FEDERAL REPUBLIC OF SOMALIA

MINISTRY OF HEALTH (MoH)

IMPROVING HEALTHCARE SERVICES IN SOMALIA PROJECT
'DAMAL CAAFIMAAD'

STAKEHOLDER ENGAGEMENT PLAN (SEP)

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1. INTRODUCTION

1. Somalia's health indicators remain among the worst in the world, with an average life expectancy of fifty-six years. These indicators lag behind those in the WHO AFRO and select, comparable Fragility, Conflict, and Violence (FCV) impacted countries in EMRO regions. Somalia suffers from high levels of mortality especially among children, underlined by stunting, high fertility, high maternal mortality, low school enrollment, and limited public and private sector financial protection mechanisms. The country's high poverty rates further compound low human capital as poverty limits opportunities for people to access basic services, exacerbating poor education and health outcome. In addition, the country is faced with the impacts of cyclical floods and droughts, together with protracted and ongoing armed conflict that has displaced more than 2.6 million people internally. The interlinkages between climate and environmental change, cyclical drought, poverty, fragility, severe food insecurity, conflict, and the recent global COVID-19 crisis will further strain the already-fragile healthcare system.

2. **"Improving Healthcare Services in Somalia Project",** also known as ***"Damal Caafimaad",*** is expected to run from May 2021 to June 2025 in selected geographical areas in Somalia. With an overarching Project Development Objective (PDO) to "*improve the coverage of essential health and nutrition services in project areas and strengthen stewardship capacity of Ministries of Health*," the project seeks to scale up high-impact health services across the population in project target regions and develop the Federal and State Ministries' of Health capacity to act as stewards of the health sector, effectively governing and building core functions that will enable the Government to lead and manage the sector. The criteria for geographic selection is based on objective criteria, including population size, accessibility (based on 2019 Polio program accessibility data), poverty data from the Somalia High Frequency Survey (SHFS), health service delivery data from the Somalia Health and Demographic Survey (SHDS), and current partner support.

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

4. The development of this Stakeholder Engagement Plan (SEP) is critical for environmental and social (E&S) risk management in the Damal Caafimaad project. It outlines how different stakeholders will be engaged throughout the project cycle and provides mechanisms for their feedback to be used to improve project implementation. The SEP will entail the identification and analysis of key stakeholders (including disadvantaged groups), their characteristics and interests, and the methods of communication, engagement, and consultation that are appropriate for different groups of stakeholders. The SEP will outline the type of information to be provided to and collected from different groups to facilitate their meaningful engagement in identifying, monitoring, and mitigating E&S risks associated with project implementation.

5. 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 on the project. After each substantial engagement, the government will summarize key feedback and share it with relevant project teams and contractors to incorporate

as appropriate to improve project performance. Stakeholders will be notified of the responses to the feedback and/or grievances. The Project Implementation and Coordination Unit (PCIU) at the FGS Ministry of Health (MoH) and the Project Management Team (PMT) at the FMS MoH level will keep updated documentation on the engagements and the actions taken as a result of the feedback.

2. PROJECT DESCRIPTION

6. In alignment with the PDO to "*improve the coverage of essential health and nutrition services in project areas and strengthen stewardship capacity of Ministries of Health*," the Project will support the delivery of a package of health services to beneficiaries, which includes procurement of health commodities (including medicines), procurement of key equipment, developing capacity of the regional level to manage health service delivery including support for HMIS, and supportive supervision. Delivery of prioritized, essential health services will result in improved quality and availability of health services, followed by uptake of quality health services. In the long term, improved coverage of quality health services will lead to improved health outcomes among Project beneficiaries.

7. In addition, the Damal Caafimaad project aims to respond to the institutional, operational, and technical capacity needs in Somalia's Ministries of Health (MoHs). At the request of the Federal Ministry of Health (FMoH), this project will strengthen the FMoH public financial management capacity (PFM) in fiduciary and contract management in the short, medium and long-term. Short-term activities will be supported during project preparation using WB executed financing, and longer-term activities will help build credible PFM systems in Somalia's MoHs in a consistent and phased approach.

8. **T**he project will have four components as described in the sections below:

(i) **Component 1:** Expanding the coverage of high-impact health and nutrition services in select geographic areas;
(ii) **Component 2:** Strengthening Government's stewardship to enhance service delivery;
(iii) **Component 3:** Project Management and Knowledge Management and Learning;
(iv) Component 4: Contingency Emergency Response Component (CERC);

9. **Component 1:** Expanding the coverage of high-impact health and nutrition services in select geographic areas; will finance delivery of essential health and nutrition services to enhance service coverage and quality, focusing on: (i) child health services (routine immunization, micronutrient supplementation, promotion of infant and child feeding and nutrition referral); (ii) maternal and neonatal health services, including testing and interventions during ANC visits, basic and comprehensive emergency obstetric and newborn care (BEmONC and CEmONC), and family planning; (iii) gender-based violence (GBV) services (awareness raising, case identification, counselling, and management); and (iv) disease surveillance (strengthening and maintaining disease surveillance and response as well as preparedness and response to disease outbreaks) in selected geographic areas.

10. Three potential delivery platforms are envisaged for expanding the coverage of high-impact health and nutrition services in select geographic areas:

- Contracting service delivery to non-state actors: Considering limited service delivery capacity in the public sector, the Government has agreed that the main health service delivery modality under the proposed Project will be Government contracting of health services in public facilities, to be implemented by NGOs. This is likely in the South-west State, Hirshabelle, and Puntland, and will involve contracting experienced partners, especially where there is lacuna in services by the government;
- Strengthening government service delivery system to expand service coverage: this is likely in selected regions of Puntland, where there is existing government service delivery capacity; and
- In urban areas, the Project may support Government contracting of private sector networks as a pilot. This modality aims to facilitate effective Government engagement with private sector service providers to enhance delivery of high-impact health and nutrition services in select geographic areas.

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

Sub-component 2.1: HMIS and Data Use for Decision Making: The HMIS and data use subcomponent aims to improve data timeliness, quality, and use of DHIS2 to contribute to the long-term goal of ensuring a high-functioning health information system producing regular, quality and reliable data that are used for routine decision making.

Sub-component 2.2: PFM, Contract Management and Health Financing: The PFM, contract management and health financing subcomponent will build Government contracting capacity and strengthen efficient resource use and accountability to mitigate fiduciary risks. PFM and contract management support will build off interim support financed by the World Bank during project preparation to address immediate PFM needs in the FMoH and develop initial contracting systems to accelerate project implementation.

Sub-component 2.3: Private Sector Development and Regulatory Reforms: The private sector development and regulatory reform subcomponent will improve quality of health services delivered by the private sector through private sector networks, setting up basic regulatory and accreditation systems with a focus on the health workforce as well as health products and devices to improve quality of care. At the FGS level, the focus will be on the development of national regulatory bodies and regulations, and at the FMS level, the focus will be on development of registration and compliance units.

Sub-component 2.4: Organizational Development: The organizational development subcomponent will support development of systems and process for decision making, internal information sharing, internal communication, external communication, and information storage/record keeping; and enhancing capacity for planning, learning and review including development and implementation of systems and processes for regular review and learning.

12. Component 3: Project Management and Knowledge Management and Learning; will support day-to-day project management including coordination, administration, communication, management, procurement, M&E, and dissemination of project activities at both FGS and FMS levels. To this end, the component will finance the following activities: (i) supervising, coordinating, and providing oversight for project implementation facilitating; and (ii) learning and knowledge sharing across and within FGS and FMS. The component will also support the cost of specialists necessary for project management.

13. Component 4: Contingency Emergency Response Component (CERC) – This component is a zero cost component known as a Contingency Emergency Component (CERC). It will provide immediate surge funding in the event of a public health emergency, such as a disease outbreak and is included if the need to reallocate funds arises. This component will only be triggered in the case of a public health emergency and when certain actions, as agreed by the Government and Bank teams, are met.

A summary of the project will be developed in Somali and published on the FGS Ministry of Health website.

3. STAKEHOLDER IDENTIFICATION AND ANALYSIS

14. The project will engage a large and diverse array of stakeholders during planning and implementation. The FGS and the participating FMS will be responsible for project implementation and management, together with contracted implementation partners, who will implement the EPHS services 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 involved regularly through the life of the project. Additional diverse groups such as private sector health service providers, international NGOs working in the health sector, and civil society groups, 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.

15. Special consideration will be taken to ensure that women, youth, minority groups, and persons living with disabilities will be represented amongst the stakeholder groups. Various other stakeholders such as religious leaders, clan elders and opinion leaders - who may influence the perception and uptake of health services and involvement of women in the project, will also be engaged.

16. For the purposes of effective and tailored engagement, stakeholders of the proposed project and sub-projects can be divided into the following core categories:

- **a** **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;
- **b** **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
- **c** **Disadvantaged and vulnerable Groups:** persons who may be disproportionately impacted or further disadvantaged by the project as compared with other groups due to their vulnerable status and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making processes associated with the project. These may include people living with disabilities, minority groups, IDPs, nomads, etc.

3.1 Affected Parties

17. This section of the document identifies the affected parties (i.e. stakeholders and others affected) at both the federal level and federal member state levels, and their relevance and needs can be classified as summarized in Table 1.

Table 1: Project affected parties

No	Project Stakeholders	Relevance to the Project	Needs
A: Directly affected parties			
1	Somali citizens such as community members who will benefit from the healthcare services (i.e. mothers, children, pregnant women, youth including those from disadvantaged and vulnerable groups e.g. IDPs, minority groups and nomads).	The Somali citizens who reside in the project locations 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. Their feedback about the project implementation is crucial to the overall success of the project and elicits views from disadvantaged groups and particularly from women themselves who are the main beneficiaries of the project. Provision of quality healthcare service for all members of the society (i.e. women and children, and VMGs) will lead to a healthy and prosperous population.	To be consulted and be informed about the potential environmental and social risks of the project - in order to address and mitigate, as possible. To contribute their feedback and concerns about the implementation of the project.
2	People and companies who will benefit from project-related employment (i.e. health workers, consultants, private businesses in the health sector).	These people ensure the provision of inclusive, accessible and quality services for all, ensuring that their human rights and dignity are respected	To be consulted and be informed about the potential environmental and social risks of the project - in order to address and mitigate them. To contribute their feedback and concerns about the implementation of the project.
3	The Ministry of Health and FMS line ministries, departments and government agencies directly supported by the project (i.e. ministries of health at both levels of the federation).	The main governmental ministries to be engaged with the project will be ministries of health at FGS and FMS level. These ministries are integral to the overall success of the project at all stages and are crucial to the establishment of the physical, technical, legal and regulatory framework of the project as well as providing the human resources. As a result of the project activities, the capacities of the ministries of health (both levels of the federation) will be strengthened. The ministries' feedback and cooperation throughout the project cycle is crucial to the overall success of the project.	To be consulted and be informed about the potential environmental and social risks of the project - in order to address and mitigate them. To respond and act on the feedback/suggestions provided by other stakeholders about existing risks. To create an easily accessible communications channels for other stakeholders to air their views. To address the grievances of other stakeholders.
	Traditional health providers e.g. Traditional birth attendants or healers.	May benefit from linkages with expanded coverage of high-impact health and nutrition services, e.g. antenatal visits and improved nutrition and care of expectant mothers and referral possibilities or may compete against them.	To be consulted and engaged in the project - in order to support its outcomes.

B: Other interested parties			
1.	International NGOs and bilateral donor agencies.	Development partners will have a convenient platform to provide technical advice and financial assistance and performance standards for service provision in the health sector. Engagement with these groups can improve coordination and avoid duplication of duties.	To learn about the project's activities, share information, lessons learned, and explore opportunities to maximize impact with similar projects.
2.	Civil society organizations (i.e. women and youth groups) and direct and indirect representatives of disadvantaged groups.	Civil society organizations especially those which work closely with 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.	To learn about the project's activities and to have a platform to advise on social risks management and mitigation.
3.	Elders, religious leaders, traditional health providers and opinion influencers including among VMGs who may influence uptake of health services	The community elders, religious leaders and/or traditional health providers can promote positive opinion towards services and articulate issues and amplify the voices of those who may be otherwise hard to reach or not empowered to raise issues. Given the role of religion in Somalia religious leaders can be important agents of change if engaged meaningfully.	To learn about the project's activities and to have a platform to advise on social risks management and mitigation.
C: Disadvantaged and vulnerable groups			
	Disadvantaged groups including: IDPs, persons with disabilities, and minority groups and their representatives	These disadvantaged groups have the most to benefit from accessing the health services under this project.	To contribute their feedback and concerns regarding project implementation and sharing of project benefits, through an easily accessible mechanism.

3.2. Description of Somali Disadvantaged and Vulnerable Groups

18. The ethnic identity of Somalis is informed by a complex history of clans and sub-clans, associations which form the primary organizing social unit, as well as the basis of the current political dispensation. The four major clans in Somalia are the Hawiye, Isaaq, Darod and Rahanweyn, with the Dir clan and other ethnic minorities making up most of the rest of the population. Marginalized communities in Somalia include ethnic minorities from the Bantu and Arabicized peoples as well as castes such as the Midgan. These groups have been traditionally marginalized from political life while also bearing the brunt of insecurity and economic decline since the collapse of the Somali State in 1991. Many of these communities can be found amongst IDP populations in urban areas as well as in rural areas including in areas controlled by Al-Shabab. In Al-Shabab-controlled areas, the local communities, including the marginalized groups, are often unable to access social services provided by the government or development partners, or are discriminated against in the provision of services and they are not included or have less voice in consultations and community decision making. During the planning and implementation of the proposed project, disadvantaged and vulnerable groups will be fully engaged.

19. Other disadvantaged and vulnerable groups include people living with disabilities, female headed householders, people who live far from towns in remote rural areas and those with low literacy levels. Given that in

health interventions men tend to be left out, there will be efforts made to ensure that they are consulted and their voices heard during all the stages of this project.

4. STAKEHOLDER ENGAGEMENT

20. The government will promote genuine stakeholder engagement to build mutual trust, foster transparent communication with both the project beneficiaries and other stakeholders, and ensure social and environment risks are identified and mitigated. In Somalia, consistent and meaningful dialogue with stakeholders is critical to maximize opportunities for the project's success, enhance project acceptance and ownership and improve the social contract between the government and its citizens and promote security.

21. The SEP and the citizen engagement platform will be implemented in such a way as to leverage the stakeholder engagements to further the goals of monitoring E&S risks while also setting mutual expectations, clarifying the extent of the government's commitments and resources, and obtaining feedback on activities. Lastly, the SEP will include a grievance mechanism (GM) to allow for the implementing partners and different levels of MoH to act upon complaints and suggestions for improvements in a timely manner.

4.1 Summary of stakeholder engagement done during project preparation

22. Engagement in the project design and the planned activities, and implementation arrangements have been carried out with relevant government agencies, development partners and non-government project-affected stakeholders. As part of the development of the SEP, the Social Management Frameworks (SocMF) and the EMF, a series of consultations were carried out with a diverse set of stakeholders including government staff, health workers, civil society and NGO staff, including 39 individuals, 6 of whom were women. The consultations provided valuable insights on potential E&S risks and mitigation measures related to the implementation of the "Damal Caafimaad" project as indicated in Annex 1. Due to the COVID-19 pandemic, these engagements were done virtually with stakeholders in the confirmed regions, and additional consultations will occur with remaining regions once they have been finalized. Once conditions permit, more in-depth stakeholder engagement to regularly validate the identified E&S risks will commence on the ground. The SEP will be a living document that is continuously updated based on the information provided via the various stakeholder consultations at different levels.

23. The implementing partners will develop a contractor-specific SEP as part of their E&S assessment and management plans (ESMP) contained in their bids, outlining how stakeholders will be engaged in the region where they are working. They will carry out consultations and dissemination of information about services throughout the region, at community and at regional levels via FM radio and social media. The consultation process needs to be culturally appropriate, non-discriminatory and gender sensitive and reach disadvantaged and vulnerable groups. It needs to ensure that all groups whose lives might be affected by the project are properly consulted to verify and assess the significance of social risks and that all affected groups are provided the opportunity to participate in the development of mitigation measures.

24. Given the context of fragility of Somalia, the social risk rating is <u>substantial.</u> The rating takes into account the weak governance institutions, continued insecurity, and conflictual socio-political dynamics that contribute to a myriad of social risks. Below is a list of the social risks been identified through the initial consultation process.

25. <u>Conflict and Security Risks</u>

- Though the country has made tremendous progress towards improving security in the country, insecurity remains an issue in many parts. Al Shabaab attacks and/or flare-ups of clan conflict in the project locations

are particularly likely to cause disruptions to the project particularly against government services and affiliated groups. Deteriorating security conditions in the project locations may hinder access and the ability to implement activities, and may pose a threat to workers and patients.

26. Exclusion and Selection Bias

- Recruitment of health professionals and consultants may be influenced by nepotism and clannism whereby people from minority groups, IDPs, and people living with disabilities may be excluded. In addition, people who live in remote rural areas may have limited access to services.
- People in senior positions at the MoH and relevant government agencies may set higher employment qualifications which may marginalize people from disadvantaged and vulnerable groups.
- Elite capture of project benefits, especially recruitments and contracts of private healthcare businesses, may limit project quality and inclusion.
- Inadequate female and disadvantaged group voices at senior management level.

27. Occupational Health and Safety (OHS)

- Health workers and other professionals under the project may be directly targeted by violent groups because of their affiliation with the government. This is a particular threat to those working near areas outside of government control and areas where people congregate, such as health centers and markets may also be targeted.
- Physical structures from which workers provide services to the community may not cater for females, or may not be discreet e.g. for family planning or GBV services, which may limit their accessibility for women.
- Health workers may be exposed to infections such as coronavirus, especially if they are not trained well, appropriate social distancing and sanitizing is not carried out and personal protective equipment (PPE) is not provided. Health workers and professionals operating at the Health facilities and district/regional offices, state level and federal level health ministries might be exposed to several emergency events including fire, shoot outs etc. and therefore need to be trained and equipped for first aid treatment.
- Communities and health service users may also be exposed to Covid-19 if the health protocols are not followed at the health facilities including hand washing/sanitizing, social distancing and wearing masks at all times. In addition, communities may be exposed to other infectious diseases such as sexually transmitted illnesses including HIV due to labor influx.
- The effects of the global Covid-19 pandemic have forced organizations to rethink how to implement programs that require human contact in Somalia. There is a limit on meetings and protocols have been widely distributed that limit the number of people and the length of engagement that have interfered with the manner and form of consultations.
- There is no clarity on how long the pandemic might last and this might delay project start and/or implementation, thereby denying communities access to healthcare.

28. Socio-cultural beliefs

- Since responsibility for household decisions mostly resides with men, women often have to seek their husbands' permission before they seek medical assistance at health centers, thus it is important to ensure that men understand the importance of healthcare services for women and children and trust the service provision, including by ensuring that female medical workers are an option and women are treated in a secure and culturally sensitive environment.
- Men tend not to be engaged in health interventions since the focus tends to be on women. There is however evidence that male involvement leads to better and sustained health outcomes as opposed to focus only on women. The project will need to deliberately focus on men as key stakeholders.

- Clan structures and cultural practices are believed to have a major impact on the utilization of formal healthcare services. Most communities in Somalia have high regard for traditional medicine (use of herbal medicinal products) due to its perceived value over conventional medicines. This has affected the popularity and the use of conventional medicines in many parts of Somalia. The traditional birth attendants continue to play a critical role in maternal and child health in the country.
- There is particular stigma associated with family planning, vaccination and GBV services and strong cultural beliefs around FGM/C, which need to be carefully promoted by engaging with key influencers including elders, religious leaders and community influencers for men and women.

29. Gender Based Violence/Sexual Exploitation, Abuse and Harassment (GBV/SEAH)

- Female health workers at all service delivery points may face GBV/SEAH, especially when they travel to work alone or on foot late in the evening or at night to provide health services.
- Female healthcare workers (whether civil servants or consultants) may be subject to GBV/SEAH in the recruitment or retention process especially as men dominate the hiring positions in most if not all government offices. In addition, there is lack of awareness and accountability for such issues and voice of women to hold workers to account.
- Community members may be subjected to GBV/SEAH when they seek services at the health facilities.
- There is lack of integrated policies providing a protective environment free from GBV/SEAH.
- Limited training for key personnel providing services to GBV survivors, including women as well as lack of information on who provides what, cultural barriers and lack of confidentiality which can increase harm, violence, and death to survivors.
- Due to limited understanding of survivor-centered approaches, reinforcement of community conflict resolution in some cases may cause harm to women and girls including revictimization, stigma, and marriage to the perpetrator. In most cases, *maslaha* (community conflict resolution) is not in favor of women, on the contrary it causes more harm to women since the focus is on community reconciliation and conflict prevention rather than the welfare of SGBV survivor.

30. Gender discrimination in employment practices

- While official government policy is to allow for female employees to take maternity leave and have access to time off for breastfeeding, women are vulnerable to losing their jobs after pregnancy since these policies are rarely adhered to in reality. The policies are also not female friendly, for example, the length of maternity is three months and female staff are required to take one month before delivery hence acting as barrier to women working in the formal sector.
- There is also a risk that the workplace may not have adequate facilities for women workers, such as washrooms and changing rooms and this may affect the dignity of the women workers.

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

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

FHWs are recruited from the lower economic rankings, therefore, they are in dire need of their salaries and would not be willing to do anything to jeopardize their income.

32. Mitigation measures for the social risks outlined above are provided in the EMF and the SocMF. The Labor Management Procedures (LMP) will outline fair treatment, non-discrimination and equal opportunity of project workers, and define separate worker grievance procedures and a Security Management Framework (SecMF) will outline how security risks and those associated with the use of security personnel will be managed. A GBV/SEAH action plan will identify actions to prevent GBV/SEAH among staff, patients and community members and ensure a separate, survivor-centric and confidential grievance mechanisms and procedures for dealing with cases and provision of services for survivors.

4.2 Summary of project stakeholder engagement tools and techniques

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

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

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

36. Meaningful stakeholder engagement depends on timely, accessible, and easily understood information. Making available project-related information as early as possible in the project cycle and in a manner, format, and language appropriate for each stakeholder group is important. Table 2 indicates the methods for stakeholder engagement and information disclosure. Formats to present information may include presentations, non-technical summaries, project leaflets, diagrams, posters and pamphlets, where possible sent by mobile phone as well as physically depending on accessibility and stakeholder needs. Due to the COVID-19 restrictions, socially distanced meetings and remote and virtual approaches will be used as necessary, as well as through radio and other social media platforms.

37. Table 2 presents the different ways through which the stakeholders will be consulted and kept informed on the project progress

Table 2. Consultation processes

No	Stakeholder	Channels of Engagement	Frequency	Purpose	Who will carry out
1	Somali citizens, such as community members who will benefit from the healthcare services (i.e. mothers, children, pregnant women, IDPs and nomads, people living with disabilities and other disadvantaged and vulnerable groups.	Public fora using approaches such as community conversations or dialogue forums.	At initiation of services and as needed.	- To educate communities on the project's goals and activities. - To collect views on social risks and how they could be managed or their management could be improved. - Provide dialogue opportunities where citizens have access to and engage with government representatives and other stakeholders. - Collect feedback from the target communities to understand their concerns, issues and perceptions of the overall project implementation.	PCIU/PMTs and Social safeguards officers at FGS and focal points at FMS levels.
2	People and companies who will benefit from project-related employment (i.e., health workers, consultants, NGOs private businesses in the health sector).	-Regular meetings to review progress of project implementation to report effectiveness and challenges. -Workshops with technical officers. -WhatsApp groups formed to share information. -Telephone interviews and questionnaires via virtual applications such as GEMS.	As needed.	-To provide timely access to information, data, documents, and other relevant project information - Learn about any issues related to OHS, GBV/SEAH. - Solicit feedback on project implementation. - To increase understanding and support GBV/SEAH and GM monitoring processes.	Supervisors and social safeguards officers at FGS and FMS levels.
3	The MoH and FMS line ministries, departments and government agencies directly supported by the project (i.e. ministries of health at both levels of the federation).	Series of high-level and technical engagement, meeting and working sessions with technical ministry counterparts. All-day workshop with technical officers.	As needed	- Project reviews including social risks and how they are being managed - Seeking clearance to implement the project components - Raise awareness of key provisions to provide a protective environment free from GBV/SEAH. - Review GM monitoring processes. - To promote shared responsibility and partnership.	PCIU/PMTs and Social safeguards officers at FGS and focal points at FMS levels.

4	International NGOs and bilateral donor agencies.	Discussion in meetings: sector, public and focal. These meetings/assemblies are to stimulate collaboration and get feedback. This could be achieved through existing technical working groups such as development partners group on health e.g. the health cluster coordination group Regional/FMS health coordination working groups	During project formulation and implementation.	- Sharing of information, reviews, clearance and seeking support. - To solicit guidance and feedback on project effectiveness and social risk management. - Learning and building on ongoing work by various partners and creating synergy and avoid duplication of efforts.	PCIU/PMTs and Social safeguards officers at FGS and focal points at FMS levels.
5	Civil society organizations (i.e. women and youth groups) and direct and indirect representatives of disadvantaged and vulnerable groups.	Discussion in meetings: sector, public and focal. These meetings/assemblies are to stimulate collaboration and get feedback.	During project formulation and implementation	- Sharing of information, reviews, clearance and seeking support. - To solicit guidance and feedback on Project effectiveness and social risk management. - Learning and building on ongoing work by various partners and creating synergy and avoid duplication of efforts - Strengthening local capacities as first responders	PCIU/PMTs and Social safeguards officers at FGS and focal points at FMS levels.
6	The disadvantaged and vulnerable groups including the poorest communities, IDPs, minority groups and clans, people living in remote rural areas and people living with disabilities.	-Public fora using approaches such as community conversations or dialogue fora. -Using local FM radio stations, meetings and local community communication structures for more coverage	At launch and as needed.	- To educate communities on the project's goals and activities. - Collect views on social risks and how they could be managed or how their management could be improved. - Provide dialogue opportunities where citizens have access to and engage with government representatives and other stakeholders. - Supporting the communities to understand their rights to access to quality health services and demand for services and accountability.	PCIU/PMTs and Social safeguards officers at FGS and focal points at FMS levels.

5. INCLUSION PLAN

5.1 Introduction

38. The project will give special consideration to disadvantaged groups, which include: minority castes and groups;[1] IDPs; people who live in remote rural areas or areas characterized by violence that are bereft of social services and amenities; nomadic pastoralist communities; PWDs; and female headed households including vulnerable orphans and unaccompanied minors.

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

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

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

5.2 Engaging disadvantaged and vulnerable groups

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

43. Community and Health worker training will emphasize non-discrimination and access to health for all including disadvantaged and vulnerable groups. Special effort will be made to ensure that healthcare staff are trained and sensitized on inclusion of disadvantaged and vulnerable groups including minorities and PWDs as well

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

as age and associated healthcare needs. CoCs, ethical guidelines and procedures for health staff will be established to support safe and appropriate provision of healthcare including right to impartial needs-based healthcare, and procedures for obtaining informed consent for services. In addition, healthcare staff will be made aware of the increased risk of sexual violence faced by people with disabilities (women and girls, but also boys and men) and train them in the safe identification and care of PWDs who have experienced sexual violence, while respecting confidentiality. Social barriers affecting access to information and services for these groups, such as discrimination and stigma, will be identified and addressed.

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

45. The participation of disadvantaged and vulnerable groups in the selection, design and implementation of project activities will largely determine the success of this 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.

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

47. 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.

48. 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 imple-

mented in a timely manner. The project should ensure benefits to the disadvantaged and vulnerable by ascertaining that they are consulted, have accessible and trusted GM to channel the complaints they might have on the project.

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

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

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

6. RESOURCES AND RESPONSIBILITIES

51. The project will be implemented by the Project Coordination and Implementation Unit (PCIU) at the FGS Ministry of Health, and the Project Management Teams (PMTs) at the FMS level. The FGS MoH will have project management responsibility, coordinating overall project implementation. It will also be responsible for knowledge management, capacity strengthening, monitoring, and evaluation of project activities, procurement, contract management, and technical implementation support to the FMS line ministry. The project implementation at the federal level 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, Safeguard Specialists (Social and Environmental Safeguards), GBV specialist, Security Specialist and a Communication Specialist, and other supporting staff. In the long term, the Federal MoH PCIU aims to serve as the coordination and management unit for development partner financing and activities in the health sector.

52. At the state level, each state will have a Project Management Team (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, as well as Safeguard Specialists (one full-time Social/ GBV Specialist, and one full-time Environmental Safeguards Specialist) in FMS with project activities only. Overall, the Senior Project Coordinator of FGS and Project Manager in each FMS will coordinate efforts within their respective governments, as well as between the FGS and the FMS. A Social and 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 requite social and environmental expertise to implement the project.

53. The Stakeholder Engagement Plan (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 Ministry of Health. The Social Safeguards Specialist and Communication Specialist 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. Reports on stakeholder engagement and a summary of grievances will be received by the FGS Social Specialist and implementing partners every three months.

7. GRIEVANCE MECHANISM

7.1 Introduction

54. 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 Grievance Mechanism (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 sexual harassment, exploitation and abuse. 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.

55. For the **'Damal Caafimaad'** 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. The FGS social specialist will carry out training of FMS social officers and project officers on complaints' handling and reporting.

56. 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 conducting following 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.

7.2 Objective and types of GM

57. The objectives of the GM for '**Damal Caafimaad' project** are to:

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

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

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

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

7.3 Building Awareness on GM

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

61. The project will aim to address grievances through using the steps shown in Table 3 and indicative timelines.

Table 3: Grievance resolution timelines

No	Steps to address the grievance	Indicative timeline*	Responsibility
1	Receive, register and acknowledge complaint in writing. Serious complaints immediately reported to the PM who will report to the PCIU and the World Bank.	Within two days	SS specialist at FGS level and SS Officer at FMS level supported by PMT
2	Screen and establish the basis of the grievance. Where the complaint cannot be accepted (for example, complaints that are not related to the project), the reason for the rejection should be clearly explained to the complainant and where possible directed to the relevant department.	Within one week	SS specialist at FGS level and SS Officer at FMS level supported by PCIU.

3	Program manager and social specialist to consider ways to address the complaint if required in consultation with the GRC and where appropriate the complainant.	Within one week	Program manager supported by PCIU.
4	Implement the case resolution and feedback to the complainant.	Within 21 days	Program manager with support from GRC.
5	Document the grievance and actions taken and submit the report to PMT.	Within 21 days	SS specialist and GRC supported by PMT
6	Elevation of the case to the government judiciary system, if complainant so wishes.	Anytime	The complainant
* If this timeline cannot be met, the complainant will be informed in writing that the GRC requires additional time.			SS specialist, GRC supported by PMT/consultant

7.4 Grievance Management Process

62. 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 7) 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.

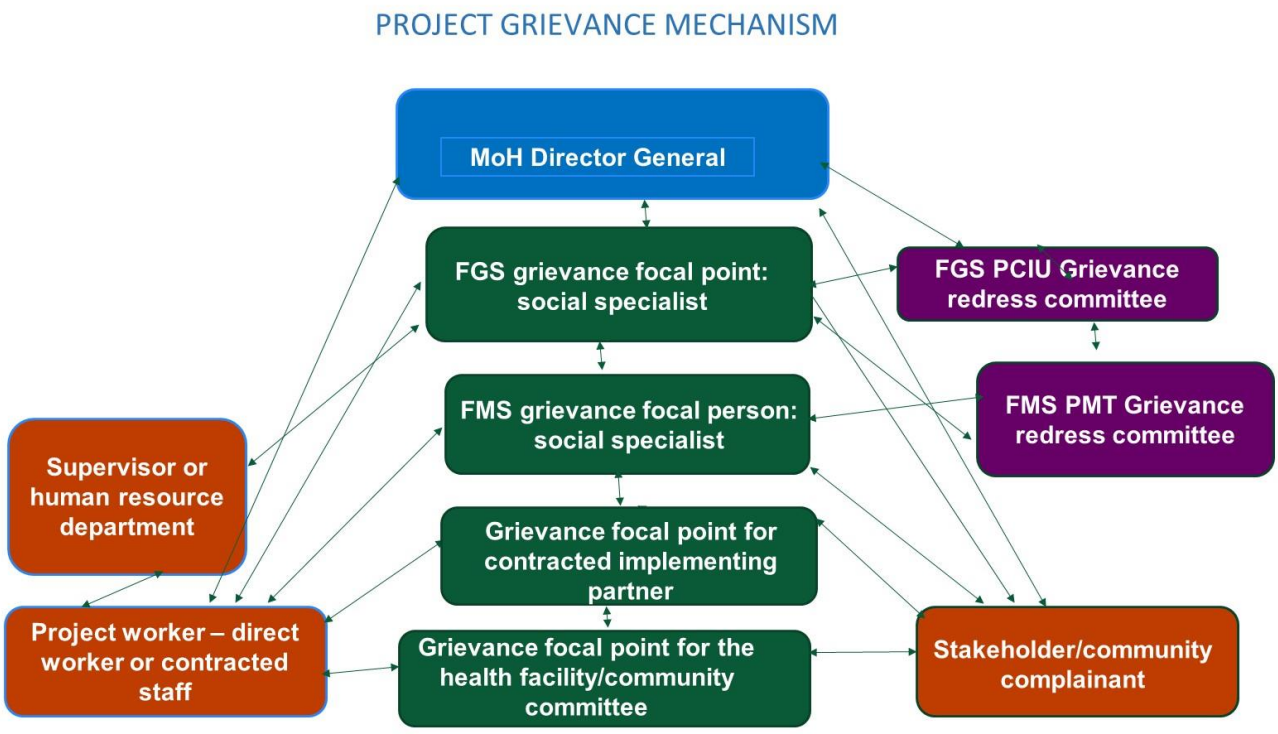

Figure 1: Structure of Grievance Mechanism

7.5 Grievances Related to GBV/SEAH

63. 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.

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

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

of the survivor will be recorded and the case will be considered closed**.** Recorded cases should be reported to the World Bank project team within 24 hours.

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

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

7.6 World Bank's Grievance Service

67. 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.

68. 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

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

8. MONITORING AND REPORTING

70. 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 outlined as part of their Environmental and Social Assessment and Management plan submitted with their bidding documents. The Project Coordinator of the project will ensure that the objectives of the plans are met and successful implementation of the plan by the allocation of the necessary resources for its implementation and ensure synergy and community feedback with the third-party monitor.

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

a. Number of project beneficiaries, government agencies, international NGOs (including bilateral donor agencies), civil society organizations, private sector and other stakeholder groups that have been involved in consultations on the project implementation and feedback on a quarterly basis. Means of verification: minutes and reports of consultations disaggregated according to gender, group and region.
b. Number of engagements (e.g. meetings, workshops, consultations, participants' sex and age in disaggregated form) with stakeholders during the project implementation phase (on an annual basis). Means of verification: Minutes Reports and other documentation of stakeholder engagement plan.
c. Percentage of stakeholders who rate as satisfactory the level at which their views and concerns are taken into account by the project (disaggregated by sex and disadvantaged group in each areas). The responsible party for measuring this indicator is MOH PCIU when they conduct the Mid-Term and Terminal Evaluation, and the third party monitor when they collect beneficiary feedback). Means of verification: impact and satisfactory assessments as part of project evaluation.

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

9. DISCLOSURE OF PROJECT DOCUMENTS

73. Table 4 outlines what information should be disclosed on the project and how.

Table 4: Project information disclosure

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

10. INDICATIVE BUDGET, SUMMARY ACTIONS AND TIMELINES

74. Table 5 presents the estimated budget for implementing the SEP. It is anticipated that this budget will be reviewed and adjusted based on the project engagement needs.

Table 5: Estimated budget for implementing the SEP

Stakeholder Engagement Activities	Timeline	Q-ty/per years (months)	Unit Cost, USD per year	No. of years	Total cost (USD)
GM toll free hotlines 1 at each of 3 FMS and FGS (4 total)	Before sub-project implementation	Per year	5,000	3 years	15,000
Communication materials (leaflets, posters on project and GM, GM forms, registers in Somali)	Before sub-project implementation	Per year	5,000	3years	15,000
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	3years	36,000
FM radio press conferences and call ins (one per year at FGS and FMS level)	Before sub-project implementation	Once a year	5,000	3years	5,000
Monitoring visits by FMS social officers	Once component activities start	Per quarter	10,000	3years	30,000
Annual stakeholder feedback survey (call Centre) as part of TPM survey	By December 2021	Per year			N/A
Subtotal					106,000
Contingency 5%					5300
Total					111,300

ANNEXES

ANNEX 1: INDIVIDUAL STAKEHOLDER CONSULTATIONS HELD DURING DEVELOPMENT OF THE INSTRUMENTS

1. Stakeholders Consulted

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

2. Summary of the key risks raised and potential mitigation measures

	Key Risks	Mitigation Measures
Perception about the project and its implementation	-The process of contracting NGOs may not be as transparent as required and this may lead to the delay of the project implementation. The contract may be awarded to an NGO with less capacity and the process may be flawed due to nepotism. Often the MoH officials have interest in the procurement processes. - Provision of health services to women and children may not be prioritized by the ministries and NGOs due to existence of high number of facilities within the state (It is important for the ministry to know that these facilities do not have capacity to provide quality health services). **-Elite capture** - powerful individuals or groups may influence the project implementation process and end up benefiting their businesses and their process through employments and contracts. - Socio-cultural beliefs about medicines and vaccines within communities is however common in remote areas. For example, people may be discouraged to use conventional medicine, and instead encouraged to seek traditional medicines.	-The procurement process should be conducted in a transparent manner and due diligence followed. -The ministries should remain focused on the activities set in the project. -The ministries and World Bank should have supervision role in the implementation of the project and monitor it closely. -Contracting of employees from the local areas and improving their capacity because they understand the dynamics of the areas.

	Community acceptance/ownership and participation: Acceptance of the project by the communities in the implementation areas. The communities have to understand the project components very well before implementation. - Recruitment of qualified people, especially the medical professionals – doctors, nurses, and midwives.	- Social risks can be minimized if all clans and communities are consulted about the project equally. - Proper consultation with the key stakeholders, community members and local administration in order to avoid exclusion of certain groups.
	Challenges: -Tension and fights between clans and village elders, and between the ministries and local administrations office over the management of the project. -The project may end up in the hands of the few people either through elite capture or contracts. - Lack of proper security assessment in the project locations may lead to selection of insecure areas. E.g. areas controlled by AS. -Duplication of activities i.e. health services already supported by other organizations. -Transparency in the procurement and contracting processes. - The project implementation process may be flawed because of tribalism. - Exclusion of certain clans and groups within the communities especially minority clans and women in consultations and provision of health services. - Role of gate keepers in implementation – they often play an intermediary role between the IDPs and the services providers. **Environmental risks** - disposal of syringes, injections and other equipment cause risks to the communities. There is no proper mechanism to dispose medical equipment.	-Review security risks in the target areas. - Conduct proper security analysis and prior site visit before the target locations are chosen. - Community representation should be increased especially women. - Recruitment of medical professionals from local communities. -Awareness raising conducted by experienced women regarding misperceptions of vaccines -Proper disposal mechanism for health equipment such as burning of the equipment. -Selection of proper sites for health facilities (always avoid flood-prone areas).

Exclusion during project implementation	-There could be exclusion of certain groups such as minority groups, IDPs and people living with disabilities due to elite capture. -People from minority clans have little representation in the ministries and local administration, therefore they may also be excluded from receiving services provided at the health facilities and the contracts awarded. Similarly, IDPs may be excluded from receiving health services because they are regarded as external community. -Issues such as family planning and GBV services may be rejected by the communities and cause tension. -Exclusion of certain groups such as IDPs are expected especially in consultation and benefits. They are supposed to be treated as part of community but they are most often treated as an external group. IDPs are not in most cases considered to be part of the communities. - Similarly, people living with disabilities are supposed to be part of the communities and should equally benefit from health services provided. -Dominant clans and elite groups may take over the implementation of the project. E.g, the project workers may be selected from dominant clans and leave out minority clans. For example, the project workers may be recruited from dominant clans leaving out minority clans and NGOs owned and led by dominant clans may be contracted. -There may be rejection of family planning services and GBV services by community elders, imams etc. -Dominant clans and elite group might take over the project but it depends on the NGO implementing the activities. The organization can put systems in place to avoid clan/elite capture. -Family planning services might cause tension and rejection in some communities if proper awareness raising is not conducted.	-Proper consultation with these communities, and awareness to the communities regarding their rights to be part of the project. -Procurement of staff and services must be done in a balanced manner. -Be conscious of the IDPs and minority groups and include them in the implementation of the project. Make the project as inclusive as possible. -Establish health centers in IDP populated areas/districts.

Labor-related risks	-Non-compliance of Somali labor laws are expected during the project implementation. For example, recruitment of workers may be flawed due to nepotism and elite capture. -Somali labor laws are not often followed in many organizations in the country and the rights of workers are abused. For example, fair recruitment may not be practiced during the implementation of the project. -Risks related to pay and working hours, GBV are likely. -Recruitment of project workers may be flawed - many people from dominant clans may be recruited and people from minority clans/groups excluded. - Non-Somalis in the top management of the project within the Ministry of Health. - Non-equal pay for project workers. Some employees are paid incentives while others are paid salaries.	-advocacy groups should be established to counter flawed processes. Monitoring of labour laws - Equal payment for project workers depending on the qualifications and experience.
Security issues and conflict	-The project can be implemented in all the locations where there is presence of Somali government forces/AMISOM. -Presence of security forces may increase attention from AS, even though AS do not target health agencies. -No security threats in Puntland.	-Specific security protocol for health workers may increase security threats against them. -Medical workers should minimize unnecessary movements and limit their operations in AS-controlled areas.
Socio-cultural beliefs	-Some health facilities are associated with certain clans; therefore, some clans (especially minority groups) may not feel comfortable seeking medical assistance from it. This is because these medical facilities are dominated by certain clans.	-Awareness raising on services for all. -Put policies in place to stop influence of clans in recruitment of health workers and initiate elimination of discriminatory behavior in recruitment processes.
Grievance Mechanism	-Grievance feedback mechanisms do exist but people are not confident using them because they believe that their problem will not be solved. These mechanisms are not effective and transparent. -Somalis are oral society; people would prefer phone calls rather than suggestion boxes or email. It is important to provide a toll number where they would call and pass their concerns. -Due to security reasons, they do not trust anyone so it is difficult for them to complain about issues regarding a project. -In many projects, beneficiaries do use suggestion/feedback boxes provided to air their views and grievances about the project (Hirshabelle state). - People do not use suggestion boxes due to high illiteracy level. It is better for them to call and air their grievances (Puntland state).	Toll-free numbers are established and the calls are managed by an external actor, the people may be comfortable conveying their grievances. - Contract a third party to manage GRM on behalf of the MoH. -Conduct forums/meetings at the community level regarding the implementation of the project.

Gender-based violence (GBV)	-Female health workers may be sexually exploited even though this is minimal. Security may cause GBV to FHWs. -Due to Somali culture which denounces GBV, such cases are expected to be minimal in the project locations, but it may happen in some places. -Due to the Somali culture and religious teachings, GBV is not expected.	-Awareness raising about the consequences of the GBV in work places.
Occupational health and safety	-AS do not mostly target/attack health facilities. - If proper security analysis is not conducted in target locations, the health workers may be attacked. -They can protect themselves from infectious diseases if they use PPEs. Medical professionals are prone to infectious diseases and PPEs are not sufficient for them. They are at risk of contracting diseases. -Employees may witness violence and injuries and death at work-place. -Most health workers do not have PPEs and are not able to protect themselves from infectious diseases.	-Put security measures in place. Emergency response. -Provide PPEs to the health workers including the FHWs. -Awareness raising on protection of health workers -Capacity building for health workers on protection of infectious diseases.
Stakeholder engagement	Stakeholder engagement can be conducted through meetings, community fora and bilateral meetings with elders and community influencers.	-Engage various groups/segments within the community including women, community elders, religious leaders, youth, women groups and professionals through meetings and community forums. -Use media platforms such as TVs and radio especially during peak hours.
Recommendations	-Proper implementation of the project and engagement of wide range of stakeholders throughout the implementation process. -It is important to invest on the local ownership of the project and its sustainability after the funding ceases.	-Close monitoring by 3rd party and World Bank

ANNEX 2: Virtual Stakeholder consultations on the E&S instruments for the Damal Caafimaad Project

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

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

Agenda

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

Participants List

Name	Organization	Email
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Environmental and Social concerns raised during the workshop and suggested mitigation measures

Environmental and Social Risks	Mitigation measures
Concern about public private partnerships is problematic, as services are not free, this not accessible to the poor	The focus will be strengthening private providers though regulations, not as the form of implementation. Given around 80% population use private health providers they need to be regulated.

Exclusion of marginalized and minority communities (including persons living with disabilities) in consultations as well as beneficiary of the services offered under the project.	Special effort will be made to reach all communities regardless of their background and status both in consultation and in beneficiary. Varying forms of communication to reach a range of people including those who may have hearing, visual or intellectual impairments needs to be considered. Grievance and feedback procedures should also be accessible in various forms and accessible to persons with disabilities, women and children.
It would be useful to establish a civil society advisory group for the project who would advise on transparency and accountability in the project.	Transparency and accountability will be promoted as part of the project including via the SEP. There will be annual stakeholder meetings including of CSOs to feedback on the project
Concern that RCRF social specialists will be asked to support this project as well as RCRF	Separate social specialists will be employed, but the two projects need to work in synergy and learn from each other
How to address resistance of the community for family planning and condom use	Child spacing is a more accepted term by the community and awareness raising its importance will be carried out
Confidentiality on reporting GBV-related cases	Confidentiality of reporting GBV cases will be guaranteed for victims. This is well explained in the GBV action plan. All healthcare workers providing these services will be trained.
Need to harmonize medical waste management both of health facilities and pharmacies	This could be considered as part of the project
Concern over management of medical waste, especially disposal of placenta in health facilities	Incinerators will be installed in health facilities and consideration will be made of culturally appropriate ways of placenta disposal
Promotion of occupational health and safety	Training will be conducted on OHS issues for all health staff

ANNEX 3: Example of COMPLAINTS FORM (to be translated into Somali)

1. **Complainant's Details**

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

Male/Female

Mobile _____

Email _____

District_____

Relationship to the project _____

Age (in years): _____

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

_____

_____

_____

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

☐ Yes ☐ No

4. If yes, which one?

_____

_____

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

☐ YES ☐ NO

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

_____

_____

_____

_____

7. What action would you want to be taken?

_____

_____

_____

_____

Signature _____

Date _____

ANNEX 4: 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: COMPLAINTS REPORTING TEMPLATE

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

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

ANNEX 6: REFERENCES

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

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

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

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

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

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