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**FEDERAL REPUBLIC OF SOMALIA**

**MINISTRY OF HEALTH**

# DRAFT 1 STAKEHOLDER ENGAGEMENT PLAN

# COVID-19 EMERGENCY VACCINATION PROJECT

**5th AUGUST 2021**

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## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| CBO | Community-based organization |
| CERC | Contingency Emergency Response Component |
| CHC | Community Health Committee |
| CHS | Community Health and safety |
| CoC | Code of Conduct |
| CSO | Civil society organization |
| DG | Director General |
| E&S | Environment and Social |
| EHSGs | Environmental Health and Safety Guidelines |
| EMF | Environmental Management Framework |
| EPHS | Essential package of health services |
| ESCP | Environment and Social Commitment Plan |
| ESF | Environment and Social Framework |
| ESIA | Environmental and Social Impact Assessment |
| ESMF | Environmental and Social Management Framework |
| ESMP | Environmental and Social Assessment and Management Plan |
| ESS | Environment and Social Standards |
| FCV | Fragility, Conflict & Violence |
| FGS | Federal Government of Somalia |
| FMS | Federal Member State |
| FRS | Federal Republic of Somalia |
| GBV | Gender-based Violence |
| GIIP | Good International Industry Practice |
| GIS | Geographic Information System |
| GM | Grievance mechanism |
| IDPs | Internally displaced person |
| IP | Implementing Partner |
| IPF | Investment Project Financing |
| LMP | Labour Management Procedures |
| M&E | Monitoring and Evaluation |
| MDAs | Ministries, Departments and Agencies |
| MIS | Management Information System |
| MoH | Ministry of Health |
| MoLSA | Ministry of Labour and Social Affairs |
| MTR | Medium Term Review |
| NGO | Non-governmental Organization |
| NSAs | Non-state actors |
| OHS | Occupation health and safety |
| PCIU | Project Coordination and Implementation Unit (FGS level) |
| PDO | Project Development Objective |
| PFM | Public Financial Management |
| PLWDs | People living with disabilities |
| PMT | Project Management Team (FMS level) |
| PWDs | Persons living with disabilities |
| RCRF | Recurrent Cost and Reform Financing (WB funded project) |
| SEAH | Sexual Exploitation, Abuse and Harassment |
| SecMF | Security Management Framework |

| | |
|---|---|
| SecMP | Security Management Plan |
| SEP | Stakeholder Engagement Plan |
| SocMF | Social Management Framework |
| SocMP | Social Management Plan |
| TA | Technical Assistance |
| ToR | Terms of Reference |
| TPM | Third Party Monitoring Agent |
| TTL | Task Team Leader |
| WB | World Bank |
| WHO | World Health Organization |

## 1. INTRODUCTION

1. The COVID-19 pandemic runs the risk of undermining the modest recent progress on economic and political reforms in one of the most challenging country contexts in the world. While Somalia has reported a cumulative total of only 15,000 cases and approximately 800 deaths, these figures likely underestimate the actual scope and magnitude of the pandemic. The cumulative positivite case rate is 5.5 percent, and the cumulative case fatality rate is estimated at 3.2 percent with males representing 76 percent of all cases. To tackle the pandemic, the government has: (i) strengthened testing capacity at the National Public Health and Reference Laboratory in Mogadishu and established testing capacity in Somaliland and Puntland; (ii) put in place rapid response teams; (iii) expanded the country's intensive care unit bed capacity; and (iv) launched nationwide multi-media awareness raising and COVID-19 prevention campaigns to enable citizens to protect themselves (including TV, Radio, and through the network on community mobilizers on the ground). Since the first case was confirmed in March 2020, there has been widespread local transmission to all states, diverting limited resources towards the COVID-19 health response, triggering economic disruptions, and exacerbating long-standing vulnerabilities and disparities. Border closures have hurt trade, livestock exports, and household incomes. Due to disruptions in economic activity stemming from lock down measures, the economy is anticipated to contract by 1.5 percent in 2020. The growth outlook for 2021 is projected at around 2 per-cent, compared to a pre-COVID 19 forecast of 3.2 percent. The global impact of COVID-19 has also disrupted remittances, which are a key source of income for many households in the country.

2. The situation appears to be worsening since February 2021, as Somalia has been experiencing a new wave (Figure 1) with widespread and intense community transmission in all regions, and suspected emergence of new variants, as seen in many other countries. The vaccination program is underway with the first 300,000 doses of the Astra Zeneca vaccines received in March 2021 through the COVAX Facility that overall is expected to provide vaccines for 20 percent of the population. In addition, Somalia has received 200,000 doses of the Sinopharm vaccine from China and 2,500 doses of the Sputnik vaccine from Russia. As of June 9, 2021, nearly 44 percent of the first dose has been administered, ranging from 25 percent in Jubaland to over 80 percent in Somaliland. Overall, roughly 37 percent of health workers; 29 percent of frontline workers; and 33 percent of the elderly in Somalia have received their first dose. Modelling and projections show an elevated risk of transmission, underscoring the urgency of accelerating the roll out of the COVID-19 vaccination program.

3. The capacity of the country's Federal Ministry of Health (FMoH) is nascent and at the early stages of building capacity to manage health services, including contract management. The FMoH was established in 2012 along with the formation of the Federal Government. The Ministry's stewardship, leadership, and managerial functions are still developing. The Government's role in health service delivery is limited, with most services delivered by NGOs financed by partners. As a result, key functions—including planning, budgeting, finance and governance—are not fully developed. Further, the FMoH is highly reliant on external support for its operations. Approximately 25 percent of the FMoH's over 500 employees are civil servants; the remainder are donor-financed and are primarily contracted on a short-term basis. While the FMoH has leadership structures and some policies and procedures in place, its decision-making process and management systems are not fully defined, and capacity to manage programs independently of partners is limited.

4. The SOMALIA COVID-19 EMERGENCY VACCINATION PROJECT (P176956) is being prepared under the World Bank's Environment and Social Framework (ESF). As per the Environmental and Social Standard ESS 10 (Stakeholders Engagement and Information Disclosure), the implementing agencies should provide stakeholders with timely, relevant, understandable and accessible information, and consult with them in a

culturally appropriate manner, which is free of manipulation, interference, coercion, discrimination and intimidation.

5. 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. The SEP 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. The involvement of the local population is essential to the success of the project in order to ensure smooth collaboration between project staff and local communities and to minimize and mitigate environmental and social risks related to the proposed project activities. In the context of infectious diseases, broad, culturally appropriate, and adapted awareness raising activities are particularly important to properly sensitize the communities to the risks related to infectious diseases. For COVID-19 vaccination programs, stakeholder engagement is key to communicating the principles of prioritization of vaccine allocation and the schedule for vaccine rollout, reaching out to disadvantaged and vulnerable groups, overcoming demand-side barriers to access (such as mistrust of vaccines, stigma of COVID-19, cultural hesitancy- as defined by delay or refusal to take vaccines), and creating accountability against misallocation, discrimination and corruption.

6. The SEP will be an iterative strategy that is reviewed and updated periodically as a result of the feedback and information gleaned from the regular engagements with a wide range of stakeholders and community representatives 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.

7. Overall, this SEP will serve the following purposes:
   a. Identify and analyze different stakeholders at different levels;
   b. Plan engagement modalities through effective communication, consultations and feedback;
   c. Define roles and responsibilities for the implementation of the SEP;
   d. Define reporting and monitoring measures to ensure the effectiveness of the SEP and periodic reviews of the SEP based on monitoring findings; and
   e. Elaborate the GM for the project.

## 2. PROJECT DESCRIPTION

8. The proposed Project will include two mutually reinforcing components. The first component (Vaccine Deployment and Acquisition) will support investments to bring immunization systems and service delivery capacity to the level required to successfully deliver COVID-19 vaccines at scale. To this end, the Project is geared to assist the government of Somalia working with key partners (UNICEF and WHO) to overcome key bottlenecks identified in the COVID-19 Vaccine readiness assessments and to support the main strategies of the vaccination program outlined in the NVDP. The component will also support the financing of additional vaccines over and above those acquired through the COVAX Facility with the amounts to be procured to be defined once the deployment costs are firmed up. The second component (Implementation Management) will support program coordination and project management as described in greater detail below.

9. **Component 1. Vaccine Deployment and Acquisition.** The main objective of this component is to support the deployment of the COVAX acquired vaccines to cover about 20 percent of the target population and other vaccines which meet World Bank financing criteria. In addition, the Project will support additional vaccine acquisition in case the government may need to make use of this option. To this end, the Project will support the following key activities: (i) *transportation, supply chain and logistics capacity strengthening* for in country distribution; (ii) *human resources cost, including salaries and allowances for personnel engaged in the vaccination program and related training* of health workers and community workers, and other personnel responsible for the delivery, storage, handling, transportation, tracking and safety of vaccines; (iii) *social mobilization efforts, including* developing communication materials, community outreach activities mobilizing local and religious leaders, and conducting social mobilization efforts to increase awareness, address vaccine hesitancy, and bolster demand; (iv) procuring *additional vaccines;* (v) targeted support for vaccinating refugees and internally displaced persons (IDPs); and (vi) strengthening *healthcare waste management* and occupational health.

10. **Component 2. Implementation Management.** The Project will support the national COVID-19 vaccination program by strengthening implementation capacity at different levels (national, state, region and district). To this end, the Project will: (i) strengthen capacity to track and monitor the impacts of the vaccination program (i.e., coverage, effectiveness and safety); (ii) conduct supervision and provide implementation support to the FMS; (iii) provide surge support by recruiting additional human resources to ensure personnel are not diverted from delivery of essential health services; and (iv) recruit organizations to provide support in the roll out of the COVID-19 vaccination program (e.g., UNICEF, WHO) and to facilitate third party independent monitoring.

## 3. STAKEHOLDER IDENTIFICATION AND ANALYSIS

### 3.1 Description of project stakeholders

11. Project stakeholders are defined as individuals, groups or other entities who:
    (i) are impacted or likely to be impacted directly or indirectly, positively or adversely, by the Project (also known as 'affected parties'); and
    (ii) may have an interest in the Project ('interested parties'). They include individuals or groups whose interests may be affected by the Project and who have the potential to influence the Project outcomes in any way.

12. The project will engage a large and diverse array of stakeholders during the planning and implementation phases. The FGS and the participating FMS will be responsible for project implementation and management, together with contracted partners, who will implement the vaccination programs 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., will be consulted regularly throughout 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—will also be engaged as appropriate. Relationships with existing non-government actors—including UN agencies, NGOs, and private sector organizations—will also be established and/or enhanced to ensure the project leverages the activities of the agencies within the health sector in Somalia.

13. Special consideration will be taken to ensure that women, youth, minority groups, and persons living with disabilities (PWDs) will be represented amongst the stakeholder groups. Various other stakeholders—such as religious leaders, clan elders and opinion leaders—who may influence the perceptions and uptake of vaccination and involvement of women in the project, will also be actively engaged. Particular effort will be made to engage the target groups, particularly frontline workers who can act as role models for others as well as older people (over 50 years) and people with co-morbidities. This should be done by careful analysis of their information sources and social leaders and media influencers, e.g., through professional associations and through their health providers and support groups, including pharmacies.

14. Cooperation and negotiation with the stakeholders throughout the Project development often also require the identification of persons within the groups who act as legitimate representatives of their respective stakeholder group, i.e., the individuals who have been entrusted by their fellow group members with advocating the groups' interests in the process of engagement with the Project. Community representatives may provide helpful insights into the local settings and act as main conduits for dissemination of the Project-related information and as a primary communication/liaison link between the Project and targeted communities and their established networks. Community representatives, cultural leaders and women leaders may also be helpful intermediaries for information dissemination in a culturally appropriate manner, building trust for government programs or vaccination efforts. Especially for vulnerable and disadvantaged groups, stakeholder engagement should be conducted in partnership with their representative organizations and traditional authorities. Among other things, they can provide help in understanding the perceptions of local people on the causes of the virus, which will influence their opinions around the vaccination campaigns as a proposed solution. Women can also be critical stakeholders and intermediaries in the deployment of vaccines as they are familiar with vaccination programs for their children and are the caretakers of their families.

15. Verification of stakeholder representatives (i.e. the process of confirming that they are legitimate and genuine advocates of the community they represent) remains an important task in establishing contact with the community stakeholders. Legitimacy of the community representatives can be verified by talking informally to a random sample of community members and heeding their views on who can represent their interests in the most effective way. With community gatherings limited or forbidden under COVID-19, it may mean that the stakeholder identification will be on a much more individual basis, requiring different channels to reach affected individuals.

### 3.2 Methodology

16. In order to meet best practice approaches, the project will apply the following principles for stakeholder engagement:
    - *Openness and life-cycle approach*: public consultations for the project(s) will be arranged during the whole life cycle, carried out in an open manner, free of external manipulation, interference, coercion or intimidation.
    - *Informed participation and feedback*: information will be provided to and widely distributed among all stakeholders in an appropriate format; opportunities are provided for communicating stakeholders' feedback, for analyzing and addressing comments and concerns.
    - *Inclusiveness and sensitivity*: stakeholder identification will be undertaken to support better communication and build effective relationships. The participation process for the projects is inclusive. All stakeholders at all times are encouraged to be involved in the consultation process. Equal access to information is provided to all stakeholders. Sensitivity to stakeholders' needs is the key principle underlying the selection of engagement methods. Special attention is given to vulnerable groups, in particular women, youth, elderly, persons with disabilities, displaced persons, those with underlying health issues, and the cultural sensitivities of diverse ethnic groups.
    - *Flexibility*: if social distancing inhibits traditional forms of engagement, the engagement process should adapt other forms of engagement, including various forms of internet communication, mobile phones, community radio networks and community and religious groups.

17. For the purposes of effective and tailored engagement, stakeholders of the proposed project are 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 and Disadvantaged Groups** – persons who may be disproportionately impacted or further disadvantaged by the project as compared with any other groups due to their vulnerable status[1], and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project.

[1] Vulnerable status may stem from an individual's or group's race, national, ethnic or social origin, color, gender, language, religion, political or other opinion, property, age, culture, literacy, sickness, physical or mental disability, poverty or economic disadvantage, and dependence on unique natural resources.

### 3.3 Affected parties

18. Affected Parties include local communities, community members and other parties that may be subject to direct impacts from the Project. Specifically, the following individuals and groups fall within this category for the proposed Project:
    - Somali citizens, especially people over 50 years and those with co-morbidities (cardiovascular diseases, hypertension, and diabetes). Others include people from disadvantaged and vulnerable groups, e.g., IDPs, minority groups and nomads, PWDs, chronically ill people and the elderly who may have particular barriers accessing information or vaccination centers.
    - Frontline workers: (a) Healthcare workers in both public and private facilities – collaboration with the doctors and nurses' associations; (b) Teachers; (c) Municipal workers; and (d) Border patrol staff and police/armed forces/security agents.
    - People and companies running health facilities, both public and private, and pharmacies.
    - The MoH and FMS line ministries, departments and government agencies directly supported by the project (i.e., MoHs at both levels of the federation).

### 3.4 Other interested parties

19. The projects' stakeholders also include parties other than the directly affected communities, including:
    - Media and communication service providers;
    - International NGOs and bilateral donor agencies;
    - Civil society organizations (CSOs), i.e., women and youth groups, and direct and indirect representatives of disadvantaged and vulnerable groups; and
    - Elders (including House of Elders Council Members), religious leaders, traditional health providers and opinion influencers including among others disadvantaged and vulnerable groups who may influence uptake of health services.

### 3.5 Disadvantaged / vulnerable individuals or groups

20. It is particularly important to understand whether project impacts may disproportionately fall on disadvantaged or vulnerable individuals or groups, who often do not have a voice to express their concerns or understand the impacts of a project and to ensure that awareness raising and stakeholder engagement with disadvantaged or vulnerable individuals or groups on infectious diseases and medical treatments in particular, be adapted to take into account such groups or individuals particular concerns and cultural sensitivities and to ensure a full understanding of project activities and benefits. The vulnerability may stem from person's origin, gender, age, health condition, economic deficiency and financial insecurity, disadvantaged status in the community (e.g., minorities, fringe groups or PWDs), dependence on other individuals or natural resources, etc. Engagement with the vulnerable groups and individuals often requires the application of specific measures and assistance aimed at the facilitation of their participation in the project-related decision making so that their awareness of and input to the overall process are commensurate to those of the other stakeholders.

21. Within the Project, the vulnerable or disadvantaged groups may include and are not limited to the following: IDPs; PWDs, minority groups and their representatives; the elderly, female and child headed households, chronically ill and the elderly whose mobility is limited.

22. Vulnerable groups within the communities affected by the project will be further confirmed and consulted through dedicated means, as appropriate. Description of the methods of engagement that will be undertaken

by the project is provided in the following sections. For any vaccination program, the SEP will include targeted, culturally appropriate and meaningful consultations for disadvantaged and vulnerable groups before any vaccination efforts begin.

**Table 1: Project affected parties**

| No | Project Stakeholders | Relevance to the Project | Needs |
|---|---|---|---|
| **A: Directly affected parties** | | | |
| 1. | Somali citizens, especially people over 50 years and those with co-morbidities (cardiovascular diseases, hypertension, and diabetes). Others include people from disadvantaged and vulnerable groups, e.g., IDPs, minority groups and nomads who may have particularly barriers accessing information or vaccination centers. | The Somali citizens in the urban and rural areas in all the federal member states including Somaliland are the primary beneficiaries of healthcare services offered by the project. Their views about the potential environmental and social risks are essential in identifying and mitigating those risks.<br><br>Their understanding of the COVAX project details and providing feedback on best way of ensuring acceptance to the vaccine by all especially the people with co-morbidities and access options convenient for them. | To be consulted and be informed about the potential E&S risks of the project - in order to address and mitigate, as possible.<br><br>To provide their feedback and concerns about the implementation of the project.<br><br>To understand from citizens directly the best means of communication and information exchange. To ensure they have access to accountability platforms (hotlines, helpdesks etc.) to report concerns, questions or to seek answers to their questions. |
| 2. | Frontline workers: (a) Health workers in both public and private facilities – collaboration with the doctors and nurses' associations; (b) Teachers; (c) Municipal workers; and (d) border control workers and police. | The frontline workers have direct access to the target beneficiaries of the vaccine, they will have direct influence on the success of the vaccination program.<br><br>Encouraged to be role models in the vaccination program and advocate for vaccine safety.<br><br>To be used as means to address the rumours, myths and misconceptions on vaccination<br><br>Providing timely, quality and inclusive access to all during the vaccination process. | To be consulted and be informed about the potential E&S risks of the project - in order to address and mitigate, as possible.<br><br>To contribute their feedback and concerns about the implementation of the project especially the Vaccine hesitancy.<br><br>Be champions of the vaccination drive in the country.<br><br>To ensure they have access to accountability platforms (hotlines, helpdesks etc.,) to report concerns, questions or to seek answers to their questions.<br><br>To respond and act on the feedback/suggestions provided by other stakeholders about existing risks. |

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|---|---|---|---|
| 3. | People and companies running health facilities, both public, and private and pharmacies | Promote information sharing and communication of the COVID vaccine to the patients.<br><br>These people should provide 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 E&S risks of the project - in order to address and mitigate them.<br><br>To contribute their feedback and concerns about the implementation of the project especially the Vaccine hesitancy.<br><br>To ensure they have access to accountability platforms (hotlines, helpdesks etc.,) to report concerns, questions or to seek answers to their questions.<br><br>To respond and act on the feedback/suggestions provided by other stakeholders about existing risks. |
| 4. | The MoH and FMS line ministries, departments and government agencies directly supported by the project (i.e., MoHs at both levels of the federation). | The main governmental ministries to be engaged with the project will be MoHs at FGS and FMS level.<br><br>These ministries are integral to the overall success of the project at all stages and are crucial to advancing the vaccination program utilizing the existing infrastructure and expertise.<br><br>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.<br><br>To respond and act on the feedback/suggestions provided by other stakeholders about existing risks.<br><br>To develop and implement E&S mitigation measures as necessary.<br><br>To create an easily accessible communications channels for other stakeholders to air their views.<br><br>To address the grievances of other stakeholders. |
| **B: Other interested parties** | | | |
| 5. | Media and communication service providers | Will benefit from the dissemination of information and messaging on the COVID vaccine safety and benefit of vaccination. Will also be used a medium of information sharing on vaccine accessible health facilities, referral centers and other relevant information. Thus, will have considerable amount of impact on the access and acceptance of the vaccine. This group will also serve to hold the project to account and to ensure a responsive project. They will also be channels of information to address the rumours, myths and misconceptions on vaccination | To be consulted and engaged in the project - in order to support its outcomes.<br><br>To report on community level concerns and questions about the project and to showcase the success, outline the challenges and areas of improvement. |

| | | | |
|---|---|---|---|
| 6. | International NGOs and bilateral donor agencies | Some development partners and NGOs are already engaged in COVID-19 vaccine and overall COVID-19 response, they may provide technical, networking and advise on lessons learnt and help in curbing vaccine hesitancy.<br><br>Engagement with these groups can improve coordination and avoid duplication of services and other resources. | To learn about the project's activities, E&S risks and mitigation measures, share information, lessons learned, and explore opportunities to maximize impacts with similar projects.<br><br>To be transparent and report on community level concerns and questions about the project and to shine a light on areas of success, challenges and areas of improvement.<br><br>To ensure that accountability mechanisms are well promoted, well functioning and the project is responsive. |
| 7. | Civil society organizations (CSOs), i.e. women and youth groups, and direct and indirect representatives of disadvantaged and vulnerable groups. | CSOs, especially those that work closely with vulnerable and disadvantaged groups in the focus regions of the 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.<br><br>They will also be channels of information to address the rumours, myths and misconceptions on vaccination | To understand the project's activities, E&S mitigation measures and to have a platform to advise on SRM and mitigation.<br><br>To ensure that accountability mechanisms are well promoted, well functioning and the project is responsive.<br><br>To ensure that the voices of those on the margins of society are heard and have access to the project services as entitled. |
| 8. | Elders, religious leaders, traditional health providers and opinion influencers including among others disadvantaged and vulnerable groups who may influence uptake of health services. | Given the role of religion in Somalia, religious leaders can be important agents of change if engaged meaningfully. To provide options of accelerating the vaccination to their congregations.<br><br>The community elders, religious leaders and/or traditional health providers can promote positive opinion towards the vaccination program and articulate issues and amplify the voices of those who may be otherwise be hesitant to the vaccines. | To understand the project's activities, especially the COVID Vaccine safety, E&S mitigation measures and to have a platform to advise on SRM and mitigation.<br><br>To serve as listening groups and to share concerns and rumours, myths and misconceptions as needed to the project implementers.<br><br>To lead in discussions on strategy and next steps to improve areas that need strengthening.<br><br>To ensure that the voices of those on the margins of society are heard and have access to the project services as entitled. |
| **C: Disadvantaged and vulnerable groups** | | | |
| 9. | Disadvantaged and vulnerable groups including IDPs, persons with disabilities, and minority groups and their | These disadvantaged and vulnerable groups have the most to benefit from accessing the vaccines. Yet, they face real and potential barriers that have to be deliberately addressed | To contribute their feedback and concerns regarding project implementation and sharing of project benefits, through an easily accessible mechanism. |

| | | | |
|---|---|---|---|
| | representatives the elderly, female and child headed households, chronically ill and the elderly whose mobility is limited | by the project for them to benefit from the project. | To serve as listening groups and to share concerns and rumours, myths and misconceptions as needed to the project implementers.<br><br>To lead in discussions on strategy and next steps to improve areas that need strengthening.<br><br>To ensure that the voices of those on the margins of society are heard and have access to the project services as entitled. |

## 4 STAKEHOLDER ENGAGEMENT PROGRAM

### 4.1. Summary of stakeholder engagement done during project preparation

23. During preparation consultation individual meetings were carried out with a number of stakeholders. A comprehensive stakeholder engagement workshop will be carried out on the 26th July 2021. About 60 people attended the meeting (see Annex 1).

Table 2: **Results of individual stakeholder interviews**

| Stakeholders | Identified social risks | Suggested mitigation measures |
|---|---|---|
| Implementing partners WHO and UNICEF | Hesitancy and access<br><br>Inclusion | Wide media coverage on the vaccine safety in all areas available.<br><br>Strengthen listening groups, especially among hard to reach groups and to share concerns and rumors/myths/misconceptions as needed to the project implementers.<br><br>Ensure that all hard to reach and disadvantaged groups have accessible communication channels and feedback mechanisms and are comfortable raising questions/concerns. |
| | Stakeholder engagement | To understand from citizens directly the best means of communication and information exchange. To ensure citizens have access to accountability platforms (hotlines, helpdesks etc.) to report concerns, raise questions and get prompt and comprehensive responses.<br><br>To ensure that all stakeholders have access to accountability platforms (hotlines, helpdesks etc.) to report concerns, raise questions and get prompt and comprehensive responses.<br><br>To respond and act on the feedback/suggestions provided by other stakeholders about existing risks.<br><br>To report on community level concerns and questions about the project, including areas of success, challenges and potential improvements. |
| | Coordination – with other service providers like NGOs and other development partners | Ensure that awareness is raised among all stakeholder particularly disadvantaged groups on grievance and accountability mechanisms and that they are trusted and functioning.<br><br>Ensure regular coordination meetings receive lessons learnt from other programs/organisations to improve implementation |

| Media / Strategic communication – Spotlight | Hesitancy and access to information | Ensure information about vaccine efficiency and importance shared to all groups including disadvantaged groups and that communication modes that are appropriate.<br><br>Engagement of community opinion leaders e.g. well-known and respected religious leaders in the vaccination drive and following up communications e.g. doing the vaccinations at or near the mosques or after Friday prayers.<br><br>Use of local celebrities accompanied by followers to partake in the vaccination programs. This will ignite interest in the vaccination and boost the confidence of the public especially the youth.<br><br>On social media – use more targeted messaging on Facebook and twitter and bearers of the message should be known influencer with integrity and following. |
|---|---|---|

24. A follow-up consultation meeting was hold on July 26, 2021 (see Annex 2). This meeting was attended by 37 people representing various organizations and agencies including MoH, WHO, Unicef, Save the Children, PSI community organization and media representation among others. This was a virtul consultation. During discussions the key issues raised were on the SEAH risks which were considered not founded on facts given that vaccination is currently ongoing and no cases of SEAH have been reported. It was noted that the safeguards instruments are aimed at preventing the occurrence of such incidents. Experience in other jurisdictions show that once the vaccine uptake goes up, the demand increases together with the risk of SEAH.

### 4.2. Summary of project stakeholder needs and methods, tools and techniques for stakeholder engagement

25. A precautionary approach will be taken to the consultation process to prevent infection and/or contagion, given the highly infectious nature of COVID-19. The following are some considerations for selecting channels of communication, in light of the current COVID-19 situation:
    - Avoid public gatherings (taking into account national restrictions or advisories), including public hearings, workshops and community meetings in the open air if weather permits.
    - If smaller meetings are permitted/advised, conduct consultations in small-group sessions, such as focus group meetings. If not permitted or advised, make all reasonable efforts to conduct meetings through online channels.
    - Diversify means of communication and rely more on social media and online channels (Facebook is a popular platform for local radio stations for example who stream content). Where possible and appropriate, create dedicated online platforms and chat groups appropriate for the purpose, based on the type and category of stakeholders.
    - Employ traditional channels of communications (TV, newspaper, radio, dedicated phone-lines, and mail) when stakeholders do not have access to online channels or do not use them frequently. Traditional channels can also be highly effective in conveying relevant information to stakeholders and allow them to provide their feedback and suggestions.
    - Where direct engagement with project affected people or beneficiaries is necessary, identify channels for direct communication with each affected household via a context specific combination of email messages, mail, online platforms, dedicated phone lines with knowledgeable operators.
    - Each of the proposed channels of engagement should clearly specify how feedback and suggestions can be provided by stakeholders.

- Identify trusted local civil society, local/clan-based organizations, community organizations and similar actors who can act as intermediaries for information dissemination and stakeholder engagement; engage with them on an ongoing basis. For effective stakeholder engagement on COVID-19 vaccination, prepare different communication packages and use different engagement platforms for different stakeholders, based on the stakeholder identification above. The communication packages can take different forms for different mediums, such as basic timeline, visuals, charts and cartoons for newspapers, websites and social media; dialogue and skits in plain language for radio and television; and more detailed information for civil society and media. These should be available in different local languages. Information disseminated should also include where people can go to get more information, ask questions and provide feedback.

26. In line with the above precautionary approach, different engagement methods are proposed and cover different needs of the stakeholders as illustrated in Table 3.

Table 3. **Plan for stakeholder engagement of different groups**

| No | Stakeholder | Channels of Engagement | Frequency | Purpose | Responsible entity or individual |
|---|---|---|---|---|---|
| 1. | Somali citizens, especially people with co-morbidities (cardiovascular diseases, hypertension, and diabetes). Others include the elderly, men, women, youth, and people from disadvantaged and vulnerable groups, e.g., IDPs, minority groups and nomads. | -Public fora using approaches such as community conversations or dialogue forums.<br>-Messages through phones and social media platforms (e.g., WhatsApp).<br>-Community feedback surveys. | At initiation of services and as needed throughout the project period. | -To inform communities on the vaccination program especially the safety of the vaccines and to make them aware of their availability and their entitlement to receive them.<br>-To collect views on social risks and how they could be managed, or their management could be improved.<br>-Provide dialogue opportunities where citizens have access to and engage with government representatives and other stakeholders.<br>-Collect feedback from the target communities to understand their concerns, issues and perceptions of the vaccine and overall project implementation. | PCIU/PMTs and social safeguards officers at FGS and focal points at FMS levels. |
| 2. | Frontline workers: (a). Health workers in both public and private facilities – collaboration with the doctors and nurses' associations; (b) eachers; and (c) police and military/armed/security agencies | -Regular meetings to review progress of project implementation to report effectiveness and challenges.<br>-Workshops with technical officers.<br>-WhatsApp groups formed to share information | At launch and as needed. | -To provide timely access to information, data, documents, and another relevant project information.<br>- Secure their collaboration in promoting and championing the vaccination drive.<br>- To inform them of their entitlement to receive the vaccines and to come forward if they have not already done so.<br>- To highlight their role as community role models and trusted information channels | PCIU/PMTs and social safeguards officers at FGS and focal points at FMS levels. |

| No | Stakeholder | Channels of Engagement | Frequency | Purpose | Responsible entity or individual |
|---|---|---|---|---|---|
| 3. | People and companies running health facilities both public and private and pharmacies; | -Regular meetings to review progress of project implementation to report effectiveness and challenges.<br>-Workshops with technical officers.<br>-WhatsApp groups formed to share information.<br>-Telephone interviews and questionnaires via virtual applications such as GEMS. | As needed | -To provide timely access to information, data, documents, and another relevant project information.<br>- Secure their collaboration in promoting the vaccination drive.<br>-Learn about any issues related to OHS, GBV/SEAH.<br>-Solicit feedback on project implementation.<br>-To increase understanding and support GBV/SEAH and GM monitoring processes. | Component leads, supervisors, and social safeguards officers at FGS and FMS levels. |
| 4. | The MoH and FMS line ministries, departments and government agencies directly supported by the project (i.e., MoHs at both levels of the federation). | -Series of high-level and technical engagement, meetings and working sessions with technical ministry counterparts.<br>-All-day workshop with technical officers.<br>-WhatsApp groups formed to share information.<br>-Telephone interviews and questionnaires via virtual applications such as GEMS. | As needed | -Project reviews including social risks and how they are being managed.<br>- Learn from the first phase of the vaccination drive and lessons learnt,<br>-Seeking clearance to implement the project components.<br>-Update the project documents based on the implementation progress and concerns.<br>-Review GM monitoring processes.<br>-To promote shared responsibility and partnership. | PCIU/PMTs and social safeguards officers at FGS and focal points at FMS levels. |
| 5. | International NGOs and bilateral donor agencies. | -Discussion during meetings: sector, public and focal.<br>These meetings and assemblies are to stimulate collaboration and get feedback.<br>-Use of existing technical working groups such as development partners group on health, e.g. the health cluster coordination group<br>-Regional/FMS health coordination working groups | During project formulation and implementati on. | -Sharing of information, reviews, clearance and seeking support.<br>-To solicit guidance and feedback on project effectiveness and SRM.<br>-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. |
| 6. | Civil society organizations (CSOs), i.e. women and youth groups, and direct and indirect representatives of disadvantaged and vulnerable groups. | -Discussion during meetings: sector, public and focal. These meetings/assemblies are to stimulate collaboration and get feedback.<br>-Messages through phones and social media platforms (e.g. WhatsApp).<br>-Community feedback surveys. | During project formulation and implementati on | -Sharing of information, reviews, clearance and seeking support especially countering vaccine hesitancy.<br>-To solicit guidance and feedback on Project effectiveness and social risk management.<br>- Learning and building on ongoing work by various partners and creating synergy and avoid duplication of efforts<br>- Strengthening local capacities as first responders | PCIU/PMTs and social safeguards officers at FGS and focal points at FMS levels. |

| No | Stakeholder | Channels of Engagement | Frequency | Purpose | Responsible entity or individual |
|---|---|---|---|---|---|
| 7. | Elders, religious leaders, traditional health providers and opinion influencers including among others disadvantaged and vulnerable groups who may influence uptake of health services. | -Targeted meetings with profiled influential clerics.<br>-Public fora using approaches such as community conversations or dialogue fora.<br>-Using local FM radio stations, meetings and local community communication structures for more coverage.<br>-Hold small group meetings to discuss issues specific to the groups.<br>-Community feedback surveys. | At launch and as needed. | - Agree on joint strategies for augmenting the vaccination program.<br>- Sharing of information, reviews, clearance and seeking support.<br>- To solicit guidance and feedback on Project effectiveness and social risk management.<br>- Learning and building on ongoing work by various partners and creating synergy and avoid duplication of efforts<br>- Agree on joint strategies for augmenting the vaccination program. | PCIU/PMTs and social safeguards officers at FGS and focal points at FMS levels. |
| 8. | Disadvantaged and vulnerable groups including IDPs, persons with disabilities, and minority groups and their representatives the elderly, female and child headed households, chronically ill and the elderly whose mobility is limited | -Public fora using approaches such as community conversations or dialogue fora.<br>-Using local FM radio stations, meetings and local community communication structures for more coverage.<br>-Hold small group meetings to discuss issues specific to the groups.<br>-Community feedback surveys. | At launch and as needed. | -To sensitize communities on the project's goals and benefit of vaccination.<br>-Collect views on social risks and how they could be managed or how their management could be improved.<br>-Provide dialogue opportunities where citizens have access to and engage with government representatives and other stakeholders.<br>-Support the communities to understand their rights to access to quality health services and demand for services and accountability. | PCIU/PMTs and social safeguards officers at FGS and focal points at FMS levels. |

### 4.3. Proposed strategy for information disclosure

27. In line with WHO guidelines on prioritization, the initial target for vaccination under the World Bank COVID-19 Multi Phase Programmatic Approach financing [Talaal Kaabe] is to reach 20% of the population in each country, prioritizing healthcare workers, other essential workers, and the most vulnerable, including the elderly and people with underlying co-morbidities. As all people will not receive vaccination all at the same time, inadequate or ineffective disclosure of information may result in distrust in the vaccine or the decision-making process to deliver the vaccine.

28. The government will, therefore, ensure that information to be disclosed:
- Is accurate, up-to-date and easily accessible;
- Relies on best available scientific evidence;
- Emphasizes shared social values;
- Articulates the principle and rationale for prioritizing certain groups for vaccine allocation;
- Includes an indicative timeline and phasing for the vaccination of all the population;

- Includes explanation of measures that will be used to ensure voluntary consent, or if measures are mandatory that they are reasonable, follow due process, do not include punitive measures and have a means for grievances to be addressed;
- Includes explanation of vaccine safety, quality, efficacy, potential side effects and adverse impacts, as well as what to do in case of adverse impacts;
- Includes where people can go to get more information, ask questions and provide feedback (and contact persons as appropriate); and
- Includes the expected direct and indirect economic costs of the vaccines and addresses measures should there be serious adverse impact on stakeholders due to the vaccine, such as serious side effects.
-

29. Other key considerations will include:
- If the information is communicated in formats taking into account language, literacy and cultural aspects;
- Over time, based on feedback received through the Grievance Mechanism and other channels, information disclosed should also answer frequently asked questions by the public and the different concerns raised by stakeholders;
- Misinformation can spread quickly, especially on social media. During implementation, the government will assign dedicated staff to monitor social media regularly for any such misinformation about vaccine efficacy and side effects, and vaccine allocation and roll out;
- In response, the government will disseminate new communication packages and talking points to counter such misinformation through different platforms in a timely manner; and
- If the engagement of security or military personnel is being considered for deployment of vaccines, ensure that a communication strategy is in place to inform stakeholders of their involvement and the possibility of raising concerns and grievances on their conduct through the Grievance Mechanism.

### 4.4. Stakeholder engagement plan

30. The project team will prepare and disclose documents based on the schedule provided in Table 4. Updated versions of the various instruments will be developed as necessary and disclosed.

**Table *4*: Project information disclosure**

| **Stakeholder Engagement Plan** | | | |
|---|---|---|---|
| **Project stage** | **Target stakeholders** | **Information to be disclosed** | **Methods and timing proposed** |
| Before bidding process | **Affected Persons:**<br>Somali citizens especially people with co-morbidities (cardiovascular diseases, hypertension, and diabetes). Others include Elderly, men, women, youth, people from disadvantaged and vulnerable groups e.g., IDPs, minority groups and nomads.<br><br>Frontline workers – (a) Health workers in both public and private facilities – collaboration with the doctors and nurses' associations; (b) Teachers; and (c)Municipal workers (d) Border officials and police.<br><br>People and companies running health facilities both public and private and pharmacies.<br><br>The MoH and FMS line ministries, departments and government agencies directly supported by the project (i.e., MoHs at both levels of the federation). | More site-specific environmental and social impacts and mitigation measures in ESMP (including GBV/SEAH Action Plan), LMP and SEP.<br>Awareness-raising on the GM<br>ESMF, ESMP, SRA, SMP, SEP disclosures. | Public and individual meetings during the preparation of the project.<br>Disclosure of written information - widespread Radio, TV (in parts of the country), social media, mobile phone IVR ring tone messages. Brochures / flyers are less appropriate and effective – translated in Somali<br>Face-to-face meetings: separate meetings specifically to affected vulnerable groups and individuals.<br>Social Media<br>Grievance mechanism |
| | **Other interested parties:**<br>International NGOs and bilateral donor agencies.<br><br>Civil society organizations (CSOs), i.e., women and youth groups, and direct and indirect representatives of disadvantaged and vulnerable groups.<br><br>Elders, religious leaders, traditional health providers and opinion influencers including among others disadvantaged and vulnerable groups who may influence uptake of health services. | Technical details on project design<br><br>Compliance with national regulations and collaboration with relevant programs.<br><br>Communication strategy<br><br>Identification of vulnerable groups of people relevant to the project<br><br>Compliance with legislations and regulations<br><br>GM Process | Social Media<br>Public meeting and individual meetings during the preparation of the project.<br>Disclosure of written information - Brochures, posters, flyers, websites (Social Media Communication) – translated in Somali<br>Face-to-face meetings: separate meetings specifically to affected vulnerable groups and individuals.<br>Grievance mechanism |

| | | | |
|---|---|---|---|
| | Media and communication service providers | | |
| | Disadvantaged and vulnerable groups including IDPs, persons with disabilities, and minority groups and their representatives, the elderly, female and child headed households, chronically ill and the elderly whose mobility is limited | Awareness-raising on the GM<br>More site-specific environmental and social impacts and mitigation measures in RAP, ESMP (including GBV Action Plan), LMP and SEP.<br>ESMF, ESMP, SRA, SMP, RPF, SEP disclosures. | Meetings with groups representatives. |
| Project Impleme ntation | **Affected Persons**: (listed above) | Area/subproject specific ESMPs including plans for implementation of SEP, EMF including MWMP, SMF including GBV action plan, and LMP | WB and MoH website FMS and regional consultation meetings and community consultation meeting with all groups including disadvantaged and vulnerable groups |
| 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 |

### 4.5. Proposed strategy to incorporate the views of vulnerable groups

31. The project will carry out targeted stakeholder engagement with vulnerable and disadvantaged groups and individuals to understand their concerns/needs in terms of accessing information, medical facilities and services and other challenges they face at home, at workplaces and in their 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.

32. The project will promote inclusion of disadvantaged and vulnerable groups and individuals by ensuring their involvement in consultations in the sub-project design and the development of the ESMPs. This will entail ensuring that health facilities are accessible to people with physical disabilities (e.g., having ramps and rails where appropriate or deploying mobile teams as needed) and training health staff and community health committees on provision of services without discrimination. The health facilities will also record PWDs in the health information tools and share the reports with the PCIU for monitoring and response where necessary. In addition, efforts will be made to promote diversity in staffing (see LMP). In addition, community health committees will have diverse representation including disadvantaged and vulnerable individuals and groups.

33. Community and health worker training will emphasize non-discrimination and access to health for all including disadvantaged and vulnerable groups and individuals. 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 PWDs (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.

34. 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 know their own vulnerabilities compared to external actors and the engagement of local structures is most effective in such projects where administrative capacity is limited.

35. 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.

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

37. 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 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.

38. 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 and sensitive 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.

39. To help ensure that the process does not marginalize disadvantaged and vulnerable groups, representation for these groups will be required in the grievance committee (GC) tasked to resolve grievances/complaints at the community level. The following issues will be addressed during the implementation stage of the project:
    a. Provision of an effective mechanism for monitoring implementation of the Inclusion Plan by the PCIU and PMTs, social safeguards team and contracted NGOs;
    b. Involve suitably experienced CBOs/NGOs to address the disadvantaged and vulnerable individuals and groups through developing and implementing targeted action plans that are issue focused (e.g. on access to health services for women in remote areas);
    c. Ensuring appropriate budgetary allocation of resources for the contractors' Inclusion Plans as part of the contractors' ESMPs; and
    d. Provision of technical assistance for sustaining the activities addressing the needs of the disadvantaged and vulnerable individuals and groups.

### 4.6. Reporting back to stakeholders

40. Stakeholders will be kept informed through regular meetings and dissemination of information through other means as the project develops, including reporting on project environmental and social performance and implementation of the SEP and grievance mechanism.

## 5 RESOURCES AND RESPONSIBILITIES FOR IMPLEMENTING STAKEHOLDER ENGAGEMENT ACTIVITIES

### 5.1. Resources

41. The senior social safeguard specialists, embedded in the PCIU at MOH-FGS, will be in charge of stakeholder engagement activities, together with communication staff of MoH, UNICEF and WHO.

**Table 5: Estimated budget for implementing the SEP[2]**

| 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 at each of 5 FMS and FGS (4 total) | Before sub-project implementation | Per year | 5,000 | 3 years | 30,000 |
| Communication materials (leaflets, posters on project and GM, GM forms, registers in Somali) | Before sub-project implementation | Per year | 50,000 | 3 years | 150,000 |
| Training of all staff and contractors on GM | Before sub-project implementation | Per year | 5,000 | 1 year | 5,000 |
| Annual stakeholder consultation and feedback meeting (one in each FMS and FGS) | Before sub-project implementation | Once a year | 12,000 | 3 years | 96,000 |
| FM radio press conferences and call ins (one per year at FGS and FMS level) | Before sub-project implementation | Once a year | 50,000 | 3 years | 150,000 |
| Monitoring visits by FMS social officers | Once component activities start | Per quarter | 10,000 | 3 years | 60,000 |
| Annual stakeholder feedback survey (call Centre) as part of TPM survey | By December 2021 | Per year | | | N/A |
| **Subtotal** | | | | | 491,000 |
| **Contingency 5%** | | | | | 24,550 |
| **Total** | | | | | 515,550 |

### 5.2 Management functions and responsibilities

42. The project will be implemented by the PCIU at the FGS MoH, and the PMTs at the FMS level. The FGS MoH will have project management responsibility, coordinating overall project implementation. It will also be responsible for knowledge management, capacity strengthening, monitoring, and evaluation of project

[2] Does not include general communication, or staffing including social specialists, behavioral change communication specialists and GM focal points which will be included in PIU and contractors' contracts.

activities, procurement, contract management, and technical implementation support to the FMS line ministries. The project implementation at the federal level will be led by a Senior Project Coordinator and supported by the following specialists: Contract Management/M&E Specialists, Procurement Specialist, Public Financial Management Specialist, separate Social and Environmental Specialists, GBV specialist, Security Specialist, Communication Specialist, among 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. UNICEF and WHO and other technical agencies are expected to provide technical assistance as requested by the PCIU and/or the MoH and Human Services Directorates.

43. At the state level, each state will have a PMT at the FMS MoH, who will be 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 will be led by a Project Manager in all FMSs. It will also have Safeguards 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 will coordinate efforts within their respective governments, as well as between the FGS and the FMS. A Social/GBV Specialist will be 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.

44. The SEP will be implemented and monitored by the PCIU. The direct responsibility of its implementation will be designated to the Social Safeguards Specialist within the FGS MoH. The Social Safeguards and Communication Specialists will work 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.

45. Reports on stakeholder engagement and a summary of grievances will be received by the PCIU Senior Social Specialist and implementing partners every three months.

## 6. GRIEVANCE MECHANISM

46. The main objective of a GM is to assist to resolve complaints and grievances in a timely, effective and efficient manner that satisfies all parties involved. Specifically, it provides a transparent and credible process for fair, effective and lasting outcomes. It also builds trust and cooperation as an integral component of broader community consultation that facilitates corrective actions. Specifically, the GM will:
    - 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, PAPs, 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.

47. **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 in distribution of the vaccines;
    - Safety and handling of the vaccination process;
    - 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.

### 6.1 Description of GM

48. The project risk rating is Substantial. 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 GM will be developed which will enable the effective resolution of any grievances of the project stakeholders, including civil servants and communities where the health services will be provided. There will be confidential, appropriate mechanisms to deal with complaints regarding GBV/SEAH. There will also be a 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 will 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 will be trained in grievance handling, and resolution, including confidentiality requirements and whistle blower protection.

49. For the **vaccination project**, the FGS MoH will have the responsibility to resolve all issues related to the project in accordance with the laws of FGS and the World Bank ESSs through a clearly defined GM that outlines its process and is available and accessible to all stakeholders. The entry point for all grievances will be with the social specialists at the FGS and FMS levels who will receive grievances by phone, text or email to publicized mobile phone lines and email addresses. The social safeguards specialists will be the focal point initially, but the GM officers will be employed as needed. The social safeguards specialists will acknowledge, log, forward, follow-up grievance resolution and inform the complainant of the outcome. The complainant has the right to remain anonymous, in which case the identifying details will not be logged.[3] The PCIU Senior social specialist will carry out training of FMS social officers and project officers on complaints handling and reporting.

50. A Grievance Committee (GC) will be established at both levels of the Federation within 2 months of effectiveness, consisting of the project coordinator, and relevant staff, with the social safeguards' specialist acting as the secretary to the meeting and taking minutes and follow up the grievance resolution process. 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. Such complaints should be highlighted in the regular reports to the World Bank.

51. The FGS MoH PCIU will initially brief all its staff, and the staff of the line ministries at FMS level, on the GM procedures and formats to be used including the reporting and resolution processes. A public awareness campaign will be conducted to inform all communities and staff on the mechanism. A one-pager will be developed providing summary details on the GM, while a poster and leaflet will be produced for ease of reference. Various mediums will be used to sensitize the communities on the project GM 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 physical address for further information. The GM will be represented in simple visual formats as well as in Somali dialects, as needed.

52. The GM will include the steps and indicative timelines shown in Table 6.

Table 6. Tentative GM timelines

| No | Steps to address the grievance | Indicative timeline* | Responsibility |
|---|---|---|---|
| 1 | Receive, register and acknowledge complaint in writing. Serious complaints immediately reported to the coordinator 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. |

[3]It is however notable that it may be difficult to fully resolve a personal grievance if the complainant is completely anonymous.

| 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 | Coordinator 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 | Coordinator supported by PCIU. |
| 4 | Implement the case resolution and provide feedback to the complainant. | Within 21 days | Coordinator 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 |

53. The GM will provide an appeal process if the complainant is not satisfied with the proposed resolution of the complaint. Once all possible means to resolve the complaint has been proposed and if the complainant is still not satisfied then he/she should be advised of his/her right to legal recourse.

54. It is important to have multiple and widely known ways to register grievances. Anonymous grievances can be raised and addressed. Several uptake channels under consideration by the project include:
    - Toll-free telephone hotline / Short Message Service (SMS) line;
    - E-mail;
    - Letter to Grievance Focal Points at local health facilities and vaccination sites;
    - Complaint form to be lodged via any of the above channels; and
    - Walk-ins may register a complaint on a grievance logbook at healthcare facility or suggestion box at clinic/hospitals.

<u>Grievances Related to GBV/SEAH</u>

55. To avoid the risk of stigmatization, exacerbation of the mental/psychological harm and potential reprisal, the GM shall have different channels and protocols to enable a confidential and sensitive approach to GBV related cases that ensures the safety of survivors and enables survivor-centred care. These procedures are contained in the SEAH Prevention and Response Plan as provided for in the SocMF for this project.

56. 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, radio and other means of communication modalities will be used. The information shared will include messages on GBV/SEAH risks related to the project and potential response services (such as hotline numbers and where to seek services).

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

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

    Corso Somalia Street,
    Shangaani District,
    Mogadishu, Somalia,
    Email: info@moh.gov.so,
    Url: http://moh.gov.so

Grievance Management Process

59. Grievance resolution requires localized mechanisms that take into account the specific issues, cultural context, local customs and tradition, and project conditions and scale. The following is the outline of the grievance process to be followed (the structure is illustrated in Figure 3):
    - Receive, register and acknowledge complaint (see Annex 5) for a Grievance Registration Form Template.
    - Screen and establish the basis of the grievance (e.g. nuisance complaint may be rejected but the reason for the rejection should be clearly explained to the complainant);
    - GRC to hear and resolve the complaint.
    - Implement the case resolution or the unsatisfied complainant can seek redress at a formal court of justice.
    - Elevation of the case to a formal court if complainant is not satisfied with the GRC resolution; and
    - Document the experience for future reference.

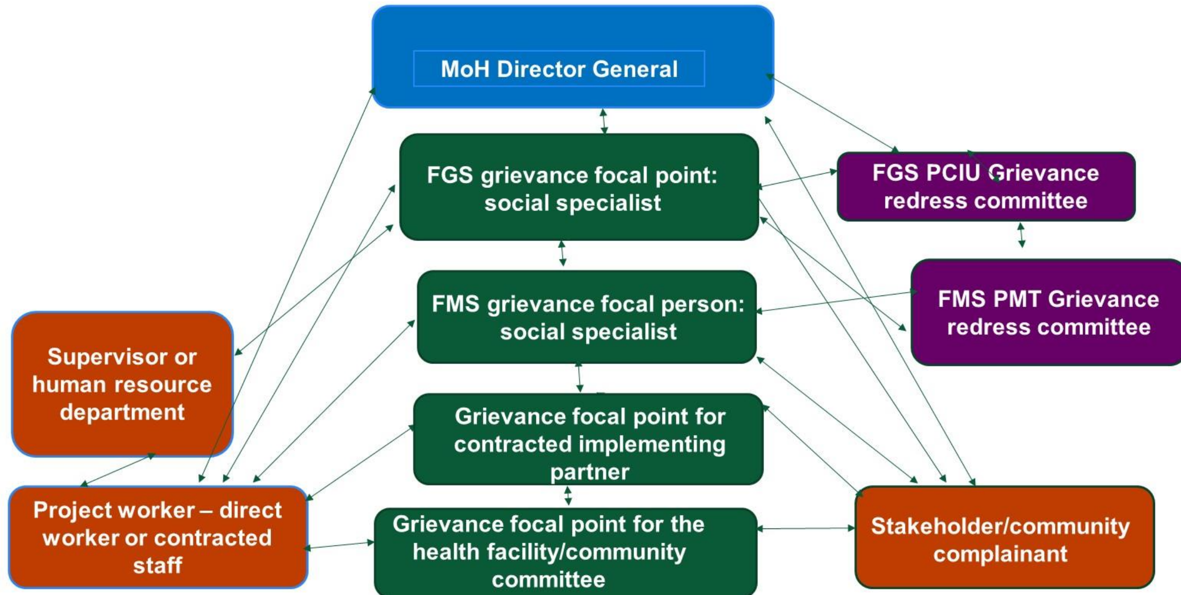


Figure 3: Grievance management flow chart

**World Bank's Grievance Service**

60. **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.
**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

61. 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 complaints 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

### 7.1. Involvement of stakeholders in monitoring activities

62. The overarching implementation and monitoring of the stakeholder engagement plan will be 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 part of their ESMP submitted with their bidding documents. The Project Coordinator of the project will ensure that the objectives of the ESMP 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 TPM.

63. The FGS MoH 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), CSOs, 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 it conducts the Mid-Term and Terminal Evaluation, and the TPM when collecting beneficiary feedback). Means of verification: impact and satisfactory assessments as part of project evaluation.

### 7.2 Reporting back to stakeholder groups

64. The SEP will be periodically revised and updated as necessary in the course of project implementation in order to ensure that the information presented herein is consistent and is the most recent, and that the identified methods of engagement remain appropriate and effective in relation to the project context and specific phases of the development. Any major changes to the project related activities and to its schedule will be duly reflected in the SEP. Monthly summaries and internal reports on public grievances, enquiries and related incidents, together with the status of implementation of associated corrective/preventative actions will be collated by responsible staff and referred to the senior management of the project. The [monthly] summaries will provide a mechanism for assessing both the number and the nature of complaints and requests for information, along with the Project's ability to address those in a timely and effective manner. Information on public engagement activities undertaken by the Project during the year may be conveyed to the stakeholders in two possible ways:

- Publication of a standalone annual report on project's interaction with the stakeholders.
- A number of Key Performance Indicators (KPIs) will also be monitored by the project on a regular basis, including the following parameters:[4]
    a. *number of public hearings, consultation meetings and other public discussions/forums conducted within the quarterly reporting period;*

b. *number of studies/survey showing reduced vaccination hesitancy particularly in the target groups reached;*
c. *number of public grievances received within the quarterly reporting period and number of those resolved within the prescribed timeline;*
d. *number of press materials published/broadcasted in the local, regional, and national media]*

## ANNEXES

### ANNEX 1: Consultation meeting held with key stakeholders

**Date:** 26th July 2021 (to be completed)
**Meeting Mode:** Zoom
**Objective:** to get input and suggestions on improving the social and environmental instruments for **the Covid 19 Emergency Vaccination** Project.

**Participants:** representatives of disadvantaged groups, target groups, and different NGOs working on behaviour change communication, and Covid 19 throughout Somalia

**Agenda**

| Time | Session | Lead |
|---|---|---|
| 9-9.15 | Opening and introduction to the Covid 19 Emergency Vaccination Project. | MoH |
| 9.15-10.15 | Social risks, Stakeholder Engagement Plan, Labor Management Procedures, Security management framework | |
| 10.15-10.30 | Health break | |
| 10.30-11 | GBV/SEAH action plan | |
| 11-11.30 | Environmental risks and mitigation measures | |
| 11.30-12.30 | Discussion on social and environmental risks and mitigation measures | |

**Participants List**

| NON-GOVERNMENTAL ORGANIZATIONS/CIVIL SOCIETY ORGANIZATIONS | | | | |
|---|---|---|---|---|
| **Regional state** | **Person in charge** | **Institution name** | **Location** | **Email** |
| **Multi-regional** | | | | |
| Somalia NGO consortium – to invite health sector NGOs covering Puntland, SWS and Hirshabelle | Dulmar Farah | Communications and Membership Manager | Nairobi/ Mogadishu | Email: dulmar.maalim@care.org<br>Tel: |
| People living with disability rep | Abdifatah Mohamed Dahir | Disabled Welfare Foundation | | Email: dwfsomalia@gmail.com<br>Tel: +252612592726 |

| Minority group rep | Ibrahim Hassan Mohamed (Qorsheeye) | General Director MCA-Network/MVTC Network of marginalized and vulnerable groups | Mogadishu | Email: mcadvocates.somali@gmail.com |
|---|---|---|---|---|
| Women and health groups including NGOs, CSOs, faith groups, academia | Abdirizak Rashid /Ahmed Abdinasir | Save Somali Women and Children | Mogadishu | Abdirashid- Email: rashid@sswc-som.com +252617720727<br>Ahmed- Email: ahmednasir@sswc-som.com +252616954039 |
| Organizations involved in social accountability and grievance redress | Mohamed Aded Ali (Shire) | Executive Director Somalia Non-State Actors (SONSA). CSO umbrella body. | Mogadishu | Email: executivedirector@soscensa.org |
| Women and health groups including NGOs, CSOs, faith groups, academia | Amina Arale | Somali Women Development Centre | Mogadishu | swdc.org@gmail.com / +252615565518 |
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| Concern International | Mandeq Abukar | Nurse/Safeguards Team | | mandeq.abukar@concern.net |
| Population Services International | | | Mogadishu / Garowe | kchukwumalu@psi.org<br>ihassan@psi.org |
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| Save the Children | Ahmed Omar Ibrahim | Area representative | Mogadishu | Ahmed.ibrahim@savethechildren.org |
| Danish Refugee Council (DRC) | Eliab Mulili | | Mogadishu | Eliab Mulili / e.mulili@drcsomalia.org / +254722332668<br>Jim Kangichu / j.kangichu@drcsomalia.org / +252907560635 |
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| **Southwest state** | Mohamud Sheikh | Iniskoy for Peace and Development Organization (IPDO) | Baidoa | Email: info@iniskoy.org |
| | Alinur Ali Aden | GREDO | Baidoa | alinur.aden@gredosom.org |
| | Iman Abdullahi. | CARE Somalia | Baidoa | Email: iman.abdullahi@care.org Tel: +252 634000310 |
| | | Breast Feeding Promotion and Protection Support Consortium | Baidoa | Email: Info@bpsc-consortium.org; / bpsc.network@gmail.com. |
| | | Somali Vulnerable Actors | Baidoa | Osman Ibrahim Mohamed / sovasomalia@yahoo.com / +252613136818 |

| | | | | |
|---|---|---|---|---|
| | Dahir Mayow | DREDO | Wajid, Xudur, Tayeglow | Dahir Mayow Muktar, Tel 0615010005 |
| | Adan Ali | SCWRD | Wajid, Xudur, Tayeglow | Adan Ali Tel 0615928661 |
| | Hassan Ibrahim Gedi | African Relief and Development | Xudur; Waajid, Rab Dhuure | Hassan Ibrahim Gedi / ard.relief@gmail.com / 252616565703 |
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| | | WARDI Relief & Development Initiative | Jowhar | Email: wardiorg@yahoo.com<br>Tel: +252615522780, +252618112528 |
| | | HIWDO Family Care (Hiiran Women Development | Beledweyne | Dahir Dhi'isow Tel. 0615109151; E-mail: hwdfamilycare@gmail.com |
| | | Rajo Relief and Development Organization | Beledweyne | Farah Hassan Mohamed Tel. 0615536247 E-mail: rrdo99@gmail.com; |
| | | SHARDO | Bal'ad health center | Hassan Shariff, Tel. +252615563994<br>shardo@shardo.org |
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| | | PUNTLAND MINORITY WOMEN DEVELOPMENT ORGANIZATION | | Email: pmwd2000@gmail.com; Tel:.+252907795960, 252907795961<br>Alternative Email: pmwd2000@yahoo.com, pmwd2000@hotmail.com |
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| | | Somali Young Doctors Association | | Ibrahim Abdulkadir / somyoungdoctors@gmail.com / +252615881993 |
| | | SIDRA | | Dr. Said Aden<br>said.aden@sidrainstitute.org<br>director@sidrainstitute.org |
| **GOVERNMENT AGENCIES** | | | | |
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| Civil Service Commission | Hassan Abshirow | Chairperson | Mogadishu | Email: |
| FGS MoH | Abdisalam Abdullahi Mohamud | HSS/Community Health Coordinator (Community health safety (RCRF)) | Mogadishu | Email: hss@moh.gov.so |
| FGS MoH | Zahra Ali Barre | National GBV Manager (Member – supporting GBV information and planning) | Mogadishu | Email: gbv@moh.gov.so |

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| FGS MoH | Ibrahim Mohamed Nur | Director of Human Resources for Health | Mogadishu | Email: hr@moh.gov.so |
| FGS MoH | Mohamed Aweis | Head of Occupational Health and Safety (OHS) | Mogadishu | Email: occhealth2020mog@gmail.com |
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| FGS MoF (RCRF) | Adow Mohamed Adan | Social Safeguards Specialist | Mogadishu | Email: adow46@gmail.com |
| FGS MoF (RCRF) | Ali Adan Hassan | RCRF Project Secretary FGS-MOF | Mogadishu | Email: sirali.adan@gmail.com |
| MoH reps for Puntland, SWS and Hirshabelle | | | | |
| MoLSA reps for Puntland, SWS and Hirshabelle | | | | |
| Representative from the Crisis recovery project | Nasra Hassan;<br>Eng. Barre;<br>Halima;<br>Ali Haji | | | Nasra Hassan – nasra.scrp@gmail.com; Eng Barre – engbarre.scrp@gmail.com; Halima – halima.scrp@gmail.com; Ali Haji – alihaji.scrp@gmail.com |
| Ministry of Labour and Social Affairs | Fardowsa Abdullahi | | | Email: dowsaahmed79@gmail.com |
| Other MOH Staff / Colleagues: FMS and FGS | | | | dg.moh@plstate.so;<br>dg-moh@jubalandstate.so;<br>dg@moh.gm.so;<br>dr.hussien114@gmail.com;<br>tahlilibra2@gmail.com;<br>abdinurkamar@gmail.com;<br>hmis@moh.gov.so<br>coordination@moh.gov.so<br>communication@moh.gov.so |

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| **Additional stakeholders** | | | | |
| Somali Union for the Blind Somali National | Blind | | | somaliunionfortheblind@gmail.com |
| Disability Council | Disability | | | ndc.somalia@gmail.com |
| Somali Women Disability | Women disability | | | uwd01@hotmail.com |
| Somali Association Female with Disability | Women disability | | | safdi.somalia@gmail.com |
| Somali Association for the Deaf | Deaf | | | sonad.deaf@gmail.com |
| Somali National Association of the Deaf | Deaf | | | sonaddeaf@gmail.com |
| Somali Disability Journalists Association | Disability journalists | | | shaaciye011@gmail.com |
| Media | SNTV | Agg: Sharma'arke Maxamed Warsame | | director.sntv@moi.gov.so |
| | Sportlight | Abdullahi Mohamed | | info@sportlight.so |
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| | Banadir University | Dr. Tahliil (dean faculty medicine) | | dean-medicine@bu.edu.so |

**Environmental and Social concerns raised during the workshop and suggested mitigation measures**

| Environmental and Social Risks | Mitigation measures |
|---|---|
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## ANNEX 2: Consultationm Meeting held on July 26, 2021

**MEETING NOTES**

**CONSULTATION WITH STAKEHOLDERS ON SOMALIA COVID-19 EMERGENCY VACCINATION PROJECT**

### 1. Meeting participants

This was a virtual meeting coordinated by the Federal Ministry of Health (MoH) and conducted via zoom. It was attended by 35 participants as shown in Table 1.

**Table 1: List of participants**

| # | Name | Position and place of work |
|---|---|---|
| 1. | Abdirahman Taysiir | Radio Ergo Editor |
| 2. | Abdirahman Zeila | Environmental Specialist, WB |
| 3. | Abdiweli MDR | |
| 4. | Abdullahi Abdihakim | FMoH public health director |
| 5. | Ayan Said | RCRF GBV Expert |
| 6. | Bernard Olayo | Task Team Leader, World Bank |
| 7. | Bile Abdi | Communications, National Institute of Health and MoH |
| 8. | Coletta Aoko | Program Development Coordinator, IMC |
| 9. | Dr. Abdiwali Ahmed | DG, Galmudug MoH |
| 10. | Ibrahim Hassan | Marginalized Communities Advocates Network (MCAN) |
| 11. | Khamar Abdirahman | World Bank Health and Nutrition Consultant/Project Management Consultant |
| 12. | Kingsley Chukwumalu | CoP, FHW, PSI |
| 13. | Louise Tunbridge | International Media Support (IMS) Somalia Programme and Radio Ergo Coordinator |
| 14. | Maksim Faslitdinov | OIC for C4D, Unicef Somalia |
| 15. | Mary Nyamongo | Social Specialist, World Bank |
| 16. | Matilda Cherono | |
| 17. | Meena Bhandari | Senior Advisor, C4D (COVAX), Health Team, Unicef Somalia |
| 18. | Mohamed Ali Magan | Save the Children |
| 19. | Mohamed Derow | Ministry of Health |
| 20. | Mohamed Hassan | |
| 21. | Mohamed Hussein | International Medical Corps |
| 22. | Mohamed Samantar | CEO, SIDRA |
| 23. | Mohammed Derow | Head of Public Health, Emergency and Surveillance |
| 24. | Muhumed Hussein | Social Safeguards Specialist, World Bank |
| 25. | Mukhtar Bulale | Public Health Specialist |
| 26. | Nur Ali Mohamud | Director of Planning, MOH |
| 27. | Omar A. Mohamed | Save the Children |
| 28. | PAhmed | |
| 29. | Said Mohamoud | Senior Researcher, SIDRA Institute |
| 30. | Samantar | |
| 31. | Shair Ibrahim | GBV Consultant, World Bank |
| 32. | Walid Abdulkadir Osman | Associate Dean, Faculty of Health Sciences, Mogadishu University |
| 33. | Colleta Odera | |
| 34. | Tahlil Ibrahim | Hirshabelle MoH DG |

| 35. | Abdiweli Mohamed | Galmudug MoH DG |
|---|---|---|
| 36. | Hussein Mohamed | Southwest MoH DG |
| 37. | Abdirizak Hersi | Puntland MoH DG |

## 2. Objectives

To receive key stakeholders' input into proposed framework for management of the project-level environmental and social risks in order to mitigate environmental and social risks and to strengthen its positive impacts and outcomes of the Somalia COVID-19 emergency vaccination project.

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: Labour 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 that the World Bank requires that all Bank funded projects consider the potential environmental risks and impacts that a project may generate. The Federal Ministry of Health (MoH) is obliged to ensure that adverse environmental risks and impacts are avoided, minimized, managed and mitigated. The meeting was therefore called as part of ESS 10 on stakeholder consultation.

## 3. Project instruments

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

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

| Instrument | Purpose | Key issues for consideration |
|---|---|---|
| SEP | 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, minority groups* and castes etc.<br>2. Behavior change communication strategy to address vaccination hesitancy especially for priority groups.<br>3. Stakeholder feedback surveys: TPM, Communication effectiveness<br>4. Grievance Redress Mechanisms (GRM): accessible, trusted, functional and confidential.<br>5. Complaints: focal points at vaccination sites, UNICEF, WHO and PCIU<br>6. Separate channels for reporting incidents through GRM: project, direct workers, and GBV/SEAH cases. | 1. What is working so far to promote vaccination uptake among priority groups: health and frontline workers; elderly, people with co-morbidities especially in hard to reach areas?<br>2. How best to overcome vaccine hesitancy particularly among hard to reach and disadvantaged groups including: minority groups: women, IDPs, nomadic pastoralists. Are different approaches needed in different FMS?<br>3. How best to get stakeholder feedback on project implementation at FGS and FMS levels?<br>4. Who and how can complaints be received and resolved impartially and confidentially, including from workers and regarding sexual harassment, exploitation and abuse: |

| | | |
|---|---|---|
| | 7. Disclosure: All key documents with Somali summary will be publicly disclosed on MoF/H and WB websites | a) During vaccination campaigns?<br>b) At FMS and FGS level? |
| ESMF | 1. Outlines all environmental and social risks and mitigation measures and provides an overview of all instruments including ones not yet prepared.<br>2. Policy environment and institutional framework<br>3. Framework for vaccine logistics – and its implications<br>4. Roles and responsibilities – MOH, WHO, UNICEF<br>5. Capacity assessments of FGS MOH, UN partners, orientation and training plan<br>6. Staffing – FGS: environment, social and GBV specialists, security?<br>7. ESIRT incident reporting<br>8. Medical waste and infection control plan for the vaccination program<br>9. SEAH Prevention and Response Action Plan<br>10. Monitoring and reporting – who will monitor and report E&S issues?<br>11. Budget | 1. What are the potential risks from implementing this project?<br>2. What measures should be put in place to ensure that the identified risks are addressed and mitigated?<br>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)?<br>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? |
| LMP | 1. All workers involved with delivering the project: Prevention of *forced and child* (under 18) labour; Occupational health and safety concerns including security protocols and protection from GBV and infectious diseases;<br>Need: training including security personnel, code of conduct and access to project GRM, GBV/SEA/SH<br>2. Direct workers: PIU staff & contracted workers:<br>a. Promote *fair treatment, non-discrimination* & equal opportunity.<br>b. Measures to *prevent and address harassment, intimidation, and/or exploitation.*<br>d. Provide *accessible means to raise workplace concerns*/ grievance redress including GBV/SH – *confidential and non-retaliation* | 1. Responsibilities for workers involved in vaccination from NGOs, private sector for security, CoCs, training on OHS requirements and monitor requirements at vaccination site. How's its being done now?<br>2. Do vaccination teams have adequate PPE? Are they paid on time, for overtime, CoC's, awareness on complaints mechanism?<br>3. How good are the procedures for entry into health care facilities, including minimizing visitors and undergoing strict checks before entering;<br>4. How is security managed at health facilities given publicly advertised amassing of people and AS ban? Has there been follow-up action by AS on the continued vaccination<br>5. What security system is used at vaccination sites? For travel? How will security forces be oriented in use of force and GBV prevention etc. |
| SEAH Plan | 1. Define and reinforce GBV/SEAH requirement s in procurement processes and contracts<br>2. Review the Implement Agencies' capacity to prevent and respond to GBV/SEAH | 1. Are there additional risks that have been left out and might exacerbate the risks of GBV/SEAH within the project? |

| | 3. Inform project stakeholders about GBV/SEA risks<br>4. Establish GBV/SEAH sensitive channels for reporting in the GM | 2. What additional mitigation measures can be put in place to prevent SEA/SH<br>3. be put in place to address GBV/SEAH allegations in the project? |
|---|---|---|

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

**Table 3: Key environment and social risks**

| # | Theme | Risks |
|---|---|---|
| 1. | Environment | • Vaccine storage and transportation and vaccine cold chain logistics<br>• 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<br>• 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<br>• 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 | • Vaccination hesitancy: increased misinformation, household and community tensions over vaccination acceptance<br>• 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.<br>• Security risks: targeting e.g. by AS, lack of community buy in<br>• Labour risks: Covid, long hours, delayed remuneration; nepotism<br>• GBV/SEAH: harassment including in exchange for vaccine or prioritization, travel to vaccination sites; security personnel;<br>• Grievance mechanism: no trusted, accessible mechanisms, and fear of retribution |
| 3. | GBV/SEAH | • Potential abuse of power and sexual exploitation in labour practices<br>• High risks related to limitations on mobility during vaccine rollout in remote areas<br>• Unequal gender and power relations can exacerbate the risks of GBV in vaccination points.<br>• Misinformation or lack of information throughout the project's components can lead to harm and violence towards the communities<br>• Vaccine shortages and rationing might contribute to increased risks of sexual abuse and harassment |

## 4. Discussion

The issues presented in Table 4 were raised during the discussion and responded to.

**Table 4: Issues raised and responses**

| Theme | Issue | Response |
|---|---|---|

| | | |
|---|---|---|
| GBV/SEAH | There was an issue on the focus of the project on GBV/SEAH but there was no evidence that the demand for the vaccine would be a lot to create room for exploitation on the basis of gender | UNICEF and WB responded that although there is no evidence that GBV/SEAH may occur on the project, the SEAH Prevention and Response Plan is a safeguards measures to ensure that this does not happen, and when (if) it happens the Government would be prepared.<br>There is also a possibility that following communication and mobilization activities, the uptake of the vaccine could increase and overwhelm the system. Global supply is also limited hence the need to plan |
| Hesitancy | There has been good uptake of the vaccine already and although there are reports of hesitancy, it should not be a big problem to hinder the people from being vaccinated | Hesitancy is a global problem and should be addressed through the communication and community mobilization activities. There would be a need for leaders and other influencers to take the vaccine publicly and become advocates for the program. |
| Security | Although there are threats from Al Shaabab, the country leadership is able to deal with this risk so it should not be a big problem | Due to the need for inclusion, the government will be tasked with providing security for the vaccination team and the users. |

It is notable that there was limited time for discussion during the meeting, hence the team prepared an information collection form that was shared with the participants for input.

**5. Questions for further consultation**

To enable the MoH to develop effective environmental and social risk management strategies, the project team is seeking additional input from the key stakeholders. The participants are being asked to consider the following key questions and comment on any other aspect of the project.

**Stakeholder engagement**

i. What is working so far to promote vaccination uptake among priority groups: health and frontline workers; elderly, people with co-morbidities especially in hard to reach areas?
ii. How best to overcome vaccine hesitancy particularly among hard to reach and disadvantaged groups including: minority groups: women, IDPs, nomadic pastoralists. Are different approaches needed in different FMS?
iii. How best to get stakeholder feedback on project implementation at FGS and FMS levels?
iv. Who and how can complaints be received and resolved impartially and confidentially, including from workers and regarding sexual harassment, exploitation and abuse:
    c) During vaccination campaigns?
    d) At FMS and FGS level?

**Environmental and social risks in general**

i. What are the potential risks from implementing this project?
ii. What measures should be put in place to ensure that the identified risks are addressed and mitigated?
iii. 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)?
iv. 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?

**Environmental risks**

i. What are the key environmental risks of concern to the country?
ii. What are some of the key gaps in management of waste (as experienced with the ongoing vaccination program)?
iii. What measures should be put in place to mitigate this risk building from the ongoing project?

**Social risks**

i. Vaccination hesitancy: what are the key drivers? What can we do to address these drivers?
ii. Lack of inclusion: What strategies can be used to reach hard to reach/marginalized areas?
iii. Security risks: what measures could be used to address security risks for workers/vaccinators and other workers?
iv. Grievance mechanism: how can the program operate a trusted, accessible mechanisms, and fear of retribution?

**Labour management issues**

i. Responsibilities for workers involved in vaccination from NGOs, private sector for security, CoCs, training on OHS requirements and monitor requirements at vaccination site. How is this being done currently?
ii. Do vaccination teams have adequate PPE? Are they paid on time, for overtime, CoCs, awareness on complaints mechanism?
iii. How good are the procedures for entry into health care facilities, including minimizing visitors and undergoing strict checks before entering?
iv. How is security managed at health facilities given publicly advertised amassing of people and AS ban? Has there been follow-up action by AS on the continued vaccination
v. What security is used at vaccination sites? For travel? How will security forces be oriented in use of force and GBV prevention etc.

**Sexual exploitation and abuse/sexual harassment**

i. Are there additional risks that have been left out and might exacerbate the risks of GBV/SEAH within the project?
ii. What additional mitigation measures can be put in place to prevent SEA/SH
iii. be put in place to address GBV/SEAH allegations in the project?

**General considerations**

i. What experiences and lessons have you learnt in the implementation of similar interventions (especially those funded by the World Bank)?
ii. What other stakeholders do we need to consult?
iii. What is the most effective way to hold consultations with project beneficiaries, share information and get feedback in the context of COVID-19?
iv. What other issues should be considered by the MoH in implementing this project?

## ANNEX 3: Example complaints form

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 4: Example 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 5: Example complaints reporting form

**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 6: References

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