHCs), and implementing partners. The meeting reviewed project progress, environmental and social safeguards performance, and key lessons learned.

Stakeholders acknowledged significant achievements, including expanded access to health services, improved gender balance in the health workforce, and strengthened implementation of Environmental and Social Safeguards (ESF), GBV/SEA-SH prevention measures, and grievance redress systems.

Key issues raised included the need to:

- Strengthen inclusion of marginalized groups, particularly persons with disabilities (PWDs) and internally displaced persons (IDPs);
- Enhance accessibility of information, including local dialects and disability-inclusive communication;
- Improve service continuity in fragile and displacement settings; and
- Address stigma and barriers related to GBV reporting and response.

Participants emphasized the critical role of CHCs in strengthening community accountability and ownership, and recommended expanding partnerships with civil society organizations (CSOs) and the private sector to support long-term sustainability.

20 August 2025 – Launch of the Health Help Desk (GRM Platform 9444)
On 20 August 2025, the Federal Ministry of Health officially launched the Health Help Desk (GRM Platform 9444) in collaboration with the Recurrent Cost and Reform Financing (RCRF) Project. The platform provides a unified, digital system for grievance redress and citizen feedback across health programs, aimed at improving transparency, efficiency, and accountability.

Stakeholders highlighted the importance of:

- Ensuring language accessibility (including Maay and Maxaa dialects);
- Maintaining confidentiality and survivor-centred handling of SEA/SH complaints; and
- Integrating existing fragmented grievance channels into a single national platform.

Participants expressed strong commitment to promoting and utilizing the 9444 Help Desk, including through nationwide awareness campaigns using media, telecommunications, and community outreach mechanisms. The consultations demonstrated strong government leadership and stakeholder commitment to inclusive,

participatory project implementation. They reaffirmed the importance of continuous engagement, gender equality, and a zero-tolerance approach to SEA/SH.

Further details are provided in **Annex 1**.

ANNEX 1: Summary of Stakeholder Consultation Meetings on Covid-19 Project

The Federal Ministry of Health and Human Services (MoH), through the Project Coordination and Implementation Unit (PCIU), organized three major stakeholder consultation meetings between 2022 and 2025 to ensure inclusive engagement, transparency, and responsiveness under the Somalia COVID-19 Emergency Vaccination Project -These consultations provided a platform to share progress updates, present risk management instruments, and gather stakeholder feedback critical to improving project design, implementation, and accountability.

The **first stakeholder consultation** was conducted virtually on **18 April 2022**, bringing together 34 participants. The main objective was to introduce the World Bank's Environmental and Social Framework (ESF) and collect feedback on key instruments developed to manage the project's environmental and social risks. These included the Stakeholder Engagement Plan (SEP), Environmental and Social Management Framework (ESMF), Labor Management Procedures (LMP), Sexual Exploitation, Abuse and Harassment (SEAH) Prevention and Response Plan, and the Security Management Framework (SMF). Stakeholders raised concerns around vaccine hesitancy, particularly among rural communities and health professionals. In response, the MoH emphasized continuous community engagement, involvement of female health workers, and the visibility of public leaders receiving vaccinations to increase trust. Security risks and waste management challenges were also discussed, with assurances that SOPs and integrated waste practices would be followed. While no significant SEAH cases had been reported, stakeholders supported the proactive development of the SEAH Plan and establishment of focal complaint groups. Occupational health and safety for frontline workers, misinformation, and the need for strong Grievance Redress Mechanisms (GRMs) were also prioritized, with reference to best practices from other WB-funded projects such as SCRP and RCRF.

The **second consultation meeting** took place on **13 February 2024** in Mogadishu and was attended by 68 participants, including representatives from federal and state ministries, UN agencies, civil society, persons with disabilities, minority groups, and project implementing partners. This national-level dialogue focused on project progress, social safeguard compliance, and stakeholder feedback. Presentations addressed service delivery under EPHS, health workforce expansion, solar energy infrastructure, and vaccine rollout progress. Special attention was given to environmental and social risk mitigation, including GBV/SEA, equitable access to services, and labor management in alignment with the World Bank's ESSs. A panel discussion allowed marginalized voices—especially those from IDPs, women, and disability rights groups—to share key concerns, such as inaccessible information, weak GRM awareness, and exclusion from services. Strong recommendations emerged, including the need to improve disability-inclusive services, use sign language and local dialects in communications, and partner with grassroots organizations. The meeting concluded with an action plan outlining updated stakeholder mapping, more frequent sub-national consultations, formation of Community Health Committees, and enhanced outreach via digital platforms like Talo-Wadaag.

The Third The stakeholder consultation meeting, held on **August 19, 2025**, brought together approximately 100 participants including Federal and State Ministries, UN agencies, NGOs, minority groups, IDPs, PWDs and civil society to review progress on the **Damal Caafimaad** and **COVID-19 Emergency Vaccination** projects. Achievements were substantial, demonstrating significant expansion and resilience in Somalia's health system. The Project Coordination and Implementation Unit (PCIU) reported that a total of **229 health facilities** (including 21 hospitals) are fully operational and disability-friendly. The health workforce has grown to **3,546 professionals**, with **1,990 (over 50%) being women**. Service delivery has scaled dramatically, with over **1.25 million** outpatient consultations recorded between April and June 2025 (**65%** of which were women), over **23,800** safe facility deliveries, and treatment for

42,693 cases of Severe Acute Malnutrition (SAM). Furthermore, the COVID-19 project achieved a nationwide measles campaign reaching **3.3 million** children, established the National Medicine Regulatory Authority, and installed **135 Cold Chain units** to strengthen immunization systems.

Despite this measurable progress, persistent challenges and gaps in inclusivity were highlighted through stakeholder feedback. The consultation affirmed that Environmental and Social Safeguards (ESF) and GBV prevention frameworks remain non-negotiable, with specific safeguard plans developed for six regional hospitals. Accountability was strengthened by an operational Grievance Redress Mechanism (GRM), which processed 47 formal grievances (mostly HR-related) between January and August 2025. However, marginalized groups, particularly Persons with Disabilities (PWDs) and Internally Displaced Persons (IDPs), are underrepresented in both employment and health access. Concerns were raised about the withdrawal of maternal and child health services from some IDP settlements. Other recurring issues included operational disruptions due to insecurity and climate shocks (like flooding), the persistent **cultural stigma** hindering GBV reporting, and a lack of information accessibility (e.g., no sign language interpretation or use of diverse Somali dialects).

The meeting concluded that while the health sector is on a transformative path, the key to sustained success lies in addressing inclusivity and sustainability. Stakeholders agreed on five critical **Recommendations** for the way forward:
1) Strengthen the inclusion of PWDs and IDPs in service and employment;
2) Deepen accountability and local ownership by empowering Community Health Committees (CHCs);
3) Scale up GBV prevention and ensure survivor-centred, disability-inclusive services;
4) Enhance sustainability by forging stronger partnerships with local civil society and the private sector; and
5) Rapidly roll out digital platforms, such as the new **GRM Portal**, to improve transparency and efficiency in accountability.

In addition to national-level consultations, several sub-national engagement meetings were conducted across the Federal Member States (FMS) through the respective **Project Management Teams (PMTs)**. These decentralized consultations aimed to localize feedback, monitor implementation, and ensure regional relevance and inclusion of community voices. PMT-level meetings were conducted in locations such as Galmudug, Southwest, Hirshabelle, Puntland, and Jubaland and Banadir Region enabling district health officers, local civil society, and vulnerable groups to raise context-specific concerns—particularly around service gaps, staffing issues, awareness of GBV/SEAH protocols, and equity in access to health services. These grassroots consultations played a vital role in informing the adaptive management of the project and feeding critical input into national-level planning.

ESMP Consultations

ANNEX 2: 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
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	Awareness is raised through direct communication, posters, and informal networks. However, they acknowledge the need to improve structured and culturally sensitive communication, using

	of the services?	trusted voices like local doctors via IVR, and engaging couples and male decision-makers.
3	Is there a CoC that applys 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	Enforce privacy protocols in all facilities. Retrofit counseling

clients to risks of stigma or harassment.	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)

No.	Name	Organization	Email address
1.	Dr Abdikamal Salad	PCIU	pciu@moh.gov.so
2.	Bisma Abdullahi	PCIU	bisma.maalin@gmail.com
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No.	Name	Organization	Email address
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ANNEX 3: 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 4: Virtual Stakeholder consultations on the E&S instruments for the parent Damal Caafimaad Project

Objective: to get input and suggestions on improving the social and environmental instruments for **Damal Caafimaad** Project including stakeholder engagement, grievance redress mechanism, labor and security procedures and the GBV action plan. This meeting was held on February 03, 2021.

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

Table A2-1: 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 Labor 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

Table A2-2: Participants List

Name	Organization	Email
Non-state actors		
Mohamud Sheikh Abdi	INISKOY, For Peace and Development Organization (IPDO)	info@iniskoy.org;
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Mohamed Hussein	NODO	
Dario	JOWHAR REGIONAL HOSPITAL Management	health.JRRH@terresolidali-som.org; Cc: nairobi@terresolidali.org;
Burhan Abdullahi Shiil	PMWDO	pmwd2000@gmail.com

Name	Organization	Email
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Sahra Mohammed Omar		
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World Bank		
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Abass Kassim	Social consultant	abasskassim@outlook.com
Abdi Zeila Dubow	Environmental specialist, World Bank	adubow@worldbank.org;
Shair Luli	GBV specialists, World Bank	shairluli@gmail.com;
Jazaka Alaisa Malala	Team Assistant	jmalala@worldbank.org;
Peggy Kwendo	Team Assistant	pkwendo@worldbank.org;

Table A2-3: Environmental and Social concerns raised during the workshop 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 though regulations, not as the form of implementation. Given around 80% population use private health providers they need to be regulated.
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. 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

Environmental and Social Risks	Mitigation measures

How to address resistance of the community for family planning 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	This could be considered as part of the project
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
Promotion of occupational health and safety	Training will be conducted on OHS issues for all health staff

ANNEX 5: Stakeholders Consultation Meeting for AF Components – 27th of 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 A3-1 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 A3-1: List of participants

SN	Name	Organization
1	Dr. Nur Ali Mohamud	FMOH
2.	Fadwo Hassan Jimale	FMOH
3	Mohamed Nur Haji	FMOH
4	Abdi Ali	SWS MOH-DG
5	Abdifatah Ahmed	NIH Director
6	Dr. Abdirahman Ahmed Mohamud	Director of Health and Human Services of Benadir Regional Administration
7	Abdirashiid omar warsame	FMOH
8	Abdiwahab adam ali	HWD family care
9	Abdujalil abdullahi	FMOH M&E specialist
10	Abshir yusuf	Jubaland MOH- PMT
11	Ali Adan Hassan	-
12	Aiisha Abdikarim Hassan	HINNA Organization
13	Amina nor Mohamud	Youth, Gender and social inclusion
14	Ayan Said Tukale	MOEWR-GW4R
15	Bile abdi	FMOH
16	Deka Ahmed	Putland PMT Manager
17	Dr.Rahoy	Jubaland
18	Fardowsa Abdullahi	SWS-MOH-PMT.
19	Halima farah	SCRP-PIU
20	Ibrahim Mohamed Nur	FMOH
21	Mohamed Habibula	IMC
22	Jacob Omondi	WB
23	Khadra Abdirahman	FMOH
24	Khalid Mohamud	FMOH
25	Mahad Abdi Isse	GLM-MOH-PMT
26	Mohamed Hassan Adde	IPDO
27	Mohamed AM Ahmed	Mogadishu university

SN	Name	Organization
28	Mohamed Aweys	FMOH-OHS
29	Salma	-
30	Sugoow	-
31	Zahra Ali Barre	FMOH- GBV Manager
32	Nader Fares Mohd	WB
33	Abdulkadir Abdullahi Abdi	HRS MOH ENV Specialist
34	Ahmed Sheikh Ali Ahmed	Hirshabelle, MOH, PMT

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 A3-2 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 A3-2: Key project instruments, purpose and key issues for consideration

Instrument	Purpose	Key issues for consideration
SEP – Presented by Acting social safeguard specialist for DC project	1. Outlines a plan for continuous stakeholder engagement throughout the project at all levels including with: *disadvantaged and hard to reach groups: women, IDPs, pastoralists, and minority groups* 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	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: a) During the DC service delivering campaigns? b) At FMS and FGS level?
ESMF – Presented by environmental safeguard specialist for DC project	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.	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	1. All workers involved with delivering the project: • Prevention of *forced and child* (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: a. Promote *fair treatment, non-discrimination* & equal opportunity. b. Measures to *prevent and address harassment, intimidation, and/or exploitation.* d. Provide *accessible means to raise workplace concerns*/ grievance redress including GBV/SH – *confidential and non-retaliation*	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	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.	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 A3-3 below) have been identified but the list needs to be reviewed and refined based on the local understanding of the issues.

Table A3-3: Key environment and social risks

#	Theme	Risks
1.	Environment	• 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).
2.	Social	• 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

#	Theme	Risks
3.	GBV/SEAH	• 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 A3-4.

Table A3-4: Issues raised and responses

Theme	Issue	Response
GBV/SEAH	• 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	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. • Continuation of GBV/SEAH risks and Mitigation measures. • The project will conduct GBV service mapping and Clinical Management of Rape assessment in Nationwide.
GRM	• Inclusion of all relevant complains • How do states mobilize? Are states aware the GRM?	• 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.	• Regarding managing project risk Any mitigation measures about floods in Damal Cafimaad project areas, like Hiiraan and Middle shabelle 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?	• 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	• 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.	

Attendance Sheet: Stakeholder Consultation Meeting

Date: June 18, 2025

Location: Virtual (Somaliland)

Meeting Topic: Family Planning Concept Note – Private Sector Engagement

Name	Position	Organization
Dr. Khalid Balayax	Director of Planning, Policy and Strategic Information	MoHD
Umulkhair Mohamed Good	Reproductive Health Focal Point	MoHD
Ahmed Nour Muse	M&E Specialist	Damal Caafimaad PCIU
Ayanle Jama Farah	Social Specialist	Damal Caafimaad PCIU
Hamse Ahmed Guleid	Environmental Safeguarding Specialist	Damal Caafimaad PCIU
Dr. Jama Egal	Executive Director	Somaliland Midwifery Association (SLMWA)
Amal Ahmed	Executive Director	Somaliland Family Health Association (SOFHA)
Khadar Abdi	Representative	Hospital Association
Mohamoud	Representative	Hospital Association
Dr. Layla Hashi	Team Leader / Health & Nutrition Manager	Alight
Saed Abdi Ibrahim	Health Program Manager - Somaliland	Save the Children International
Juliana Nzau	RHCS Specialist	UNFPA
Sugow Bishar	Team Leader / Program Manager	PSI
Saba Khan	Global Snr Technical Advisor Health Systems & PHC	PSI
Dr. Fadumo Jama Yusuf	Snr. SBCC & Health Manager	PSI
Dr. Mohamed Bashir	Technical Advisor	PSI
Abdirahman Ibrahim	Supply Chain Manager	PSI - Damal Caafimaad
Mohamed Yusuf	Supply Chain Manager	PSI - COVID19/FHW Project
Abdulkadir Yousuf	Operations Director	PSI

ANNEX 6: 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 _____

ANNEX 7: Complaints Log

Date	Name and contact of complainant (or reference number if anonymous)	Staff/ institution complained against	Nature of complaint/ service issue, e.g. delay	Type of cause – physical human (e.g. inefficient officers, slow, unresponsive) or organization (e.g. policies, procedures, regulations)	Remedy granted	Corrective / preventive action to be taken	Feedback given to complainant and agreement given

ANNEX 8: Complaints Reporting Template

District: **Position:** **Name:**

3 month period (start and end dates)	No. of complaints received	Main type of complaint	Main channel of complaint used	No. of complaints resolved	No. of complaints pending	Average duration taken to resolve	Recommendation for system improvement

ANNEX 9: References

World Bank Environmental and Social Framework
http://documents.worldbank.org/curated/en/383011492423734099/pdf/114278-WP-REVISED-PUBLIC-Environmental-and-Social-Framework.pdf

World Bank Guidance note on ESS10: Stakeholder Engagement and Information Disclosure
http://documents1.worldbank.org/curated/en/476161530217390609/ESF-Guidance-Note-10-Stakeholder-Engagement-and-Information-Disclosure-English.pdf

World Bank Good Practice Note on Gender
http://pubdocs.worldbank.org/en/158041571230608289/Good-Practice-Note-Gender.pdf

World Bank, Grievance Redress mechanisms, Responsible Agricultural Investment (RAI) accessed on 14th January 2019 at: http://www.worldbank.org/en/topic/agriculture/publication/responsible-agricultural-investment

World Bank (n.d.) How to Notes: Feedback Matters: Designing Effective Grievance Redress Mechanisms for Bank-Financed Projects Part 1: the Theory of Grievance Redress
http://documents.worldbank.org/curated/en/342911468337294460/The-theory-of-grievance-redress

World Bank (n.d.) How to Notes: Feedback Matters: Designing Effective Grievance Redress Mechanisms for Bank-Financed Projects Part 2: The Practice of Grievance Redress
http://documents.worldbank.org/curated/en/658351468316439488/The-practice-of-grievance-redress

Lates stakeholder documents Annex 1

Final version DC
Annex 1 - -C-19 Stakeholder En

Attendance
sheet.pdf

ANNEX 10: Translated GRM Summary in Somali

Sookoobid : Habka Xalinta Cabashooyinka ee Mashaariicda Damal Cafimad (P172031) iyo Mashruuca Talaalka COVID-19 (P176956).

1. Hordhac:

Habka cabashada waa mid kamida hababka badan ee mashruucu adeegsado si loo xaqiijiyo ka qeybgalka daneeyayaashan iyo in xohtu faafto taaas oo usahleeysa in daneeyayaashu cabashadooda usoo gudbistaan si kudhisaan is fahan si degdegana loogu xaliyo.

Wasaaradda caafimaadka ee federaalka ayaa iskaleh mas'uuliyadda xallinta cabashooyinka ka dhanka ah mashaariicda damal cafimaad iyo covid-19 ayadoo tixraaceeysa sharciyada dowladda federaalka ee Somalia iyo xeerarka Bankiga addunka ee dhoourista dadka iyo deegaanka. Wasaaraddu waxeey hubineeysa in habka cabashu yahay mid cad si fududna eey ku heli karaan ama gaari karaan dhammaan daneeyayaasha.

2. Ujeedooyinka:

Ujeedad uguweeyn ee habka cabashada waxeey tahay in uu caawiyo xallinta cabashooyinka waqti kooban, leeskuna halleey karo kaas oo qaniinaya dhammaan dhinacyada ku lugleh.

Habka cabasha waxuu nasiinayaa habraac cad, leeku halleyn karo iyo xal-waaro.

2.1 Ujeedooyinka Qaaskaa:

Ujeedada habka cabasha ee mashaariicda damal Cafimad iyo Covid-19 waxuu yahay:

:

- In la siiyo waddo wax ku ool ah oo loogu talagalay dadka/hay'adaha dhiban si ay u muujiyaan dareenkooda oo ay si ammaan ah u xalliyaan arrimaha/cabashada ay sababeen hawlaha mashruuca.
- • Kor-u-qaadista xidhiidh wax-dhis leh oo ka dhexeeya xubnaha bulshada, dadka mashruuca saameeyay, Dowladda federaalka ah, dowlad goboleedyada, wasaarrad caafimaadka iyo bankiga addunka.
- • Ka hortagga iyo wax ka qabashada welwelka bulshada;
- • in uu Caawiyo hababka badan ee abuura isbeddel bulsho oo togan; iyo

• inuu dhaqso u aqoonsado xaliyana arrimaha u horseedi kara dacwadaha garsoorka.

3 Nuucyada Cabashada

- Cadaalad falida heshiisyaad;
- Arimaha la xariira musuqmaasuqa iyo wax isdabamarinta;
- Kala saariida dadka fursad ddomka ah;
- Latashi la'aan bulshada mashruuca loogu tala galay;
- Saameey taban oo dadka iyo deeganka ah;
- Cabasho mushaar;
- Arimaha la xariira tayo xumo addegga ;
- Xaquuqda shaqaalaha
- Shaqaaleeysiinta carruurta iyo qatarab badqabka bulshada

3.1 Habka Cabashada iyo waqtiga xalinta

1. Helid, diwangalin kadibna sheegid in cabshada la helay. Cabashooyinka culus waxaa si dhaqsa ah loogu gudbinaa madaxa mashruuca kaas oo 2 maalin gudaheed oo u gudbi doono iskuduwaha mashruuca..
2. Isbuuc gudahiis in lagu baaro waxyaabaha eey cabashu salka ku heeyso.
3. In xalka lagu gaaro 21 maalin, cawadahana jawaab la siiyo
4. Tacaadiyada ka dhankaa shaqaalaha iyo loo adeegaha waxaa lagu xalinaa 24hrs gudaaho
5. Cabashooyinka waxaa lagu soo gabagabeeynaa 30 maalin gudahood

4 Habka xalinta Tacadiyada

Guddi qaasa ah oo katirsan gudiga xallinta khilaafadka ooy ka midyihiim latilyaha arimaha bulshada ee labada mashruuc ayaa qabadana doona markasta eey soo ifbaxdo cabshaso la xariirta tacadiya ka dhanka ah shaqaalaha ka faaideesta yasha mashruuca. Gudiga ayaa hubin doona in arshaxa shaqaalah loo adeegsadsay sida uu ugu qoraayahay xeerka arshaxa shaqaalaha.

- Mashruucu waxuu raacaa hanaanka hormarinta dhibama. Majirto warbixin la gudbi karo ayadoon ogolaasho laga heeysan dhibanaha.
- Hubinta iyo fududayata dariiqa gudbinta badbaadaha waa in loo soo bandhigaa si degdeg ah adeeg bixiyayaasha ku haboon iyadoo lagu salaynayo dookhooda iyo ogolaansho xog ogaal ah, sida daryeelka caafimaadka, adeega taageerada bulsheed iyo taageero sharci, hoy degdeg ah, iyo adeeg kasta oo kale ee lagama maarmaanka ah ee loo baahan yahay.

4.1 Jaalda Gudbinta Cabashada

- Telehone/whatsApp/nunberka cabashada: 7575
- emails: fmoh.complaint@gmail.com; and fmoh.complaints.seah@gmail.com
- Ugudba shaqaalaha ku shaqada leh ee labada mashruuc
- Ku rid sandunqa cabashada

5 Sare-uqaadid wacyiga

Sare-uqaadida wacyiga habka cabasha ee shaqaalah, qandaraaslayaasha, shaqaalaha caafimaadka iyo bulshada iyadoo la adeegsanayo posters, flyers, radio.

6 Dabagal iyo Riboot-gareeya

- Buugga diiwaanka iyo dabgalka cabashooyinka
- Riboot bille
- Mashruuca waxa uu dabagaala tacadiyada la xariira goobta shaqada iyo ka faaideestayaasha mashruuca.

Emails: fmoh.complaint@gmail.com; and fmoh.complaints.seah@gmail.com