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## ACRONYMS AND ABBREVIATIONS

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<th>Description</th>
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<tbody>
<tr>
<td>AF</td>
<td>Additional Financing</td>
</tr>
<tr>
<td>BRA</td>
<td>Benadir Regional Authority</td>
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<tr>
<td>CBS</td>
<td>Central Bank of Somalia</td>
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<tr>
<td>COPM</td>
<td>Comprehensive Operating Procedures Manual</td>
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<td>CMU</td>
<td>Country Management Unit</td>
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<tr>
<td>DLI</td>
<td>Disbursement Linked Indicator</td>
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<tr>
<td>EAFS</td>
<td>External Assistance Fiduciary Section</td>
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<tr>
<td>ESF</td>
<td>Environment and Social Framework</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>ESMF</td>
<td>Environment and Social Management Framework</td>
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<tr>
<td>FCV</td>
<td>Fragile, Conflict and Violence</td>
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<tr>
<td>FGS</td>
<td>Federal Government of Somalia</td>
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<tr>
<td>FM</td>
<td>Financial Management</td>
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<td>FMS</td>
<td>Federal Member States</td>
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<tr>
<td>FY</td>
<td>Fiscal Year</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>HR</td>
<td>Human Resource</td>
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<tr>
<td>IFRS</td>
<td>International Financial Reporting Standards</td>
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<tr>
<td>IGFR</td>
<td>Inter-Governmental Fiscal Relations</td>
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<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>IPF</td>
<td>Investment Project Finance</td>
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<tr>
<td>IPF-DLI</td>
<td>Investment Project Finance with Disbursement Linked Indicators</td>
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<tr>
<td>ISN</td>
<td>Interim Strategy Note</td>
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<tr>
<td>ISR</td>
<td>Implementation Status and Results Report</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MDA</td>
<td>Ministries Departments and Agencies</td>
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<tr>
<td>MoF</td>
<td>Ministry of Finance</td>
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<tr>
<td>MPF</td>
<td>Somalia Multi-Partner Trust Fund</td>
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<tr>
<td>MTR</td>
<td>Mid Term Review</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>OP</td>
<td>Operation Policy</td>
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<tr>
<td>PDO</td>
<td>Project Development Objective</td>
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<td>PIM</td>
<td>Project Implementation Manual</td>
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<tr>
<td>PIU</td>
<td>Project Implementation Unit</td>
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<tr>
<td>PFM</td>
<td>Public Financial Management</td>
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<tr>
<td>RCRF</td>
<td>Recurrent Cost &amp; Reform Financing</td>
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<tr>
<td>SCD</td>
<td>Systemic Country Diagnostics</td>
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<tr>
<td>SDRF</td>
<td>Somalia Development and Reconstruction Facility</td>
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<tr>
<td>SFMIS</td>
<td>Somalia Financial Management Information System</td>
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<tr>
<td>TA</td>
<td>Technical Assistance</td>
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<tr>
<td>TSA</td>
<td>Treasury Single Account</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
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<td>WCO</td>
<td>World Customs Organization</td>
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PREAMBLE

This is the Environmental and Social Management Framework (ESMF) for the third phase of the Recurrent Cost and Reform Finance Project (RCRF III). The ESMF ensures that the project activities are compliant with the World Bank Environment and Social Framework’s (ESF) Environmental Social Standards. The objective of this ESMF is to set out the principles, rules, guidelines and procedure to assess the environmental and social impacts and develop mitigation measures as well as carry out monitoring to ensure that environment and social aspects are duly considered. This development of this ESMF was informed by consultations with the Federal Government of Somalia’s Ministry of Finance/PIU as well as, various key stakeholders at national, state and community level in Somalia and social, environmental and GBV experts at the World Bank.
1. INTRODUCTION AND PROJECT CONTEXT

1.1 PROJECT DESCRIPTION AND OBJECTIVE

The Project Development Objective (PDO) is to support the Federal Government of Somalia, Eligible Federal Member States to strengthen resource management systems, the inter-governmental fiscal framework, and service delivery systems in health and education. PDO level indicators include:

- Strengthened resource management systems: i) share of civil servants’ salaries financed by government and ii) eligible civil servants salaries paid on time.
- Strengthened FGS transfers to FMS: FGS’ transfers execution rate to FMS.
- Strengthened Service Delivery in FMS/BRA: i) Students enrolled in schools that receive performance-based school grants (disaggregated by gender) and ii) Female Health Workers selected according to guidelines, are trained and actually providing services.

1.2 PROJECT BENEFICIARIES

The primary beneficiaries of the proposed project will be the government, civil servants and employees of the implementing ministries, departments and agencies in FGS and the Federal Member States. This includes the civil servants whose salaries will be covered under the project as well as social service workers, i.e. teachers and health workers in FGS and Federal Member States. Citizens will benefit from improved service delivery, particularly in health and education, greater government responsiveness – facilitated through the Citizen Engagement Component, and on a broader scale, from an improved public administration. Moreover, development partners will be able to leverage this platform to provide technical advice and financial assistance.

RCRF 1 focused on Benadir Region, Galmudug and Puntland States. RCRF 2 expanded to the rest of Somalia and since 2019 has been funding 377 workers in three regions, and starting in 2020 will reach 3,000 workers across all FMS and Benadir by 2023 and essential investments in government contract management capabilities. RCRF 3 will expand the number of health workers in all States and in education will transition from direct teacher payroll financing to performance-based grants to schools, which is likely to increase the number of teachers covered. The project will also continue to fund other civil service cadres in a range of sectors including non-military personnel in the Ministry of Defence as well as Judiciary, Ministry of Labor and Social Affairs and Ministry of Women and Human Rights Development in both FGS and some States. RCRF 2 will run concurrently with RCRF 3, although will continue to work under the Operational Policies (OPs), however where the government agrees, RCRF 2 will also adopt the RCRF 3 ESMF standards to avoid confusion.

RCRF 3 would also provide support for transparency and citizen engagement for improved service delivery (Component 4) will support the designing and use of tools to advance transparency and generate citizen feedback mechanisms up to the facilities level (for selected locations).

Component 1: Recurrent cost finance to reform resource management systems (Total component cost: US$21.0 million, of which US$10 million is PBC-based)

Sub-Component 1.1. Financing eligible civil service salaries in FGS: baseline (US$11.0 million) This financing supports the timely payment of civil service salaries over the three-year period (US$20 million in total) through the advance-replenishment model of payroll financing already successfully established under RCRF. It also provides a continued source of financing for the FGS’ CIM recruits (recruited through the support provided by the World Bank-funded Capacity Injection Project). In line with the ‘sliding scale’ of decreasing baseline financing to the FGS wage bill, the available financing declines from US$7.4 million in 2020, to US$ 6 million in 2021, and US$ 5 million in 2022. The FGS will therefore, over the remaining project period, be taking responsibility for co-financing an increasing share of both the civil service and CIM payrolls.
**Sub-Component 1.2. Financing eligible civil service salaries in FGS: reform benchmarks** (PBCs) (US$10.0 million) Performance-based condition (PBC) financing will enable the FGS to access up to US$10 million through reimbursement against eligible expenditures over the project period. DLs (now referred to as “PBCs” following the recent issuance of new IPF-PBC guidance) were introduced in Component 1 of RCRF II in 2018 to strengthen the reform incentives within RCRF and support strengthened policy dialogue around key reforms to meet HIPC Decision and Completion Points. In line with the introduction of FMS reform benchmarks, the number and amount of financing for FGS reform benchmarks is being reduced from US$10 million per year to US$ 5 million per year to allow for additional resources to be channeled to the FMS, with a more streamlined focus under RCRF III on five key areas: i) customs; ii) payment processes; iii) inter-governmental fiscal relations; iv) fiscal transfers to FMS, and; v) public administration.

**Sub-Component 1.3. Fiscal shock buffer for FGS and FMS (CERC) (US$0.0 million)** The COVID-19 pandemic is the latest in a series of high frequency shocks to hit Somalia, as documented in the Country Partnership Framework (CPF). This Contingent Emergency Response (CERC) Sub-Component will provide a fiscal shock buffer for FGS and FMS to provide a fast and flexible in-built mechanism to offset unforeseen revenue shortfalls arising from fiscal shocks such as the COVID-19 pandemic. This zero-cost component will finance eligible expenditures to help to offset fiscal shortfalls resulting from in the case of natural or manmade crises or disasters, severe economic shocks, or other crises and emergencies in Somalia.

**Component 2: Strengthen inter-governmental fiscal relations** (Total component cost: US$21.2 million, of which US$15.1 million is PBC-based)

**Sub-component 2.1. Support Inter-governmental Fiscal Forums and Secretariat (US$2 million)** This sub-component builds on the successful establishment of the Intergovernmental Fiscal Forum (IGFF), and dedicated Secretariat, which need to be institutionalized to sustain the gains. The IGFF comprises two bodies, supported by the Secretariat, namely: (i) the Inter-Governmental Fiscal Forum Technical Committee (IGFFTM), which operates at technical level ; and (ii) the Finance Ministers Fiscal Forum (FMFF) for the political-level deliberation and decision-making. The proposed additional support will therefore be provided to institutionalize the IGFF, including the: Secretariat, the IGFFTM and FMFF, in addition to training and capacity building, and continuing to support the running costs of these forums.

**Sub-component 2.2. Reform benchmarks for improved governance and service delivery at FMS level (US$15.1 million)** The November 2019 Finance Ministers Fiscal Forum meeting in Kampala reached agreement between the FGS and FMS on the introduction of reform benchmarks for FMS. This was intended to promote harmonization between the FMS and the FGS and to encourage greater transparency and openness. RCRF III will support the piloting of this inter-governmental policy initiative, by allowing FMS achieving agreed reform benchmarks (PBCs) to access up to a total of US$15 million.

**Sub-component 2.3. Strengthening resource management systems (US$4.1 million)** This sub-component will a) support a comprehensive plan to coordinate with other PFM projects at FMS level on sustained skills improvement (in areas of finance, accounting and financial reporting, procurement, HR and internal audit across all MDAs) to mitigate challenges identified through RCRF II implementation, with a focus on facilitating improved education and health service delivery (focusing on ministries of Finance, Education, and Health): b) support “common approach” to implementation of World Bank operations at FMS-level, including investments in ministries of finance (notably External Assistance Fiduciary Sections or “EAFS”), contract management capability in education and health, and social safeguards: c) Extend the PFM staff professionalization program, started under RCRF II, in collaboration with the DRM&PFM project, to train more PFM staff in the PFM institutions and MDAs of all FMS: and d) Support inter-governmental collaboration to improve automatic fiscal data sharing
between FGS and FMS and harmonization of budget classifications, to support automation of fiscal reports including IT equipment if needed.

**Component 3: Transfers for core government functions and foundational education and health service delivery mechanisms in eligible FMS (US$49.3 million)**

**Sub-Component 3.1. Financing core government functions (US$16.9 million)** This sub-component will continue the financing of FMS recurrent costs through the transfer grants from FGS to FMS finances to include: (i) reforms to meet the participation eligibility criteria; (ii) salaries and allowances of civil servants (excluding elected officials) in selected MDAs (i.e. Finance, Health, Education); (iii) salaries and allowances to government staff and young graduates recruited under the CIM; (iv) systems-strengthening and the establishment of basic accountability systems; (v) eligible non-salary recurrent costs for selected MDAs (i.e. Finance, Health, Education), and (vi) investments in FMS MoF capacity to manage donor funds to ensure a “common approach” to implementation of inter-related Bank operations (e.g. forthcoming IDA operations for Health and Education).

**Sub-Component 3.2. Financing education service delivery (US$ 16.2 million)** Under RCRF, reforms have been introduced to help FGS and FMS education ministries strengthen their core systems for the delivery and management of education services. This includes financing of teacher salaries and other recurrent expenses, proficiency testing of teachers and a school supervision and accountability mechanism, along with support for better budget planning and execution. Interventions under RCRF to date have been focused on basic provision of services without much emphasis on quality, which was understandably a priority for states and communities seeking stability following years of conflict. Given that educational outcomes are pivotal for human capital development and economic growth in Somalia, going forward, RCRF III proposes to enhance focus on improving the quality of delivery in payroll-supported schools. Education ministries in eligible FMS, with support from the FGS Ministry of Education, Culture, and Higher Education (MoECHE) and the Ministry of Finance, will establish and implement a performance-based school grants program in their respective jurisdictions.

**Sub-Component 3.3. Financing health service delivery (US$ 16.2 million)** The health component of RCRF III will expand the gains under RCRF II by scaling up the ‘Marwo Caafimaad’ Female Health Worker (FHW) program and strengthening the government’s stewardship and management capacities. The activity will support the payment for FHWs and their supervisors, trainings, transportation costs, supervision activities, procurement of essential supplies for FHWs as per revised FHW Compendium, reporting and reviewing of the FHW data/information, routine meetings, supervision, and routine monitoring activities. The goal is to first ensure full coverage of districts and regions with an existing FHW presence, while helping move the country towards full FHW coverage. This activity will finance the HTP to develop Government capacity to manage the FHW program at the FGS, FMS, and Regional or District level.

**Component 4. Transparency and citizen engagement for improved service delivery (US$3 million)**

**Sub-component 4.1. Deepening and widening the existing budget transparency efforts.** This Sub-Component will support stronger budget transparency (measured by the Open Budget Index) through public participation in budgeting (following the Global Initiative on Fiscal Transparency principles) by facilitating interactions with citizens on budget information, through radio shows and by capturing citizen feedback on budget execution at the Community Level. Pilot radio shows are intended to more widely disseminate budget information and facilitate dialogue between government (or elected officials) and the public on budget resources allocation. Activities to be funded are: 1) radio shows; 2) formatting budget for citizens.

**Sub-component 4.2. Support mapping, citizen feedback and corrective measures at the local level**

This sub-component will promote citizen participation in service delivery at community level by building on already significant attendance to community meetings across eligible provinces by promoting inclusive and deeper community engagement in service delivery. It will support mapping
of selected interventions, generate citizen feedback at the facility level (for selected locations and for education and/or health) and monitor the corrective actions taken. It will also support the signing and implementation of community compacts between citizens and service providers to improve service delivery at community level through mutual commitments.

**Sub-component 4.3. Impact evaluation to citizen feedback in education and health.** This sub-component will strive to incorporate citizen feedback into the provision of education and/or health services particularly the staff supported by the project and evaluate the possible impact of the interventions on health and education access and quality. A rigorous impact evaluation will be financed to assess the efficiency and inclusivity of citizen engagement on education/health access and quality with health/education teams.

The project will contribute to COVID-19 response and recovery in the following ways:

**Scale-up of the Marwo Caafimaad Female Health Worker (FHW) Program** and re-training for COVID-19 response: RCRF III will provide US$10.1 million of health sector financing, including supporting scale-up of the FHW program from 377 workers in three regions in 2019, starting in 2020 and reaching 3,000 workers across all FMS and Banadir by 2023 and essential investments in government contract management capabilities. Further, the FGS and FMS ministries of health and World Bank team are currently working to re-focus the FHW program on the COVID-19 response. Options under discussion include:

- FHW role in detecting, isolating, and reporting cases as well as community awareness raising;
- Support for system of case reporting and response;
- Support for increased supervision of the FHW system;
- PPE for FHWs and possibly other supplies (primarily masks), and;
- Accelerating roll-out of new FHWs in at-risk districts.

**Scale-up of support to schools**: RCRF III will help the education sector to get back on track once schools re-open with US$10.1 million for investments in school grants to drive improvements in student attendance, school and teaching quality, and learning outcomes. In addition to continued teacher salary financing, grants will be available to up to 500 schools that meet basic quality standards. The project will also finance strengthening of government systems for supervision and holding service delivery providers accountable for quality.

**Improved transparency and citizen engagement in use of funds**: the new Component 4 will support stronger budget transparency and promote citizen participation in service delivery at community level.

RCRF III will continue the framework established under RCRF II for ‘readiness criteria’ that governments must meet to be eligible for RCRF financing, as set out in the project operations manual (POM). Any government seeking to qualify for RCRF financing should meet the established ‘readiness criteria’, including Strategic, Macro-Fiscal and Financial Management Assessments. For example, Benadir Regional Authority (BRA) – the second largest subnational government after Puntland by total annual budget size – is not yet eligible for RCRF financing. RCRF II is financing service delivery in BRA in education (Sub-Component 3.2) and health (Sub-Component 3.3) but executed by the respective FGS ministries on an interim basis, pending BRA’s on-boarding into RCRF. The RCRF III framework is designed in such a way as to be open to BRA joining during the project period subject to meeting the readiness criteria. This assessment process could also enable Somaliland to join if it were agreed between the respective governments.
2. POLICY, LEGISLATIVE AND INSTITUTIONAL FRAMEWORKS

2.1 LAWS AND LEGISLATION ON ENVIRONMENTAL ISSUES

In all Somali territories policy and legislation with respect to the environment is evolving, in terms of assessing the potential impact of such policies on the environment, or how they could contribute to environmental conservation and sustainable livelihood improvement.

Article 45 of the Somali Federal Government Constitution states that:

a. The Federal Government shall give priority to the protection, conservation, and preservation of the environment against anything that may cause harm to natural biodiversity and the ecosystem.

b. All people in the Somalia have a duty to safeguard and enhance the environment and participate in the development, execution, management, conservation and protection of the natural resources and environment.

c. The Federal Government and the governments of the Federal Member States affected by environmental damage shall:

d. Take urgent measures to clean up hazardous waste dumped on the land or in the waters off Somalia.

e. Enact legislation and adopt urgent necessary measures to prevent the future dumping of waste in breach of international law and the sovereignty of the Federal Republic of Somalia

f. Take necessary measures to obtain compensation from those responsible for any dumping of waste, whether they are in the Federal Republic of Somalia or elsewhere

g. Take necessary measures to reverse desertification, deforestation and environmental degradation, and to conserve the environment and prevent activities that damage the natural resources and the environment of the nation.

h. In consultation with the Federal Member States, the Federal Government shall adopt general environmental policies for the Federal Republic of Somalia.

The Federal Government has introduced changes in the institutional set-up dealing with environment and a directorate of Environment has been formed within the Office of the Prime Minister. The Directorate of Environment (DE) is mandated to draft the National Environmental Policies and legislations including establishing of the Environmental Quality Standards, Sectoral Environmental Assessments (SEAs), Environment Impact Assessments (EIAs) and Environmental Audits among other items. However necessary laws or legislations have not been formulated and no commissions or authorities have been established.

2.2 LAWS AND LEGISLATION ON SOCIAL ISSUES

The following clauses of the Constitution relate to social issues and those in bold particularly relate to those in the ESF:

The Somali Constitution contains the following provisions related to social issues:

Article 10. Human Dignity
1. Human dignity is given by God to every human being, and this is the basis for all human rights.
2. Human dignity is inviolable and must be protected by all.
3. State power must not be exercised in a manner that violates human dignity.

Article 11. Equality
1. All citizens, regardless of sex, religion, social or economic status, political opinion, clan, disability, occupation, birth or dialect shall have equal rights and duties before the law.
2. Discrimination is deemed to occur if the effect of an action impairs or restricts a person’s rights, even if the actor did not intend this effect.
3. The State must not discriminate against any person on the basis of age, race, color, tribe, ethnicity, culture, dialect, gender, birth, disability, religion, political opinion, occupation, or wealth.
4. All State programs, such as laws, or political and administrative actions that are designed to achieve full equality for individuals or groups who are disadvantaged, or who have suffered from discrimination in the past, shall be deemed to be not discriminatory.

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

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

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

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

**Article 111J. The Office of the Ombudsman**
1. A member of the Council of Ministers, the Federal Parliament or any other person shall not interfere with the work of the office of the Ombudsman.

2. Each department of the Government shall co-operate with the office of the Ombudsman regarding the need to maintain its independence, integrity and effective service delivery.

3. The Ombudsman shall:
   a. Investigate complaints regarding allegations or outright violations against basic rights and freedoms, abuse of power, unfair behavior, mercilessness, lack of clemency, indiscipline or disrespect towards a person that lives in Somalia by an officer who works at the various levels of government, an apparently unfair behavior, or act in a corrupt manner, or a behavior by an officer deemed as illegal by a democratic society or regarded as mischief or injustice.
   b. Investigate complaints in relation to the activities of the Public Service Commission of the government, administrative institutions of the government, and the defense and police forces whoever such complaints relate to, failure to equally align those services or fair recruitment among all people in those services or to administer those services fairly.
   c. Take appropriate steps that the public calls for, to rectify or change items mentioned in earlier clauses through a fair, and appropriate process, which include, but are not limited to:
      i. Consultations and sacrifices among the people concerned;
      ii. Reporting on the complaints and matters presented to the Ombudsman, and submit to the head of the offender;
      iii. To forward the matter to the Attorney General;
      iv. To bring the matter before a court that forbids improper conduct by an officer.

**Article 111H. National Security Commission**

A National Security Commission shall be established by federal law. The National Security Commission shall be independent and shall comprise security experts from all sectors. The mandate of the National Security Commission shall be to:

a. Study and develop an integrated security framework to address the present and future needs of Somalia for review and adoption by the Federal Parliament;

b. Present proposals to ensure that human security is prioritized and incorporated into the national security framework;

c. Develop a framework through which the public may provide oversight and monitor security related expenditure; and

d. Seek redress from abuses by security personnel.

### 2.3 LEGISLATION AND POLICIES ON THE HEALTH SECTOR

A legal framework for the health sector in Somalia is absent but the policy environment is beginning to improve with the production of a draft National Health Policy.

Somalia’s national health planning cycle is therefore addressed in the national health policy. The Federal Government of Somalia developed second version of the national health sector strategic plan (HSSP-II 2017-2021) with chapters per each of the federal member states having similar strategic priorities. The strategy is based on nine building blocks of the health system according to the needs. It prioritizes governance and leadership, followed by human resources, services delivery, health financing, pharmaceuticals and medical technology, health intelligence and information system, social determinants of health, emergency preparedness and response and health infrastructure.

The HSSP takes a pragmatic approach to the provision of essential package of health services (EPHS) including community-based health services across the federal member states and regions of Somalia but the EPHS implementation is limited to some regions based on funding available and due to limited
security access. The EPHS is largely implemented with humanitarian and emergency support coming from humanitarian partners. The FGS is currently updating the EPHS framework and aiming to guide all development and humanitarian partners to support the EPHS framework. The priority is to consolidate and scale up of essential health services in all areas where access and security permits.

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

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

1. Public Health Act;
2. Drug policy – already developed and endorsed;
3. Drug act – the draft bill has been submitted to the Parliament – pending approval
4. Health Policy document – the last one was developed in 2014;
5. Health regulatory framework: the National Health Professional act was developed and signed by the President – it is implementation is in process;
6. WATSAN and Environmental Health policy and strategy – this has been developed and endorsed;
7. Community Health strategy has been developed in 2015.

The planning and management of the health system is poorly developed in Somalia. The federal Ministry of Health and the five state ministries of health (and the Benadir Regional Administration) are responsible for various aspects of health sector policy and service provision. The federal MoH is currently revising the essential package of health services (EPHS) which aims to deliver health services through a five-tiered system – National/Regional hospitals, Referral Health Centers; Health Centers, Primary Health Units and community based health workers all providing at least some elements of a package of preventive and curative services known as the EPHS. Most services comprise of basic primary health care and outpatient services and cater to women and children. Public sector service points are often managed, financed and at least partially staffed by employees of international or national NGOs and CBOs. The federal MoH developed a draft health workforce deployment policy in early 2020 “to train, employ, deploy and retain an adequately skilled health workforce that is well motivated to offer quality services to the general public and people living in Somalia.” The draft policy is intended to guide human resource development of non-civil servant staff. The ministry’s FHW compendium outlines an outreach strategy that “…coordinate with local health committees, community leaders, religious leaders, women’s groups and other influential community members to ensure support for health services, to spread health messages, to mobilize community members to utilize services and to resolve any challenges.”

2.4 LEGISLATION AND POLICIES IN THE EDUCATION SECTOR

A key step towards rebuilding and improving education service delivery throughout Somalia was the establishment of the Federal Ministry of Education, Culture and Higher Education (MoECHE) in 2012, and development of an interim Education Sector Strategic Plan (IESSP 2012-2106). Recently, the Federal MoECHE with support from Global Partnership for Education and other development partners developed an Education Sector Strategic Plan (ESSP) for the period of 2018-2020 which, building on the previous ESP, identifies a number of priorities for the education sector. The ESSP guides education
sector investments and coordinate various stakeholders around a single platform. Intergovernmental dialogue has improved with coordinated support from the federal Ministry of Education, Culture and Higher Education (MoECHE) to FMS on key challenges and preparing coordinated policy responses such as on the role of Community Education Committees (CECs). However, considerably more work is needed to establish a coherent system for education service delivery in the country.

2.5 LEGISLATION AND POLICIES ON THE CIVIL SERVICE

The Provisional Constitution of the Federal Republic of Somalia (adopted in August 2012) provides the legislative framework for labor issues. Somalia’s Provisional Constitution provides that “all workers, particularly women, have a special right of protection from sexual abuse, segregation and discrimination in the work place. Every Labor law and practice shall comply with gender equality in the work place” (Article 24-5). The Labor Code1 of Somalia (Law Number 65, adopted in 1972) is the specific labor law governing all aspects of labor and working conditions, which covers the contract of employment, terms and condition, remuneration, and occupational health and safety, trade unions and labor authorities. The provisions of the Labor Code apply to all employers and employees in all project areas. The Labor Code is broadly consistent with the ESS2, while there is a significant gap in the enforcement aspect of the legislation (see Section VIII on the institutional framework). The public service or public institutions are governed by the Civil Service Law (Law Number 11).

The Federal Ministry of Labor and Social Affairs (MOLSA) is responsible for labor policy and regulatory frameworks. The Labor Ministry in each State is in charge of implementation of the labor code, including the labor inspection. While five States have labor ministries, only Puntland has three labor inspectors under the minister. Others have no functioning labor inspection.

The Revised Draft Somalia Labor Code has more emphasis on occupational health and safety requirements. It makes the Director of Occupational Safety and Health (OSH) responsible for the registration of hazards and risks, regulation and supervision of all workplaces and monitoring or enforcing compliance with Labor Code and any other Labor law to the extent that they regulate safety, health and welfare in the workplaces. Part VI of the Revised Draft Labor Code covers the administration of occupational accidents, injury and disease provisions at workplace, employer’s general duties towards to OSH, insurance requirements, employees’ general duties, medical support, compensations, offenses and penalties etc. The Labor Code covers protection against risks to the workers, notification procedures in occupational accidents, medical requirements at site and conveyance of injured workers to the hospitals, among others.

2.6 WORLD BANK ESF

Relevant Environmental and Social Standards. The World Bank’s Environmental and Social Standards seek to avoid, minimize, or mitigate the adverse effects of development projects it is financing through Investment Project Financing (IPF). The compliance with these Standards is required among others, to assure that the project is eligible for World Bank support. The project will apply the World Bank Environment and Social Framework. The following five ESSs are applicable to RCRF III:

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1 The Labor Code is in the review process with support from ILO. The revised draft Labor Code was agreed and adopted in February 2019 by representatives from various ministries of the Federal Government of Somalia, all Federal Member States, employers, workers, and academia. The Federal Ministry of Labor could not predict the likely timeframe for the Parliamentary approval, and advised that the existing Labor Code (1972) shall continue to be applicable until revised code becomes the law. Consultation with both State’s Labor Ministries also have confirmed that they follow the national Labor Code in administration of Labor matters in their States.
➢ 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 10: “Stakeholder Engagement and Information Disclosure”

More details on the ESSs and how they apply to RCRF III are enumerated in Table 2 below:

Table 1 – Applicability of ESSs

<table>
<thead>
<tr>
<th>ESS Standard</th>
<th>Explanation on applicability</th>
</tr>
</thead>
</table>
| ESS Assessment and Management of Environmental and Social Risks and Impacts | ESS1 sets out the Client’s responsibilities for assessing, managing and monitoring environmental and social risks and impacts associated with each stage of a project supported by the Bank through Investment Project Financing, in order to achieve environmental and social outcomes consistent with the Environmental and Social Standards (ESSs).

According to ESS1 the Client will manage environmental and social risks and impacts of the project throughout the project life cycle in a systematic manner, proportionate to the nature and scale of the project and the potential risks and impacts. The Client is thereby responsible to cascade compliance with standards along the chain of implementing partners, contractors, and subcontractors.

While the project will not civil works or construction mainly on technical assistance, capacity building and training, some activities like distribution of medical kits, storage, use and disposal may pose OHS issues and uncontrolled outbreaks of contagious diseases and is a threat to public health. Considering the contextual medical waste challenges the environmental risk rating is Moderate. Given some FHWs may be far from the Health facility, they will undergo appropriate training on offsite MW disposal procedures, prior to issuance of medical kits. Waste management teams constituted within the FHW will do follow ups and provide regular reports to the designated waste management officers.

The social risk rating is considered Substantial taking into account the following key social risks and impacts: (i) potential exclusion of disadvantaged and vulnerable groups in recruitment and service provision and elite capture; and (ii) potential risks of increased social tension in the community (for example, on how services are delivered, or siting of services); (iii) labor risks including OHS and security risks, sexual exploitation and abuse, sexual harassment, and other forms of gender-based violence (GBV) that may occur in recruitment or retention of skilled or unskilled female workers and the delivery of both health and education services; (v) contextual risks of operating in a conflict zone and complex social context where effective and inclusive community consultations, monitoring, and developing effective and trusted grievance redress mechanisms are challenging.

As a result, this Environmental and Social Management Framework (ESMF), including a Medical Waste Management Plan (MWMP), has been prepared, in conjunction with other, appropriate safeguards documentation, including:

➢ Labor Management Procedures
➢ Stakeholder Engagement Plan
➢ GBV Action Plan
➢ Environment and Social Commitment Plan |
| **ESS2 Labour and Working Conditions** | Members of the PIU (who are not civil servants) are people who are employed or engaged directly by the Borrower (including the project proponent and project implementing agencies) to work specifically in relation to the project are considered direct workers. People employed by the contracted firms or Health Technical Partner (firms) are the contracted workers. Both of these categories of project workers will be subject to the full requirements of ESS2.

The Project will finance the salaries and allowances of other civil servants as well as female health workers. They will remain subject to the terms and conditions of their existing public sector employment, which are governed by Somalia’s Provisional Constitution (2012) and Civil Service Law (Law Number 11) that covers permanent civil servants but does not apply to local government employees and to members of the armed forces or the police and corrections corps. Thus, ESS2 requirements will not apply to them other than child labour and forced labour and occupational health and safety (OHS) considerations. OHS risks include security risks, GBV risks, as well as risks from contracting infectious diseases e.g. Covid 19, and handling health supplies and waste and risks associated with natural or manmade risks on project workplaces.

Labor Management Procedures (LMP) have been prepared and the GBV risks will be addressed in a GBV action plan. The LMP will set out the Project’s approach and requirements to meeting ESS2 requirements. |
| **ESS3 Resource Efficiency and Pollution Prevention and Management** | Female health workers will be provided with basic medical kits that could become a source of infection for healthcare staff or communities if mishandled. Of particular concern is the handling infectious waste (including sharps) without adequate protective gear, storage of sharps in containers that are not puncture-proof, particularly as Somalia lacks appropriate medical waste management regulations. A medical waste management plan (MWMP) is contained in Annex 5. |
| **ESS4 Community Health and Safety** | Communities may be exposed to health risks arising from ineffective infection control and healthcare waste management. Mitigation measures will be outlined in the medical waste management plan including an awareness raising campaign to sensitize local communities against the reuse of needles, medicine bottles, and other used or expired medical supplies. Teachers will be oriented on the prevention of spread of infectious diseases such as Covid 19 in the classroom by themselves and other pupils as outlined in the ESMF.

As most teachers are male, women’s empowerment is low, project activities may exacerbate risks of sexual exploitation and abuse, harassment and other child protection issues. Incidences may further undermine females’ access to education services. Thus, a GBV action plan has been prepared in Annex 3 Sensitization on GBV and confidential grievance handling mechanisms, in line with global guidelines on ethical engagement, will be developed in addition to direct worker GMs and the project grievance mechanism.

Additional measures will include capacity building and training of relevant stakeholders, including project workers and government partners on GBV/SEA. In addition, GBV risks will be monitored throughout project implementation through regular re-assessment, particularly as new project locations are determined, and through regular monitoring activities. The GBV Action Plan will be updated as necessary throughout the life of the project.

No security personnel will be directly funded by the project, however, government security personnel at district level may be used by the independent verification agent, and the health technical partner and to help deliver other components e.g. health worker and teacher supervision and the monitor the piloting of the citizen engagement platform, thus code of conducts and training will be used for security forces to ensure risks to communities are mitigated. |
A Stakeholder Engagement Plan (SEP) has been prepared and will be updated as necessary. The SEP provides the framework for identification and consultation of stakeholders throughout the project cycle. Robust community engagements will be conducted before commencement of project activities as well as sensitization on the project GM to support the systematic processing and resolution of project related complaints and grievances. For GBV, reporting and response protocol including identification of SEA/H and GBV-sensitive channels to be integrated into the grievance mechanism, and requirements for enabling survivor-centered care.

The project will engage a range of stakeholders during both the preparation and implementation of this project including: the different ministries of Federal Government of Somalia and the participating Federal Member States, who will be responsible for project implementation and management; non-state actors, such as Development Partners (DPs) and relevant CSOs; communities, different groups of patients, TBAs and other traditional medicine providers, koran schools and religious leaders, parents, teachers and students. Information and feedback on criteria used and location of expansion of civil service appointments should be promoted as inequitable provision may exacerbate conflict and may lead to further mistrust and barriers to accessing services. All stakeholders will be engaged regularly through the life of the project and the SEP updated as needed.

Given Covid-19 restrictions, the project will use innovative ways of consulting stakeholders in order to meet project and stakeholder needs and adhere to the restrictions put in place by the government to contain virus spread. Strategies to be employed include FGDs to be conducted as appropriate taking full precautions on staff and community safety, one on one interviews through phone calls and virtual platforms for community representatives, CSOs and other interest groups. The Transparency and Citizen Engagement component of the Project will build on and strengthen the SEP and project GM.

No social impacts related to Indigenous people/Sub Saharan African Historically Underserved Traditional Local Communities or involuntary resettlement are anticipated under any of the activities proposed under the project.

2.7 WORLD BANK GROUP EHS GUIDELINES

The WBG General Environment, Health and Safety (EHS) Guidelines serve as useful references for EHS management for general non-sector specific activities. Projects financed by the World Bank Group are expected to comply with this guideline as required by the policies and the standards. The EHS General Guidelines address occupational health and safety, community health and safety as well as on construction and decommissioning. It contains guidelines cross cutting on environmental (waste management, ambient air quality, noise and water pollution), occupational health and safety issues among others, applicable to all the industry sectors. In addition, WGB EHS Guidelines on Healthcare Facilities provides good practice guidance on handling medical waste which is relevant to the project.

2.8 WORLD BANK GROUP GUIDELINES ON GENDER AND GBV

The WBG note on gender provides guidance on how, at the project level, activities can work to close gaps between men and women, girls and boys and enhance women’s leadership and voice. The note is specifically aimed at addressing gender gaps in the context of the ESF focusing at the project level and the identification and mitigation of risks and impacts through the process of environmental and social assessment. The GBV note includes definitions of sexual exploitation and abuse and sexual harassment (SEA/SH) and their operationalization in Bank-financed projects; updated language changing Gender Based Violence (GBV) to SEA/SH where relevant; and additional information on third-party monitoring of SEA/SH. It seeks to assist Task Teams in identifying risks of SEA/SH and to advise Borrowers on how to best manage such risks.
2.9 World Bank Group Guideline on the Use of Security Forces

The good practice note on use of security forces is intended to support project teams and environmental and social specialists as they work with Borrowers in assessing and managing risks to the safety and security of project-affected communities and project workers. The focus is on identifying risks that could arise from the use or presence of security personnel that have been engaged to protect the project or related aspects. If it is decided that security personnel should be engaged, the potential risks and impacts stemming from such engagement in turn needs to be assessed and management measures identified in accordance with the mitigation hierarchy.
3. COUNTRY CONTEXT AND SOCIO-ECONOMIC SETTING

3.1 CONTEXT OVERVIEW

Somalia is currently on a path of political stabilization and reconstruction, after more than twenty years of conflict. Since the collapse of the Siad Barre government in 1991, cycles of conflict have fragmented the country, destroyed legitimate institutions and large segments of the economy, and displaced millions of people. The adoption of the Provisional Constitution in 2012, peaceful presidential elections in 2012 and 2017, and a broader regularization of Somalia’s political processes represent important milestones. Although the Somali economy has been recovering at a modest pace, there is a high degree of susceptibility to external shocks such as droughts and epidemics. In post-conflict Somalia, health and education systems remain weak, poorly resourced and inequitably distributed. The challenges in social services sectors are complex and multidimensional including the areas of training and shortage of medical and educational staff, school and health infrastructure, curriculum, unregulated private actors, and finance. The current COVID-19 pandemic is expected to result in a recessionary impact and further stretch the fragile healthcare system. Causes of insecurity remain the on-going insurgency from Al Shabaab and resource-based communal conflicts.

3.2 EDUCATION

Somalia lags behind almost all Sub-Saharan African countries in enrolment at the primary and secondary level. Primary gross enrolment rate (GER) has increased very slowly, the primary completion rate is less than 40 percent, and lower secondary schooling places are available to only about a third of primary school graduates. In Puntland and Somaliland, the secondary GER remains 12.6% and 20.5 % respectively. The situation in the central and southern FMS is much more critical and remains very low, as the secondary GER is estimated at 12.2%. An estimated 2.5 million children and youth aged 5-14, comprising some approximately 35 percent of Somalia's population remain excluded from schooling and training opportunities. Majority of these children live in the target regions of the RCRF 3 – Benadir, Galmudug, Hirshabelle, Jubbaland and South West States of Somalia.

Gains in access to education in Somalia have not been accompanied by satisfactory learning outcomes. Children who do attend school face many obstacles, including a shortage of qualified teachers (most of who quit teaching as a result of absence of a salary structure); inadequate facilities, inadequate textbooks, and language problem (most teachers have limited functional knowledge of English yet textbooks are often in English); and inadequate facilities. Less than 40 percent of primary and secondary teachers are qualified to teach. With such large number of unqualified teachers in the system, the poor learning outcomes for Somali children are not surprising and can be attributed in large part to poor teaching quality. The proportion of female teachers at primary and secondary levels is less than 20% across Somalia. Public financing of the education sector remains limited, with most of services provided by non-state actors including households, and donors. As reported from the latest school census, nearly 95 percent of the registered primary schools in Mogadishu alone are managed by non-state actors. Though the budget allocation to the education hasn’t increased much in tandem with the growth of the revenue, the share of public expenditure on education remains less than 5 percent in 2019.

3.3 HEALTH

The country ranks among the highest for maternal mortality ratio (732 per 100,000 live births in 2016) and life expectancy at birth is only 58.5 years (2017). The estimated fertility rate (6.2), second highest globally, further strains already weak service delivery systems.² Health service delivery data in Somalia

² World Development Indicators, https://data.worldbank.org/indicator/SP.DYN.LE00.FE.IN?locations=SO
are very limited and indicate weak health systems, with facilities concentrated in urban areas. Until recently, the most reliable service delivery data in Somalia were from a 2011 multi-indicator cluster survey (MICS) conducted only in Puntland and Somaliland. The 2011 Somaliland and Puntland MICS indicate, respectively 11% and 9% DPT3 coverage, 32% and 24% prenatal care by skilled personnel, and 44% and 38% skilled deliveries. In 2019, the United Nations Population Fund (UNFPA) conducted the Somalia Health and Demographic Survey (SHDS). Final and geographically disaggregated data from the survey have not yet been released, but provisional data indicate marginal service delivery improvements since 2011. Based on the SHDS, 31% of births across Somalia are estimated to take place at health facilities and coverage of DPT3 is estimated at 12% (SHDS provisional data, 2019). Health service delivery is believed to be much less developed in the four emerging states which composed the former South-Central zone where health systems are less developed and health services are provided predominately in urban areas (SARA, 2016).

The poorly regulated private sector is an important service delivery provider. At least 60% of health services are estimated to be delivered by the private sector. Analysis indicates that public perceptions of private facility quality is higher than of public facilities. It is estimated that the private sector provides around 70% of the country’s medicines and the UN provides 30%. However, due to lack of regulation in Somalia’s health sector, there are no quality standards for services or health commodities, limiting the full potential of the private sector. Other than the nascent Ministries of Health in Somaliland and Puntland, the rest of the country is just beginning to set up governance structures. Key health staff in most of the Ministry of Health units are either secondees from NGOs and other development partners or volunteers. The recently conducted institutional assessments for FMS revealed, for instance, all 57 Hirshabelle State Ministry of Health staff are externally funded and off-treasury.

Somalia does not have effective government institutions in place or an environmental health strategy to deal with waste management and control in a coherent manner. Hospital waste, like biohazardous and biological waste, including disposable medical supplies (i.e. used needles, syringes and vials, gloves, surgical dressings and unused expired medicines) are scattered around hospital premises. Owing to the lack of proper planning or control of biohazardous waste management, the public is left unprotected from this hazardous and infectious waste.

3.4 SOCIAL ISSUES – GENDER AND MARGINALIZED GROUPS

Gender and equality

Gender segregation is deeply rooted in traditional Somali socio-cultural structures and remains a formidable barrier to women’s participation in decision-making processes and access to – and control of – resources. Gender-related disparities remain an area of major concern, especially in the fields of education and health. More boys than girls are enrolled in primary, secondary and tertiary education. Moreover, there is a higher dropout rate for girls due to lack of resources and the prioritization of education for boys. Reproductive health indicators are poor, with a maternal mortality ratio of 732 deaths per 100,000 live births and a high fertility rate of 6.4. Despite recent successes, the representation of women in political positions, such as parliament remains low.3 Efforts to codify a gender quota in electoral legislation has thus far been unsuccessful. As result of the collapse of the state and the subsequent decades of conflict, women have been vulnerable to physical insecurity in the form of GBV such as rape and domestic violence. While these behaviors are still taboo, the combination of high rates of male unemployment and khat addictions, have contributed to increased instances of these types of violence against women. Women have become primary breadwinners in

3 http://applications.emro.who.int/docs/CCS_Somalia_2010_EN_14487.pdf?ua=1
many households yet are still largely restricted to the small and petty trade sectors. In the Somalia civil service, women make up only 25% of the government workforce.

**Marginalized Groups**

The ethnic identity of Somalis is informed by a complex history of clans and sub-clans, 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 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. They 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 communities where Al Shabaab have relative ease of movement. As a result, these rural communities are often unable to access social services provided by the government or international community.

**Waste Management**

Having experienced chronic conflict for over 25 years, Somalia is finally on the path towards post conflict recovery characterized by the re-establishment of formal government structures in an effort towards the provision of governance services to its citizens.

In a post conflict environment, there is a general lack of formal systems that governs certain sectors, and hence the gaps observed such as the general lack of solid waste management. There are no regulations or systems governing the disposal and management of waste. All levels of administration including cities/regional and/or district government authority are not able to provide waste management services to the public. This has caused rampant indiscriminate disposal of solid waste including open disposal of solid waste in the streets and the public beaches. Burying of waste in homes, hospitals and in public spaces is a common practice as is open burning. Hospitals generally have incinerators, but at health centre level incinerators are scarce.
4. KEY RISKS AND IMPACT MITIGATION

4.1. INTRODUCTION

Given the fragile state context of Somalia, the social risk rating is substantial. The rating takes into account the weak governance institutions, continued insecurity, and conflictual socio-political dynamics that contribute to a myriad of social risks. The project will be supporting the delivery of health and education services in all FMS, as well as supporting civil servants in FGS and FMS in a range of cadres and has a new citizen engagement and feedback component. Generally, these activities may result in positive and negative potential impacts as discussed in this chapter. Potential environmental and social impacts can be adequately managed by integrating environmental and social due diligence into the sub-project cycle. The ESMF will guide handling of project environmental and social aspects during implementation, specifically the identification of potential projects impacts.

4.2. POTENTIAL RISKS OF THE PROJECT

The potential social risks outlined below were developed through a series of consultations with a diverse set of stakeholders including government staff, health workers, civil society and NGO staff (see Annex 2). The consultations were done virtually due to the restrictions of the Covid 19 pandemic. A stakeholder consultation meeting was held to get input into the instruments once prepared.

Potential Social Risks

Equity

- Hiring decisions that bring on board staff across all categories of labor (direct and indirect) may not reflect transparent and fair processes and instead be influenced by nepotism or clannism or assumptions about women e.g. that they cannot provide certain services or cannot be relied upon unless married. Minority clans and groups and IDPs are particularly at risk of discrimination.
- Some recruited health and education staff may fail to provide services without discrimination, including to underserved populations.
- The plan to tie support for schools to a PBC linked to test scores or other quality measures may marginalize poorer communities where students do not have access to tutoring services or other methods of improving learning outcomes.

Occupational Health and Safety (OHS)

- Workers may be directly targeted by violent non-state actors for their affiliation with the government. This a particular threat for those working near areas outside of government control, areas where people congregate e.g. health centres and schools may also be a target.
- Physical structures from which workers provide services to the community may not cater for females.
- Female health workers may be exposed to infectious diseases because of a lack of personal protective equipment and training.
- Female health workers will be provided with basic medical kits that could become a source of infection for healthcare staff or communities. Of particular concern is the handling infectious waste (including sharps) without adequate protective gear, storage of sharps in containers that are not puncture-proof, particularly as Somalia lacks appropriate medical waste management facilities, awareness and regulations.
- Physical structures used by workers may be exposed to natural or man-made risks which in turn could impact the OHS of workers.
Gender-based Violence (GBV)
- FHWs often travel alone and by foot to homes to provide services. As a result, they are particularly vulnerable to GBV.
- Limited trainings for key personnel (health and education) providing services to GBV survivors as well as lack of information on who provides what, can increase harm, violence and death.
- 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 forced marriage to the perpetrator.
- With the current COVID 19 pandemic, women working in the frontline such as health may experience abuse including intimate partner violence at home and other forms of abuse while in the community.

Sexual Exploitation Abuse and/or Harassment (SEAH)
- Female workers (whether civil servants, FHW or teachers) may be subject to SEA/SH in the recruitment or retention process given men dominate the hiring management in most if not all government offices.
- Lack of integrated policies providing protective environment free from GBV, SEA/ SH.

Other gender issues
- 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 lack of female representation in school management may serve to limit the ability of communities to increase the number of female teachers – a critical component in providing a welcoming environment for girl students.

Other potential risks
- The focus of support exclusively to FHWs may marginalize traditional birth attendants who are the primary providers of pre and post pregnancy care in rural areas.

SOCIAL RISKS - MONITORING AND MITIGATION MEASURES
Using the World Bank’s ESF guidance, the borrower has developed monitoring plans to identify and mitigate the varied social risks and impacts associated with the RCRF 3 project.

Labor Risks
Potential risks are those related to labor and working conditions, such as work-related discrimination, gender-based violence (GBV) and occupational health and safety (OHS) and security risks. For labor-related risks a Labor Management Procedures (LMP) have been prepared and GBV risks are addressed in a GBV action plan contained in Annex 8. A security guideline will be developed and rolled out for all workers. The LMP includes a Code of Conduct for project workers who will receive training on OHS, GBV and security requirements.

Stakeholder Engagement
The World Bank Environment and Social Standards require continuous public consultation with affected groups and other stakeholders about the project environmental and social impacts. This is with a view of taking their suggestions and inputs into account in the project design and improving project outcomes during implementation.
The government will implement the Stakeholder Engagement Plan (SEP) 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 to the best of its ability. In Somalia, consistent and meaningful dialogue with stakeholders is critical to maximize opportunities for the project’s success and to improve the social contract between the government and its citizens. In addition, the SEP can contribute to the setting of mutual expectations and to clarify the extent of the government’s commitments and resources. The SEP includes a grievance mechanism (GM) to allow for the government to act upon complaints and suggestions for improvements in a timely fashion. All stakeholders will be engaged regularly through the life of the project, and the SEP updated as needed.

Given Covid-19 restrictions, the project will use innovative ways of consulting stakeholders in order to meet project and stakeholder needs and adhere to the restrictions put in place by the government to contain virus spread. Strategies to be employed include FGDs to be conducted as appropriate taking full precautions on staff and community safety, one on one interviews through phone and skype for community representatives, CSOs and other interest groups as well as using other platforms such as WhatsApp groups of community representatives and other virtual tools e.g. GEMS monitoring tools.

**Grievance Mechanism**

The project will have several channels for complaints and grievances including email, phone calls, texts, blogs, hotline and letter writing that will also be accessible to all workers and have confidential and appropriate mechanisms for dealing with SEA/SH complaints and whistle blower protection. Information on the project GM will be made available to workers at all facilities, government offices (both national and local) and community level (health clinic, for instance) to ensure that all workers, including indirect workers such as FHWs have adequate information on how to lodge a complaint and who to direct it to. Anonymity will be assured when handling workers’ grievances. Although ‘suggestion boxes’ exist in many worksites and appear to be a preferred form of reporting complaints, the experience has been that these boxes are hardly opened. If these have to be used as part of the GRM, a structure needs to be put in place for opening, reviewing, responding and providing feedback on the issues raised.

The table below outlines mitigation measures for the key social and environmental risks identified through the initial stakeholder consultations:

**Table 2 – Risk Mitigation Matrix**

<table>
<thead>
<tr>
<th>Social Risks</th>
<th>Mitigation/Management Strategy</th>
<th>How will this be monitored?</th>
<th>Who is responsible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unanticipated social risks</td>
<td>Monitoring of unanticipated social risks and intensification of mitigation measures by the social specialists</td>
<td>Through the monitoring and grievance mechanisms and community feedback mechanisms</td>
<td>Ministry of Finance/PIU</td>
</tr>
<tr>
<td>Discriminatory recruitment practices</td>
<td>Recruitment procedures ensuring transparent and fair practices will be required for Project workers including direct and contracted workers.</td>
<td>For direct and contracted workers, any complaints related to recruitment will be dealt with by the project workers grievance mechanisms.</td>
<td>Ministry of Finance/PIU and contractors</td>
</tr>
<tr>
<td>Issue</td>
<td>Solution</td>
<td>Ministry</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Code of conduct for civil servants include clauses on equal treatment of all without discrimination regardless of ethnic background, disability or wealth.</td>
<td>For contracted workers, any complaints related to recruitment will be channeled through the project GM.</td>
<td>Ministry of Finance/Social Specialists</td>
<td></td>
</tr>
<tr>
<td>Inequitable provision of services to communities</td>
<td>Ministry of Health and Ministry of Education, working with DPs operating in the health and education sectors, will use data to ensure areas of need are able to access services and selection process is transparent and objective.</td>
<td>The SEP will ensure regular community consultations on project performance. The project GM will allow for submission of complaints from citizens related to project performance and area selection.</td>
<td></td>
</tr>
<tr>
<td>Code of conduct for civil servants include clauses on equal treatment of all without discrimination regardless of ethnic background, disability or wealth.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Marginalisation of TBAs as FHWs will encourage mothers to go to health centres for births</td>
<td>FHWs will coordinate with traditional birth attendants, to promote utilization of antenatal care, facility delivery, postnatal care and birth spacing services. TBAs can also be selected as FHWs.</td>
<td>Community feedback and project monitoring mechanisms</td>
<td>MoH</td>
</tr>
<tr>
<td>Elite capture of jobs and benefits</td>
<td>The selection of FHWs will be done by communities in an open and transparent way and awareness raising will be carried out on service, however FHWs will serve all the community including VMGs. Also FHWs will be posted in areas of need including VMG areas and will include VMGs. The school grants program, will move from funding teacher payrolls to schools based on performance standards, which will promote selection of teacher based on merit. Code of conduct for civil servants include clauses on equal treatment of all without discrimination regardless of ethnic background, disability or wealth.</td>
<td>Community feedback and monitoring mechanisms including with VMGs</td>
<td>MoH/MoE</td>
</tr>
<tr>
<td>Lack of inclusion in the citizen engagement platform</td>
<td>Citizen Engagement will ensure inclusion and reach to vulnerable and marginalized groups.</td>
<td>Plans for citizen engagement will be reviewed closely to ensure all measures are undertaken to promote engagement with vulnerable and marginalized groups.</td>
<td>Ministry of Finance/Social Specialists</td>
</tr>
<tr>
<td><strong>Security threats to staff and users of education and health services</strong></td>
<td>The PIU will develop security guidelines and protocols for project workers and civil servants which will be rolled out to all civil servants funded by the project as well as project workers. All workers will be made aware of the protocols and compliance will be promoted within code of conducts. Project staff will be trained on security guidelines and protocols on a regular basis. Some schools may employ security guards in insecure areas or when they may be targeted. Orientation, training and code of conducts will be out in place to comply with the World Bank guidance note on the use of security personnel. Contractors will be required to include security procedures to protect staff in their bidding documents and report on serious incidents as per the ESIRT protocols. Due diligence will be carried out before awards. Ministry of Finance/PIU to monitor and address threats to direct project staff.</td>
<td>The SEP will ensure regular community consultations which will promote feedback on security concerns, buy in from communities and improve security for service provision. In addition, the project GM will further allow for submission of complaints from citizens related to security. This will be included in the POM for the school grants program and monitored by MoF and MOE. Contractors security arrangements will be included in their reports and monitored by the person supervising their contract together with the social safeguards officer. Ministry of Finance/PIU and FGS and FMS social specialists</td>
<td>Ministry of Finance/PIU and FGS and FMS social specialists</td>
</tr>
<tr>
<td><strong>SEAH/GBV</strong></td>
<td>Based on a GBV Action Plan, the project will: 1) Identify actions to mitigate GBV/SEAH risks among staff, patients, students, and community members, 2) carry out capacity building and training of relevant stakeholders, including project workers and government partners on GBV/SEAH; the project will also conduct consultation and sensitization and awareness raising activities with communities on GBV/SEAH risks; 3) Develop an effective GRM with separate channels to manage GBV-related complaints in order to enable reporting of GBV incidents in a safe, confidential and survivor centric manner.</td>
<td>The SEP will ensure regular community awareness on GBV/SEAH issues. The project GM will identify specified channels to allow for the safe, confidential and survivor-centric submission of complaints from citizens related to GBV/SEAH. The GBV advisors will provide quarterly reports on the implementation of the GBV action plan.</td>
<td>Ministry of Finance PIU/GBV advisor and social specialists at FMS level</td>
</tr>
</tbody>
</table>
ENVIRONMENTAL RISKS - MONITORING AND MITIGATION MEASURES

The environment risk rating is Moderate, due to the waste generated from the medical kits to be supplied to female health workers. The main environmental issues for the project relate to the handling and disposal of medical kits and limiting the spread of communicable diseases (e.g. Covid 19) through health and education provision. Other project activities do not pose risks, since they relate to technical assistance, capacity building and training. All potential impacts are expected to be temporary, site-specific, and mostly reversible, and mitigation measures can readily be designed. Therefore, the ESMF will include a Medical Waste Management Plan (MWMP) under annex 7 that manages risks to prevent public health risk and environmental impacts.

Potential Risks

The activities proposed under health care may potentially increase the generation of health care waste such as sharps, infectious and noninfectious waste due to the deployment and supplies medical kits by female health workers. EHS Guidelines under WGB EHS Guidelines on Healthcare Facilities (HCF). provides good practice guidance on handling medical wastes which is relevant to the project and the project will make use of it. Further the MWMP (See annex 7) will be used to manage the identified risks.

The work environment is anticipated to generate risks and impacts to the occupational health and safety (OHS) of healthcare workers, including patient handling, falls, sharps injuries, infection, security and violence, exposure to hazardous drugs, environmental hazards, and ergonomics. These will need to be managed carefully to support the wellbeing of healthcare workers in hospitals and health facilities.

Health care providers are not only at risk of infection themselves but are partly responsible for the spread of infection in the population if they do not maintain standard hygiene practices. Health care workers risk infection and spreading infection as they handle and come across different types of infectious medical waste. Examples of poor hygiene practices that can cause infection are inadequate handwashing, inappropriate use of gloves, recapping of needles, and lack of appropriate decontamination.

Disease transmission. Diseases can be transmitted from:

- Health worker to patient, resulting from unwashed hands, contaminated sharps, or improperly cleaned reusable equipment.
- Patient to health worker, resulting from accidental prick by needles or sharps that have been used on patients or blood or body fluids accidentally splashing on to or coming in contact with broken skin.
- Health worker to family and community, resulting from health workers with unclean hands or contaminated clothing or shoes carrying infection home to family members.
- Health facility to community, resulting from improper disposal of medical waste and sharps. This can lead to transmission of disease to community members due to needlestick injury or needle reuse.

Hazards from sharp items

- The main source of illness from infectious waste is most likely injuries from used sharps. Sharps cause cuts and punctures and infect the wounds with agents that previously contaminated the sharps.
- According to WHO, the risk of infection following a needlestick injury with a needle from and infected source patient is 0.3 percent for HIV, 3 percent for hepatitis C, and 6 percent to 30 percent for hepatitis B.
• Recapping of sharps continues to be a challenge. Recapping means to put the protection cap back on the needle after usage and is considered one of the main reasons for needlestick accidents.

Hazards from infectious waste
Community Health Risk due to Improper Waste Management - Improper infectious waste disposal can cause public health risks due to environmental pollution: impaired air quality, wastewater/sewage handling, storm water contamination of water courses or when adults and children rummage through raw waste stockpiles. Infectious waste may contain a great variety of pathogenic micro-organisms, which may infect the human body through one of the following pathways:
- Crack or cut in the skin (injection) through absorption.
- Mucous membranes through absorption.
- Inhalation and ingestion.

Hazards from chemical and pharmaceutical waste
Medical Stores are potential sources of infectious waste in gaseous, liquid or solid forms. These could pose unsafe conditions for healthcare staff. Of particular concern are staff handling infectious waste (including sharps) without adequate protective gear, storage of sharps in containers that are not puncture-proof. While some OHS risks will be borne by the project activities, most other effects are existing (hence cumulative) and would only be exacerbated by increased scale of healthcare services. Some examples of hazardous substances and their effects in health care facilities are:
- **Mercury** - Mercury is prevalent in hundreds of different devices but is most concentrated in diagnostic devices such as thermometers, blood pressure meters, esophageal dilators, and Miller-Abbott and Cantor tubes. It is also found in additional mercury sources such as fluorescent light tubes and batteries.
- **Disinfectants** - Disinfectants constitute a particularly important group, as they are used in large quantities and are often corrosive. It should also be noted that reactive chemicals may form secondary compounds of high toxicity.
- **Chemical residues** - Chemical residues discharged into the sewage system may have toxic effects on the operation of biological sewage treatment plants or on the natural water ecosystem.
- **Pharmaceutical residues** - Pharmaceutical residues may have the same effects, as they may include antibiotics and other drugs, heavy metals such as mercury, phenols and derivatives, and other disinfectants and antiseptics

**Table 3 – Risk Mitigation Matrix**

<table>
<thead>
<tr>
<th>Environmental Risks</th>
<th>Mitigation/Management Strategy</th>
<th>How will this be monitored?</th>
<th>Who is responsible?</th>
</tr>
</thead>
</table>


| Risk of Exposure of FHW to infectious diseases such as COVID-19 | • Provide immediate and ongoing training on the procedures to all categories of workers, and post signage in all public spaces mandating hand hygiene and PPE  • Develop a basic, responsive grievance mechanism to allow workers to quickly inform management of labor issues, such as a lack of PPE and unreasonable overtime  • Ensure adequate supplies of PPE (particularly facemask, gowns, gloves, handwashing soap and sanitizer) are available  • Ensure adequate OHS protections in accordance with General EHSGs and EHS Guideline for Health Care Facilities | An assessment of training records, medical waste management and PPE adequacy and usage by health workers will be included as part of inspections to be carried out by third-party monitors during supervision visits at the local level. Procedures to respond to the specific health and safety issues posed by COVID-19 and facilities (buildings) for project workers and protect workers’ rights as set out in ESS2. WGB EHS Guidelines and WGB EHS Guidelines on Healthcare Facilities (HCF) will be followed | Environmental officers in FMS MoF and Ministry of Health |
| Improper disposal of medical waste | ESMF provides guidance on medical waste management plan (MWMP) (See annex 7) including: training of health staff in Primary Health facilities on disinfection and waste disposal protocols; timely distribution of cleaning agents and routine monitoring to ensure Infection Prevention and Control standards are sustained. | Prior screening on MWMP (See annex 7) preparedness will be carried during the roll out for all participating HCF. While during monitoring inspection visits, an assessment of medical waste management, including PPE adequacy and usage by female health workers, will be carried out by third-party monitors using appropriate questionnaires. Where EHS issues around adequacy MW management is noted during monitoring appropriate corrective actions will be implemented to ensure adequate MWMP systems are in place (see Annex 6 for generic inspection checklist). Given some FHWs may be too far from the Health facility, they will prior to issuance of medical kits undergo appropriate offsite training on MW disposal procedures. Waste management teams constituted within the FHW will do follow up and provide regular reports to the designated waste management officers. | Environmental officers in and focal points in the Ministry of Health Ministry of Finance/Social Specialists |
5. **GRIEVANCE REDRESS MECHANISM**

Under the new World Bank ESF, Bank-supported projects are required to have a functional and trusted mechanisms in place that address concerns and grievances that arise in connection with a project. One of the key objectives of ESS 10 (Stakeholder Engagement and Information Disclosure) is ‘to provide project-affected parties with accessible and inclusive means to raise issues and grievances and allow borrowers to respond and manage such grievances’. This Project GRM should facilitate the Project to respond to concerns and grievances of the project-affected parties related to the environmental and social performance of the project. The project will provide mechanisms to receive and facilitate resolutions to such concerns.

The Ministry of Finance will have the responsibility of overseeing the resolution of all issues related to the project activities in accordance with the laws of FGS and the World Bank Environmental and Social Standards 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 Safeguards specialists at the FGS and FMS level who will receive grievances by phone, text or email to publicized mobile phone lines and email addresses at both FMS and FGS level. 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, thus their name and contacts will not be logged and whistleblower protection for complaints raised in good faith will be ensured. Grievances related to the overall project will be dealt with by the Ministry of Finance/PIU at FGS and FMS level, however those about health or education service provision will be resolved in conjunction with the relevant ministry at the FGS and/or FMS. The FGS senior social specialist will carry out training of all PIU staff and Ministry of Health and education focal points on receiving complaints and referral and complaints handling and reporting.

A grievance redress committee (GRC) will be established at FMS and FGS level chaired by the project manager, and the relevant PIU staff will be included as necessary depending on the complaint (procurement, finance, M&E GBV advisor and communications), in addition staff from the Ministries of Health and Education will be invited as required. The Social Safeguards Officers will minite the meetings and follow up the grievance resolution process. The GRC will meet monthly to review minor complaints, progress on complaints resolution, review the development and effectiveness of the grievance mechanism, and ensure that all staff and communities are aware of the system and the project. Immediate meetings will be held in case of significant complaints to be addressed at the Ministry of Finance/PIU level. Significant complaints will be outlined in the GM manual. For serious or severe complaints involving harm to people or the environment or those which may pose a risk to the project reputation, the FMS social specialist should immediately inform the FGS social specialist or head of the PIU, who will inform the World Bank within 72 hours as per the Environmental and Social Incident Reporting (ESIRT) requirements.

A serious incident is one that caused or may cause significant harm to the environment, workers, communities, or natural or cultural resources, is complex or costly to reverse and may result in some level of lasting damage or injury; or failure to implement E&S measures with significant impacts or repeated non-compliance with E&S policies; or failure to remedy Indicative non-compliance that may potentially cause significant impacts.

Examples of serious incidents may include injuries to workers that require off-site medical attention, exploitation or abuse of vulnerable groups, consistent lack of Occupational Health and Safety (OHS) plans in a civil works project, and large-scale deforestation. Serious incidents require an urgent response and could pose a significant reputational risk for the Bank.
A severe incident is one that caused or may cause great harm to individuals or the environment, or present significant reputational risks that could hamper the Bank’s ability to operate in a country or region. The Borrower’s inability or unwillingness to remedy situations that could result in serious or severe harm would be a factor in classification. A severe incident is complex and expensive to remedy (if possible), and is likely irreversible. A fatality is automatically classified as severe, as are incidents of major environmental contamination, forced or child labor, abuses of community members by project security forces or other project workers (including GBV) violent community protests a project, kidnapping, and trafficking in endangered species.

The social specialists are responsible for noting and reporting critical trends emerging in the GM process such as an increase/decrease in types of grievances to share with the GRC, as well as tracking complaints expressed on social media and whether and how these should be addressed. Throughout the process, the social specialists will receive support from the PIU.

Types of grievance: Complaints may be raised by staff, partners, consultants, contractors, members of the community where the programme is operating or members of the general public regarding any aspect of programme implementation. Potential complaints include:
1. Fairness of contracting
2. Fraud or corruption issues
3. Inclusion
4. Social and environmental impacts
5. Payment related complaints
6. Quality of service issues
7. Poor use of funds
8. Workers’ rights
9. Gender Based Violence, sexual harassment or sexual exploitation and abuse
10. Forced labour, including human trafficking and use of prison labour
11. Child labour
12. Threats to personal or communal safety

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. This will be included in contractors’ contracts and managed by the project secretary who will have this specific mandate to support the social safeguards officer.

Separate channels to manage GBV-related complaints will be identified and integrated into the GM to enable reporting in a safe, confidential and survivor centric manner to be developed under the key activities under the GBV Action Plan and to be integrated into relevant project documents, such as the Project Operations Manual. The social specialists will have some background in GBV issues, and will be trained on the GBV action plan by the GBV advisor.

Building Awareness on GM: The PIU will initially brief all its staff, and the staff of the implementing Ministries and FMS PIUs, on the GM procedures to be used including the reporting and resolution, as well as how to handle and refer complaints if they receive them. A public awareness campaign will be conducted to inform all communities, stakeholders and financed staff on the mechanism, as well as its functionality and whistle blower protection procedures to promote trust so that stakeholders feel comfortable raising concerns. A one pager will be developed providing details and a visual poster and leaflet provided in all areas where the project is implemented. Various mediums will be used to raise awareness on the GM including social media and FM radio to reach remote communities, including call ins with panels including community and government representatives and information on how complaints are handled and resolved. The radio stations will be carefully selected to reach communities targeted for support under the RCRF 3 including vulnerable and
marginalized groups. The GM procedure and contacts, will also be published on Ministry of Finance website indicating a phone number, email and address for further information. The GM will be represented in simple visual material as well as Somali dialects as needed.

The project will aim to address grievances with the following steps and indicative timelines:

<table>
<thead>
<tr>
<th>Steps to address the grievance</th>
<th>Indicative timeline*</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Receive, register and acknowledge complaint in writing. Serious complaints immediately reported to the PM who will report to the World Bank.</td>
<td>Within two days</td>
<td>The person receiving the complaint. Social specialist at FGS and FMS levels supported by PIU.</td>
</tr>
<tr>
<td>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 the complaint directed to the relevant department.</td>
<td>Within one week</td>
<td>Social specialist supported by PIU.</td>
</tr>
<tr>
<td>3 Program manager and social specialist to consider ways to address the complaint if required in consultation with the GRC.</td>
<td>Within one week</td>
<td>Program manager supported by PIU.</td>
</tr>
<tr>
<td>4 Implement the case resolution and feedback to the complainant.</td>
<td>Within 21 days</td>
<td>Program manager with support from GRC.</td>
</tr>
<tr>
<td>5 Document the grievance and actions taken and submit the report to PIU.</td>
<td>Within 21 days</td>
<td>Social specialist and GRC supported by PIU</td>
</tr>
<tr>
<td>6 Elevation of the case to the government judiciary system, if complainant so wishes.</td>
<td>Anytime</td>
<td>The complainant</td>
</tr>
</tbody>
</table>

* If this timeline cannot be met, the complainant will be informed in writing that the GRC requires additional time. Social specialist, GRC supported by PIU

Grievances related to Gender Based Violence (GBV):
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.

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

The project will identify clear channels for reporting as well develop tools to track grievances related to GBV/SEAH as well as reporting procedures and the appropriate timeline for response actions, depending on the severity of the allegation. Where such a case is reported to the GM, survivors as they so choose and with informed consent should be offered immediate referral to appropriate service providers (such as NGO or UN run GBV services or government run services), such as law enforcement, medical and psychological support, emergency accommodation, and any other necessary services. Data on GBV cases should not be collected through the GM unless the GM operators have been trained on how to manage and deal with the complainant empathetically, 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 even if the complaint is not related to the project, that referrals will be made, 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.

PIUs and social focal points will be trained to improve understanding, management, and monitoring of GBV risks. They will have basic skills to respond to disclosures of GBV in a compassionate and non-judgmental manner and know to whom they can make referrals to.

The GRM for GBV/SEAH approach will be:

- Be Survivor-centred - that ensures the response to the incident is in line the safety, respect, confidentiality and non-discrimination of the survivor.
- Strengthen the speed and effectiveness of response (should such an incident occur) through well-functioning protocols and remedial actions to enable safe and ethical care of survivors.

In consultation with the Ministry of Finance, Ministry of Education, Ministry of Health and relevant community stakeholder, separate channels and protocols for reporting and addressing allegations of GBV/SEAH will be identified and integrated into the grievance mechanism. This will include information on disclosure and reporting guidelines/protocol for GBV/SEA/SH, processes for referral, as well as culturally appropriate community-based reporting mechanism to facilitated reporting.

**Project workers GM**

All contractors including the Health Technical Partner and other contractors e.g. for the citizen engagement component or monitoring and citizen feedback, a workers GM will be required and included in bidding documents and contracts. Project staff at FMS and FGS level, will be encouraged to raise concerns with their immediate supervisor or the Project Coordinator (FMS) or Project Manager. However if the concern relates to the LMP provisions they can also raise it via the social safeguards officer at FGS level who will forward to the Project manager for resolution in conjunction with a workers’ GRC consisting of the procurement officer, the project secretary and the social safeguards specialist or if it is not resolved by the Director General of MoF who can be contacted at: mof@mof.gov.so and dg@mof.gov.so. Recipients of these emails will be oriented on how to refer complaints confidentially.

See below for flowchart outlining grievance focal points and redress committees:
COMPLAINTS TO THE WORLD BANK

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

**World Bank Grievance Redress Service:**\(^4\) If no satisfactory resolution has been received from the World Bank Country office, grievances can be raised with the World Bank Office in Washington. For more information: [http://www.worldbank.org/grs](http://www.worldbank.org/grs), email: grievances@worldbank.org

The World Bank’s Grievance Redress Service (GRS) provides an additional, accessible way for individuals and communities to complain directly to the World Bank if they believe that a World Bank-financed project had or is likely to have adverse effects on them or their community. The GRS enhances the World Bank’s responsiveness and accountability by ensuring that grievances are promptly reviewed and responded to, and problems and solutions are identified by working together.

The GRS accepts complaints in English or the official language of the country of the person submitting the complaint. Submissions to the GRS may be sent to:

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

WORLD BANK INSPECTION PANEL

The Inspection Panel is an independent complaints mechanism for people and communities who believe that they have been, or are likely to be, adversely affected by a World Bank-funded project. The Board of Executive Directors created the Inspection Panel in 1993 to ensure that people have access to an independent body to express their concerns and seek recourse. The Panel assesses allegations of harm to people or the environment and reviews whether the Bank followed its operational policies and procedures.

The Panel has authority to receive Requests for Inspection, which raise issues of harm as a result of a violation of the Bank’s policies and procedures from:

- Any group of two or more people in the country where the Bank financed project is located who believe that, as a result of the Bank’s violation of its policies and procedures, their rights or interests have been, or are likely to be adversely affected in a direct and material way. They may be an organization, association, society or other group of individuals;
- A duly appointed local representative acting on explicit instructions as the agent of adversely affected people;
- In exceptional cases, a foreign representative acting as the agent of adversely affected people;
- An Executive Director of the Bank in special cases of serious alleged violations of the Bank’s policies and procedures.

The Panel may be contacted by:

- email at ipanel@worldbank.org
- phone at +1-202-458-5200
- fax at +1 202-522-0916 (Washington, D.C.)
- mail at: Inspection Panel, Mail Stop MC 10-1007, 1818 H Street, N.W., Washington, D.C. 20433, U.S.A.

6. MONITORING AND REPORTING

Monitoring and reporting: The PIU will monitor the project implementation to assess progress on indicators defined in the project’s working documents and the results framework, such as E&S performance and functioning of the GRM; beneficiary satisfaction; employment creation; and functional maintenance systems. Environmental and social monitoring indicators will be established and the PIU will be submitting quarterly progress reports or as otherwise requested by the World Bank on a case-by-case basis.

Internal Monitoring: The PIU will prepare data on activities and outputs in regular quarterly reports. The monitoring and evaluation process will be participatory, engaging community members of the districts benefiting from the project investments. An end-line beneficiary survey will be carried out to measure who and to what extent people benefited from the project as well as how it affects their lives and the social impacts.

External Monitoring: Given the persistent insecurity in some project areas, the ability to monitor and supervise project on the ground will continue to be limited. As such, the project will have an independent monitoring agent for supervision of project implementation progress.

Reporting back to stakeholders: Regular stakeholder workshops will enable feedback on project progress and improvements to all stakeholders. In addition, component 4 of the new RCRF supports the designing and use of tools to advance transparency and generate citizen feedback mechanisms up to the facilities level (for selected locations). It also supports the learning and evaluation of the possible most impactful tools. Sub-component 4.3 Impact evaluation to citizen feedback in education and health will strive to incorporate citizen feedback into the provision of education and/or health services particularly the staff supported by the project and evaluate the possible impact of the interventions on health and education access and quality. A rigorous impact evaluation will be financed to assess the efficacy of citizen engagement on education/health access and quality with health/education teams.

Incident and Accident Reporting: ESHS Incident reporting will follow the management and reporting process below:

Incidents will be categorized into ‘indicative’, ‘serious’ and ‘severe’. Indicative incidents are minor, small or localized that negatively impact a small geographical area or a small number of people and
do not result in irreparable harm to people or the environment. A ‘significant’ incident is one that causes significant harm to the environment, workers, communities, or natural resources and is complex or costly to reverse (see Annex 4 for World Bank incident classification guide). All SEA/H cases are treated as severe. A ‘severe’ incident causes great harm to individuals, or the environment, or presents significant reputational risks to the World Bank.

Severe incidents (an incident that caused significant adverse effect on the environment, the affected communities, the public or workers, e.g. fatality, GBV, forced or child labor) will be reported within 24 to the PIU and the World Bank (see Annex 5 for key information on incident reporting). Further guidance on reporting of serious and indicative incidents is provided in Annex 4.

Where grievances are of sexual nature and can be categorized as GBV/SEAH or child protection risk, the PIU handle the case appropriately, and refer the case to the GBV referral system, defined in the GBV/SEAH and Child Protection Prevention and Response Plan. There is need to note the protocols for handing incident reporting and response for SEA/H is different from other cases or complaint.
7. **ESMF Budget**

An indicative budget has been provided in table below, meant to cover expenses related to the implementation of the ESMF, such as capacity building programs, coordination and public consultation meetings, planning workshops, monitoring work, and environmental consultancy services.

This estimated budget does not include the administrative costs for the operation of the PIU Safeguard unit are including in the overall project cost.

**Table 4: Indicative Budgetary requirements for implementing the ESMF (not including GBV action plan)**

<table>
<thead>
<tr>
<th>ESMF Requirements</th>
<th>Budget basis and assumptions</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity building for PIU personnel on ESMF implementation</td>
<td>Training held in-country (all in one year)</td>
<td>10,000</td>
</tr>
<tr>
<td>Meetings, workshops and stakeholder engagement</td>
<td>For 30 persons/year * two workshops</td>
<td>4,000</td>
</tr>
<tr>
<td>Environmental screening</td>
<td>No additional budget</td>
<td>No additional budget</td>
</tr>
<tr>
<td>Monitoring of implementation of ESMF in Project locations</td>
<td>Field visits estimated for two PIU personnel per year (to cover, transport, and daily allowances)</td>
<td>Already in PIU budget</td>
</tr>
<tr>
<td>Stakeholder Engagement at FMS and community level</td>
<td>One per year in each FMS</td>
<td>10,000</td>
</tr>
<tr>
<td>Monitoring compliance and cost of third party monitoring of health care facilities</td>
<td>Assume quarterly monitoring activities over five days, each quarter, per year (two persons plus logistics, per diem etc.)</td>
<td>20,000</td>
</tr>
<tr>
<td>Monitoring compliance including assessment of medical waste management and PPE adequacy and usage by health workers</td>
<td>Assume quarterly monitoring activities over five days, each quarter, per year (one person plus logistics, per diem, etc.)</td>
<td>20,000</td>
</tr>
<tr>
<td>Cost for preparation of any HCF specific HWMP</td>
<td>Average</td>
<td>10,000</td>
</tr>
<tr>
<td>EHS training of project workers (FHW)</td>
<td>Average</td>
<td>20,000</td>
</tr>
<tr>
<td>Printing and follow up of agreement forms on use of kits and medical waste disposal</td>
<td></td>
<td>5,000</td>
</tr>
<tr>
<td>TOTAL Estimated Budget</td>
<td></td>
<td>99,000</td>
</tr>
<tr>
<td>Contingency (5%)</td>
<td></td>
<td>4,950</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>103,950</td>
</tr>
</tbody>
</table>
8. **ROLES AND RESPONSIBILITIES OF IMPLEMENTING ENTITIES**

The FGS Ministry of Finance shall be responsible for overall coordination and implementation of the Project. Governance arrangements include a Project Implementation Unit (PIU), a Project Management Team (PMT) and the FGS PFM Reform Coordination Unit (PFMRCU). FGS is required to maintain these structures throughout project implementation with terms of reference satisfactory to the World Bank, and with adequate resources to carry out their responsibilities.

Implementation is managed by a Project Coordinator and Project Manager at the FGS, and a Project Manager at each FMS.

It is the responsibility of the Project Coordinator to coordinate among different ministries and FMS. The Project Manager will manage and track implementation progress, identify opportunities for improvements to implementation and to solve day-to-day issues that may be slowing down or blocking implementation. At the overall project level, the Project Coordinator is responsible for tracking progress against the results framework indicators. At the component level, Technical Implementation Units (TIU) will be established for monitoring and evaluation of specific component activities being implemented in their ministries and agencies.

The project will be implemented in coordination with the Ministries of Health and Education who will have dedicated social and environmental specialists at FGS level funded under other World Bank Projects with separate environmental and social focal persons within the PIUs of participating FMS.

To support ESF capacity, a social safeguards specialist and a GBV specialist will be recruited under RCRF 3 for MoF, FGS and social safeguards specialists within MoF, FMS. The social safeguards specialist at FGS will oversee implementation of social and environmental requirements in close coordination with the environmental specialist within the Ministry of Health, the social safeguards specialists in the Ministries of Health and Education and the social specialists in each FMS.

**Role of the World Bank**

The World Bank will provide technical support where requested and receive quarterly reports on safeguards performance including prior to project missions.
9. CONSULTATION AND PUBLIC DISCLOSURE

Individual virtual interviews were carried out to develop this ESMF with the people listed in Annex 2 and a stakeholder consultation on the document was carried out virtually with key government partners (see Annex 3) and non-governmental organisations (see Annex 4).

As part of implementation regular feedback will be obtained from key stakeholders including community members and VMGs as outlined in the SEP. This may be done via community monitoring, using virtual monitoring tools such as kobotoolbox. WhatsApp groups of female health workers, teachers and other staff will be encouraged and nominated representatives will be encouraged to provide anonymous feedback from the groups on social and environmental risks and the effectiveness of mitigation measures and suggestions for improvement.

The preparation of this document, took place during the Covid 19 pandemic, thus followed national and WHO guidelines as well as the World Bank guidelines on Technical Note: Public Consultations and Stakeholder Engagement in WB-supported operations when there are constraints on conducting public meetings.

DISCLOSURE OF PROJECT DOCUMENTS

The following table outlines the disclosure of project documents:

<table>
<thead>
<tr>
<th>Disclosure of project documents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project stage</strong></td>
</tr>
<tr>
<td>Before appraisal</td>
</tr>
<tr>
<td>Before effectiveness</td>
</tr>
<tr>
<td>Before project activities</td>
</tr>
</tbody>
</table>

The following table outlines the disclosure of project documents:
ANNEX 1: STAKEHOLDER ENGAGEMENT CYCLE

1. Stakeholder Identification
   The project will identify key stakeholders who will be directly affected and/or interested in the project and plan how to best reach them.

2. Public outreach to inform
   Carry out public education campaign to inform on RCOF and the SEP.

3. Stakeholder Consultations
   Carry out and document consultations with stakeholders on the project and any risks/impacts.

4. Document Feedback
   Summarize feedback, including recommendations and grievances will be shared with relevant project team.

5. Share Responses to Feedback
   Provide stakeholders with information on how the project has taken on feedback.

6. Continuous reporting
   For the remainder of the project implementation, there will be info-sharing with stakeholders and responses to feedback and grievances.
## ANNEX 2: LIST OF INDIVIDUAL STAKEHOLDERS CONSULTED IN THE PREPARATION OF THE ESMF

<table>
<thead>
<tr>
<th>INSTITUTION NAME</th>
<th>NAME</th>
<th>JOB TITLE/ROLE</th>
<th>LOCATION</th>
<th>TOPICS DISCUSSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grit Partners Consulting</td>
<td>Sahra Noor</td>
<td>Exec Director</td>
<td>Nairobi</td>
<td>Social risks, gender/GM and health care provision</td>
</tr>
<tr>
<td>Save the Children</td>
<td>Binyam Ghebre</td>
<td>Head of Health and Nutrition</td>
<td>Nairobi</td>
<td>Social risks, gender issue and health care provision, GM/citizen engagement</td>
</tr>
<tr>
<td>Concern International</td>
<td>Mandeq Abukar</td>
<td>Nurse/Safeguards Team</td>
<td>Mogadishu</td>
<td>Social risks, gender, and health care provision, GM/citizen engagement</td>
</tr>
<tr>
<td>Save the Children</td>
<td>Harun Issak</td>
<td>Director of Program</td>
<td>Nairobi</td>
<td>Social risks, gender, and health care provision, GM/citizen engagement</td>
</tr>
<tr>
<td>Action Contre le Faim (ACF)</td>
<td>Ahmed Khalif</td>
<td>Country Director</td>
<td>Nairobi</td>
<td>Social risks, gender, and health care provision, GM/citizen engagement</td>
</tr>
<tr>
<td>Save the Children</td>
<td>Kassim Mohamed</td>
<td>Field team lead</td>
<td>Abudwak</td>
<td>Social risks related to education sector support, gender, citizen engagement</td>
</tr>
<tr>
<td>Abyrint</td>
<td>Ian Hawley</td>
<td>World Bank Third Party Monitoring Agent</td>
<td>Nairobi</td>
<td>Social risks, GM labor issues</td>
</tr>
<tr>
<td>Abyrint</td>
<td>Michael Holzmann</td>
<td>World Bank Third Party Monitoring Agent</td>
<td>Nairobi</td>
<td>Social risks, GM labor issues</td>
</tr>
<tr>
<td>World Bank</td>
<td>Osman Abdullahi</td>
<td>Education Team</td>
<td>Nairobi</td>
<td>Social risks related to education sector support, gender, GM/citizen engagement</td>
</tr>
<tr>
<td>FGS Ministry of Health</td>
<td>Abdisalam Mohamed</td>
<td>Community Health Director</td>
<td>Mogadishu</td>
<td>Social risks, gender, and health care provision, GM/citizen engagement</td>
</tr>
<tr>
<td>Civil Service Commission</td>
<td>Hassan Abshirow</td>
<td>Chairperson</td>
<td>Mogadishu</td>
<td>Civil service/gender</td>
</tr>
<tr>
<td>Independent Consultant</td>
<td>Kalson Abdi</td>
<td>Communications and Outreach Specialist</td>
<td>Mogadishu</td>
<td>Outreach strategies to maximize engagement</td>
</tr>
<tr>
<td>UNICEF</td>
<td>John Ekaju</td>
<td>Education Team Lead</td>
<td>Nairobi/Mogadishu</td>
<td>Social risks related to education sector support, gender, GM/citizen engagement</td>
</tr>
<tr>
<td>Ministry of Labour and Social Affairs</td>
<td>Abdinasir Mire</td>
<td>HR Analyst</td>
<td>Mogadishu</td>
<td>Civil service, gender/ GM</td>
</tr>
<tr>
<td>FGS Ministry of Finance</td>
<td>Abdulkadir Suleiman</td>
<td>RCRF Coordinator</td>
<td>Mogadishu</td>
<td>PIU management processes</td>
</tr>
<tr>
<td>Puntland Ministry of Finance</td>
<td>Shukri Warsame</td>
<td>PL RCRF</td>
<td>Garowe</td>
<td>Social risks related to education sector support, gender, GM/citizen engagement</td>
</tr>
</tbody>
</table>
ANNEX 3: KEY ISSUES FROM VIRTUAL CONSULTATION WITH KEY GOVERNMENT PARTNERS

July 16 2020

GBV
Important to explore how to leverage the FHW program to support a survivor-centered approach to GBV victims.
There is a lot of data that exists on GBV issues within the government across the key ministries that can be shared and used to inform the GBV action plan.

Alignment with Government Policies
The draft social safeguards instruments need to be in alignment with the FGS National Development Plan and HR priorities of the federal and state governments.

Waste Management
The FGS has drafted a waste management policy which will be implemented soon.
FHW generated very little medical waste since they are providing health education and awareness to communities. What waste that may be generated will be discharged at the local health facility.

Other
Important to factor in marginalized communities and their specific needs in both programmatic coverage and outreach.
Public forums are best way to engage wider swathes of the community and educate on the program’s goals.
Capacity-building is required to ensure concept of confidentiality of complaints is understood and practiced in the Somali context.

Participants:

<table>
<thead>
<tr>
<th>INSTITUTION NAME</th>
<th>NAME</th>
<th>JOB TITLE/ROLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Galmudug State of Somalia Ministry of Health</td>
<td>Abdihakin Mohamed Dirie</td>
<td>Community Health Coordinator</td>
</tr>
<tr>
<td>Galmudug State of Somalia Ministry of Finance</td>
<td>Abdinasir Abdullahi</td>
<td>RCRF Project Manager</td>
</tr>
<tr>
<td>Hirshabelle State of Somalia Ministry of Finance</td>
<td>Abdinur Mohamed Osman</td>
<td>EAFS Director</td>
</tr>
<tr>
<td>Federal Ministry of Health</td>
<td>Abdisalam Mohamud</td>
<td>Community Health Coordinator</td>
</tr>
<tr>
<td>Southwest State of Somalia Ministry of Health</td>
<td>Abdulkadir Mohamed</td>
<td>Community Health Coordinator</td>
</tr>
<tr>
<td>FGS Ministry of Finance</td>
<td>Abdulkadir Suleiman</td>
<td>RCRF Coordinator</td>
</tr>
<tr>
<td>FGS Ministry of Finance</td>
<td>Ali Adan Hassan</td>
<td>RCRF Project Secretary</td>
</tr>
<tr>
<td>Hirshabelle State of Somalia Ministry of Health</td>
<td>Fadumo Abdulle Hilowle</td>
<td>Community Health Coordinator</td>
</tr>
<tr>
<td>Jubbaland State of Somalia Ministry of Finance</td>
<td>Faisal Muday</td>
<td>EAFS Director</td>
</tr>
<tr>
<td>World Bank</td>
<td>Haroub Ahmed</td>
<td>Environmental Specialist</td>
</tr>
<tr>
<td>Organization</td>
<td>Name</td>
<td>Position</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Jubbaland State of Somalia Ministry of Finance</td>
<td>Hassan Darwish</td>
<td>RCRF Project Manager</td>
</tr>
<tr>
<td>Southwest State of Somalia Ministry of Finance</td>
<td>Hussein Hassan Bunow</td>
<td>RCRFII Project Manager</td>
</tr>
<tr>
<td>Puntland State of Somalia Ministry of Finance</td>
<td>Said Ismail</td>
<td>EAFS Director</td>
</tr>
<tr>
<td>Hirshabelle State of Somalia Ministry of Health</td>
<td>Mohamed Kabah</td>
<td>Monitoring and Evaluation Specialist</td>
</tr>
<tr>
<td>Southwest State of Somalia Ministry of Finance</td>
<td>Mohamud Mohamed Hassan</td>
<td>EAFS Director</td>
</tr>
<tr>
<td>Hirshabelle State of Somalia Ministry of Finance</td>
<td>Mowlid Khalif Sabriye</td>
<td>RCRF Project Manager</td>
</tr>
<tr>
<td>World Bank</td>
<td>Shair Luli</td>
<td>GBV Consultant</td>
</tr>
<tr>
<td>Puntland State of Somalia Ministry of Finance</td>
<td>Shukri Warsame</td>
<td>RCRF Project Manager</td>
</tr>
<tr>
<td>World Bank</td>
<td>Vanessa Tilstone</td>
<td>Senior Social Development Specialist</td>
</tr>
<tr>
<td>FGS Ministry of Finance</td>
<td>Hodan Hassan</td>
<td>Social Safeguards Consultant</td>
</tr>
<tr>
<td>World Bank</td>
<td>Zubair Bhatti</td>
<td>RCRF Task Team Leader</td>
</tr>
</tbody>
</table>
ANNEX 4: KEY ISSUES FROM VIRTUAL CONSULTATION WITH NON STATE ACTORS

**When:** October 13, 2020, from 9:00 am – 12:00 pm on Webex Platform

**Objective:** to get input and suggestions on improving the social and environmental instruments for RCRF 3 including stakeholder engagement and grievance redress mechanism in the health and education sectors.

**Participants:** representatives of vulnerable and marginalised groups and different NGOs working in the health, education and citizen engagement and grievance redress sectors at FGS and FMS level

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-9.15</td>
<td>Opening and introduction to RCRF 3 (participants are requested to write name, function and office in the chat for the minutes)</td>
<td>Abdulakadir Suleiman - Min of Finance/PIU</td>
</tr>
<tr>
<td>9.15-10.15</td>
<td>Social risks, Stakeholder Engagement Plan and Labor Management Procedures</td>
<td>Vanessa Tilstone/Abass Kassim, World Bank</td>
</tr>
<tr>
<td>10.15-10.30</td>
<td>Health break</td>
<td></td>
</tr>
<tr>
<td>10.30-11</td>
<td>GBV action plan</td>
<td>Shair Luli, World Bank</td>
</tr>
<tr>
<td>11-11.30</td>
<td>Environmental risks and mitigation measures</td>
<td>Haroub A. Haroub - World Bank</td>
</tr>
<tr>
<td>11.30-12.30</td>
<td>Discussion and suggestions</td>
<td>Abdulakadir/Ali Hassan - Min of Finance/PIU</td>
</tr>
</tbody>
</table>

**Minutes:**

A virtual stakeholder consultation meeting was held for stakeholders on Tuesday October 13, 2020. The meeting was attended by non-state and civil society representatives including those working closely with marginalized groups, labor unions and other organizations working in the education and health sectors. Over 20 organizations (both local and international) were invited and sent the ESF instruments beforehand and were followed up by email and phone calls, yet only 10 attended. Abdulakadir Suleiman, Project Coordinator and focal point for EU Budget Support, RCRF project, Ministry of Finance facilitated the meeting, however, as the E&S specialists are yet to be recruited by the PIU, the World Bank specialists presented the E&S instruments.

The RCRF Project Coordinator, Abdulakadir Suleiman started the meeting with an overview of the project highlighting all the components as well as the scope, locations, and nature of the project. Mr. Suleiman mentioned that this project is designed to increase the capacity as well as the legitimacy of the government institutions to enable them exercise their respective functions on public service delivery. He further added that the RCRF project has three phases since it is inception on 2015 and later expanded to the Federal Members States (FMSs) in the country through multiple financing.

Mr. Suleiman’s project overview was followed by a presentation of Social Risk Management by World Bank’s Senior Social Specialist, Vanessa Tilstone and Abass Kassim, Social Safeguard consultant. The presentation covered key aspects of Social Risk Management including Stakeholder Engagement Plan (SEP), the Grievance Redress Mechanism (GRM) and the Labor Management Procedure (LMP). This was followed by a presentation on GBV/SEAH Action plan by Shair Luli, GBV Specialist and a presentation on environmental risks and management by Haroub Ahmed, Environmental specialist.
On reflections from the participants, Mohamed Ali, a representative from civil society umbrella body SONSA requested the civil society to have a role and be engaged in the project throughout its life cycle. It was further added that civic engagement as a new component for the project enables the government and it is citizens are connected. One of the main issues discussed extensively was the inclusivity of all groups including the vulnerable through-out different stages of the project.

Kamal Farah from CARE International shared an experience of how social and environmental risks can be identified and managed by adopting whistleblower protection mechanisms. Others mentioned improved the transparency in recruitment processes including for project consultancy positions and all other project positions to be advertised in all national websites to attract qualified candidates. It was also noted it is imperative to follow all recruitment guidelines and procedures when hiring project staff/consultants, and complaints related to recruitment and procurement processes can be addressed through the GM.

On environmental risks and management, the WB Environmental Specialist Haroub Ahmed noted that Environmental Risk rating of the project is moderate, because it mainly involves capacity building and provision of technical assistance. Although, Female Health Workers (FHW) might face risks such as exposure on infectious disease including spread of COVID-19 as a result of poor medical waste management and other occupational health and safety incidents.

The Chief of Party of Norwegian Refugee Council (NRC)’s “Building Resilience in Somali Communities” Perrine Piton shared her experience on community engagement for the project by using mixed approaches. She mentioned that communities can be engaged by building the capacity of the staff on community engagement skills and establishing community committees by ensuring representation of the most vulnerable groups including women. She added that regular meetings with the committees can also improve project outcome and use of feedback mechanism, as well as ensuring separate meetings of women and marginalised groups, facilitated by people trusted by them.

The presentation on GBV action plan by Shair Luli highlighted major risks including gender inequality, sexual exploitation, abuse and harassment, and other manifestations of GBV that pose significant challenges to women in Somalia. Shair noted that the risk rating of the GBV is substantial and can be prevented by increased sensitization and advocacy at all levels of the society including NGO and government staff. It was also said that there is huge gap in response to and prevention of GBV incidents across the country and that there is a need to conduct service mapping to understand available services and resources for survivors.

The meeting was concluded with an enthusiastic commitment to continue engaging the stakeholders and the participants provided interesting ideas, for example by a possible annual stakeholder forum.

Stakeholders present:

<table>
<thead>
<tr>
<th>S/N</th>
<th>Participant Name</th>
<th>Organization</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Kamal Farah</td>
<td>CARE International</td>
<td>Water Technical Advisor</td>
</tr>
<tr>
<td>2.</td>
<td>Dr. Binyam Gebru</td>
<td>Save the Children</td>
<td>Deputy PDQ Director</td>
</tr>
<tr>
<td>3.</td>
<td>Suleiman Ahmed</td>
<td>Danish Refugee Council</td>
<td>Deputy Country Director</td>
</tr>
<tr>
<td>4.</td>
<td>William Babumba</td>
<td>Danish Refugee Council</td>
<td>Country Director</td>
</tr>
</tbody>
</table>
### Issues raised by participants and how they were addressed:

<table>
<thead>
<tr>
<th>Issues raised by participants</th>
<th>How they were addressed in E&amp;S documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil society should have a role and be engaged in the project throughout its life cycle including vulnerable and marginalized groups</td>
<td>Commitments to annual CSO meeting on the project with increased effort to include minority groups and women</td>
</tr>
<tr>
<td>Need for whistleblower protection</td>
<td>Further measures to strengthen confidentiality and whistleblower protection will be included in the GM</td>
</tr>
<tr>
<td>It is imperative to follow transparent and fair recruitment guidelines and procedures when hiring project</td>
<td>Attention will be paid to fair and transparent recruitment guidelines and this will be emphasized in the GM</td>
</tr>
<tr>
<td><strong>staff/consultants, and complaints related to recruitment and procurement processes can be addressed through the GM.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Need to building the capacity of the staff on community engagement skills and establishing community committees by ensuring representation of the most vulnerable groups including women, ensuring separate meetings of women and marginalised groups, facilitated by people trusted by them.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>This will be done by the social safeguards officers and as part of component 4.</strong></td>
<td></td>
</tr>
</tbody>
</table>
### ANNEX 5: WORLD BANK INCIDENT CLASSIFICATION GUIDE

<table>
<thead>
<tr>
<th>Indicative</th>
</tr>
</thead>
</table>
| - Relatively minor and small-scale localized incident that negatively impacts a small geographical areas or small number of people  
- Does not result in significant or irreparable harm  
- Failure to implement agreed E&S measures with limited immediate impacts |

<table>
<thead>
<tr>
<th>Serious</th>
</tr>
</thead>
</table>
| - An incident that caused or may potentially cause significant harm to the environment, workers, communities, or natural or cultural resources  
- Failure to implement E&S measures with significant impacts or repeated non-compliance with E&S policies incidents  
- Failure to remedy indicative non-compliance that may potentially cause significant impacts  
- Is complex and/or costly to reverse  
- May result in some level of lasting damage or injury  
- Requires an urgent response  
- Could pose a significant reputational risk for the Bank. |

<table>
<thead>
<tr>
<th>Severe</th>
</tr>
</thead>
</table>
| - Any fatality  
- Incidents that caused or may cause great harm to the environment, workers, communities, or natural or cultural resources  
- Failure to remedy serious non-compliance that may potentially cause significant impacts that cannot be reversed  
- Failure to remedy serious non-compliance that may potentially cause severe impacts is complex and/or costly to reverse  
- May result in high levels of lasting damage or injury  
- Requires an urgent and immediate response  
- Poses a significant reputational risk to the Bank. |
ANNEX 6: INCIDENT REPORTING GUIDANCE

An incident report should contain the following information:

**Incident Report Form**
Please report any incident within 24 hours to the PIU

<table>
<thead>
<tr>
<th>Implementing Partner</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Subproject / Activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Date</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Reported By (Name and Title)</td>
<td></td>
</tr>
</tbody>
</table>

i. **Details of Incident**

<table>
<thead>
<tr>
<th>Incident Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident Time</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident Place</td>
<td></td>
</tr>
</tbody>
</table>

ii. **Identification of type of incident and immediate cause**

For each type of incident, select the relevant descriptor(s) from the list. You can select up to 5 descriptors for each type of incident. If a descriptor is not listed below, please type in short descriptor in "Other". Add more rows as necessary.

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Descriptor 1</th>
<th>Descriptor 2</th>
<th>Descriptor 3</th>
<th>Descriptor 4</th>
<th>Descriptor 5</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>H&amp;S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provide a description of the immediate cause of the incident:

Description of the Incident
Record all facts prior to and including the incident, if it was a planned activity, describe/list material, ecosystem and property damaged, etc:

Root Cause Analysis
Select the root cause(s) of the incident from the list below. If ‘Other’, please specify:
<table>
<thead>
<tr>
<th>Root Cause</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improper Planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Maintenance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Quality of Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No rules, standards, or procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of knowledge or skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improper motivation or attitude</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to comply with rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Questions:
- Is the incident still ongoing or is it contained?
- Is loss of life or severe harm involved?
- What measures have been or are being implemented by the Implementer?
ANNEX 7: MEDICAL WASTE MANAGEMENT PLAN

Introduction

Scale-up of the Marwo Caafimaad Female Health Worker (FHW) Program and re-training for COVID-19 response: RCRF III will provide US$16.2 million of health sector financing, including the supporting scale-up of the FHW program from 377 workers in three regions in 2019, starting in 2020 and reaching 3,000 workers across all FMS and Benadir by 2023 and essential investments in government contract management capabilities. Further, the FGS and FMS ministries of health and World Bank team are currently working to re-focus the FHW program on the COVID-19 response. Options under discussion include:

- FHW role in detecting, isolating, and reporting cases as well as community awareness raising;
- Support for system of case reporting and response;
- Support for increased supervision of the FHW system;
- PPE for FHWs and possibly other supplies (primarily masks), and;
- Accelerating roll-out of new FHWs in at-risk districts.

According to the World Health Organization (WHO) medical waste refers to the entirety of waste generated by health care and medical research facilities and laboratories (see also Appendix I). According to this definition medical waste includes but is not limited to:

- **Infectious waste**: waste contaminated with blood and other bodily fluids (e.g. from discarded diagnostic samples), cultures and stocks of infectious agents from laboratory work (e.g. waste from autopsies and infected animals from laboratories), or waste from patients in isolation wards and equipment (e.g. swabs, bandages and disposable medical devices);
- **Pathological waste**: human tissues, organs or fluids, body parts and contaminated animal carcasses;
- **Sharps**: syringes, needles, disposable scalpels and blades, etc.;
- **Chemicals**: for example, solvents used for laboratory preparations, disinfectants, and heavy metals contained in medical devices (e.g. mercury in broken thermometers) and batteries;
- **Pharmaceuticals**: expired, unused and contaminated drugs and vaccines;
- **Genotoxic waste**: highly hazardous, mutagenic, teratogenic or carcinogenic, such as cytotoxic drugs used in cancer treatment and their metabolites;
- **Radioactive waste**: such as products contaminated by radionuclides including radioactive diagnostic material or radiotherapeutic materials; and
- **Non-hazardous or general waste**: waste that does not pose any particular biological, chemical, radioactive or physical hazard.

Kitchen waste and general waste from patients and visitors is not classified as medical waste. This MWMP’s overall objective is to prevent and/or mitigate the negative EHS effects of medical waste. Medical Waste must be managed in a safe manner to prevent the spread of infection and reduce the exposure of health workers, patients and the public to the risks from medical waste. The plan includes advocacy for good practices in medical waste management and is to be used by health, sanitary and cleaning workers who manage medical waste.

This document represents the Medical Waste Management Plan (MWMP) for the RCRF3 Female health worker (FHW) program and provides a plan for management of waste associated with provision of medical kits to FHW. The plan also can be used to provide basic skills training for female health care workers and will be translated to Somali language where necessary.
STANDARD PRECAUTIONS

Improper management of medical waste poses a significant risk to patients, health-care workers, the community and the environment. Thus, proper management of medical waste is an important part of the overall management of Environmental, Health and Safety (EHS) risks and impacts of the Project.

Standard precautions are taken to reduce the risk of transmitting bloodborne micro-organisms and other pathogens from both recognized and unrecognized sources. These precautions should be followed, as a minimum in the care of all patients in health care facilities and settings, regardless of their diagnoses or presumed infection status.

Standard precautions include:
- Hand hygiene.
- Good housekeeping.
- Appropriate use of PPE.
- PEP.
- Appropriate hand hygiene must be carried out in the following circumstances:
  - Upon arriving at and before leaving the health care facility.
  - Before putting on gloves.
  - After removing gloves.
  - Before and after every patient contact.
- After any situation in which hands might become contaminated, such as:
  - Handling contaminated objects, including used instruments.
  - Using the toilet, wiping or blowing one’s nose, or performing other personal functions.
  - Touching waste that may have mucous membranes, blood, body fluids, secretions, or excretions or other sources of micro-organisms.
  - Before preparing, handling, serving, or eating food.

HANDWASHING

- The purpose of handwashing is to remove soil, blood, and other organic material and transient micro-organisms from the skin.
- The three elements that are essential for effective handwashing are (1) soap, (2) clean running water, and (3) friction.
- Hand hygiene is the single most important way to prevent transmission of pathogens associated with health care services.

Steps in Handwashing

Handwashing takes about 40 to 60 seconds.
- Remove all jewelry.
- Thoroughly wet your hands with running water. Do not dip hands into a basin that contains standing water, even with the addition of an antiseptic agent, because micro-organisms can survive and multiply in these solutions. Use a comfortable water temperature. Washing your hands in hot water increases the risk of skin irritation and does not remove more micro-organisms.
- Apply a handwashing agent (soap or detergent). Washing your hands with plain water without soap is not effective.
- Rub all areas of hands and fingers vigorously for 10 to 15 seconds, paying close attention to fingernails and areas between the fingers. Do not forget the wrists. Repeat each action five times.
- Remove debris from under the fingernails.
• Rinse hands thoroughly with clean running water from a tap for 10 to 15 seconds.
• Use a paper towel when turning off the water if the tap is hand-operated.
• Dry hands with paper towels or air-dry them. Avoid using common or shared towels, which might harbor micro-organisms and contaminate hands even after proper handwashing. To avoid sharing towels, use alcohol-based hand rub, disposable paper towels, or single-use hand towels. Do not dry your hands-on personal clothes or on wet and soiled towels.

Good Housekeeping
Good housekeeping refers to the general cleaning of your work area, including the floors, walls, certain types of equipment, furniture, and other surfaces. Cleaning entails removing dust, soil, and contaminants on environmental surfaces.
Housekeeping helps eliminate micro-organisms that could come in contact with patients, visitors, staff, and the community. It ensures a clean and healthy hospital environment for patients and staff.

Personal Protective Equipment
• Health workers protect themselves by establishing a barrier between themselves and the infective agent. The type of protection needed depends on the workers’ activities.
• Protective clothing must be worn at all times when handling HCW.
• PPE must be properly maintained and kept clean.
• The clothing should not be taken home; it must remain at the health facility to avoid possible contamination of the community.

Principles for using PPE
• Assess the risk of exposure to blood, body fluids, excretions, or secretions and choose items for PPE accordingly.
• Use the right PPE for the right purpose.
• Avoid any contact between contaminated (used) PPE and surfaces, clothing, or people outside the patient care area.
• Do not share PPE.
• Change PPE completely and thoroughly wash your hands each time you leave a patient to attend to another patient or another duty.
• Disinfect reusable PPE appropriately.
• Discard used PPE appropriately in designated disposable bags.

The following individuals should use PPE:
• Health care workers who provide direct care to patients and who work in situations in which they might have contact with blood, body fluids, excretions, or secretions.
• Support staff, including waste handlers, cleaners, and laundry staff, in situations in which they may have contact with blood, body fluids, excretions, or secretions.
• Laboratory staff who handle patient specimens.
• Family members who provide care to patients and could come in contact with blood, body fluids, excretions, or secretions.

Types of PPE and their recommended uses.

<table>
<thead>
<tr>
<th>Type of PPE</th>
<th>Recommended Use</th>
<th>Person Protected</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>PPE Item</th>
<th>Conditions</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gloves</td>
<td>When there is a reasonable chance of hands coming in contact with blood or other body fluids, mucous membranes, or skin that is not intact. Before performing invasive medical procedures (e.g., when inserting vascular devices such as peripheral venous lines). Before handling contaminated waste, items or touching contaminated surfaces.</td>
<td>Service providers</td>
</tr>
<tr>
<td>Caps, gowns, scrub suits, or aprons</td>
<td>When performing invasive procedures during which tissue beneath the skin is exposed. When handling immunocompromised patients or clients. When handling patients with infectious disease. When handling contaminated waste.</td>
<td>Service providers and patients</td>
</tr>
<tr>
<td>Masks</td>
<td>When performing invasive procedures. When handling patients with airborne or droplet infections. When handling medical waste.</td>
<td>Service providers, patients, incinerator operators, and visitors</td>
</tr>
<tr>
<td>Goggles or glasses</td>
<td>Situations in which splashing or spillage of blood, body fluids, secretions, or excretions is likely.</td>
<td>Service providers</td>
</tr>
<tr>
<td>Mackintoshes, plastic or rubber aprons</td>
<td>When handling infectious waste. Service providers Closed boots or Shoes</td>
<td>Service providers</td>
</tr>
<tr>
<td>Closed boots or shoes</td>
<td>Situations in which sharp instruments or in which spillage of infectious agents are likely. When handling immunocompromised patients</td>
<td>Service providers and patients</td>
</tr>
<tr>
<td>Sterile drapes</td>
<td>Sterile drapes When performing major or minor surgical procedures.</td>
<td>Patients</td>
</tr>
</tbody>
</table>

**Maintaining PPE**

Supervisors must see to it that PPE is properly cleaned, laundered, repaired, replaced, or disposed of as needed, at no cost to health workers.

The following precautions for handling and using PPE should be observed:

- Remove garments penetrated by blood and other infectious material as soon as possible.
- Place contaminated protective equipment in designated areas or containers for storage, washing, decontaminating, or discarding each day or shift.
- Replace gloves if torn, punctured, or contaminated, or if their ability to function as a barrier is compromised.
- Utility gloves may be decontaminated for re-use if the integrity of the gloves is not compromised. However, they must be discarded if they are cracked, peeling, torn, etc.

**Waste Treatment**

- HCW should be treated prior to disposal to ensure protection from potential hazards posed by the
• waste.
• To be effective, treatment must reduce or eliminate the risk present in the waste so that it no longer poses a hazard to persons who may be exposed to it.
• The common methods of waste treatment are:
  • Incineration.
  • Steam sterilization/Autoclaving
• Chemical disinfection.
• Microwave irradiation.
• Maceration.
• Other Methods – Encapsulation, inertization, shredding, and grinding.

Waste Disposal
• HCW should be treated prior to disposal to ensure protection from potential hazards posed by the waste.
• The common methods of waste disposal:
  • Municipal disposal sites.
  • Sanitary landfills.
• Protected ash pits.
• Placenta pits.
• Anatomical pits.
• Recycling.
• Return to supplier/manufacturer.
• Approved sewer/drainage systems.

Untreated waste discharged into an uncontrolled, non-engineered, open dump does not protect the local environment and should not be used. Discharging waste in open dumps either within the health care institution or in the public facility is an insufficient solution and leads to environmental pollution.

For RCRF III the following will be used:

Safe Burial in Hospital Premises
Safe burial of small quantities of pharmaceutical waste prevents scavenging and may be an appropriate disposal method for some establishments. Particular attention should be paid to prevention of ground water pollution.

Incineration
Small quantities of pharmaceutical waste may be incinerated together with infectious or general waste, provided that they do not form more than 1 percent of the total waste (in order to limit potentially toxic emissions to the air).

Roles and Responsibilities in HCWM
The overall responsibility of implementing the healthcare waste management issues particularly the present MWMP will rest with the Director General of Health Services (DGHS). Within the directorate, a dedicated, fulltime specialist will be appointed as the Medical Waste Management Focal Point (MWMFP). At the district level, the District Officer – Health (EDO-Health) of each district will be the focal point for performing/supervising the environment and healthcare waste management functions particularly implementing the present MWMP in the respective district. Finally, at the facility level, the WMO will be designated as the focal point for MWMP implementation. In addition, a Waste Management Team (WMT) will be constituted within each healthcare facility overseeing female
health workers, and an appropriate officer designated as WMO. Prior to issuance of medical kits, FHW and FHS will have to undergo training on waste disposal protocols that will cover proper use of medical kits and waste disposal. Trainings will be undertaken by MOH master trainers with experience in medical waste management protocols as detailed in Compendium to Implement Community Based Female Health Workers’ Programme on Country Systems. If FHWs are found not to be disposing of MW properly despite training and orientation, they will not be able to collect the next batch of equipment. Following OHS guidelines will also be included in their CoC.
ANNEX 8: SAMPLE MEDICAL WASTE MANAGEMENT MONITORING QUESTIONNAIRE

Health Facility (name, location): ________________________________

Type/Category of Health Facility (tick one):

☐ Tertiary: Specialist, National, Teaching Hospitals

☐ Secondary: Governorate Gen. Hospitals, Sub-HCF Hospital, Private Hospitals

☐ Primary; Health Centre, Dispensary

☐ Mobile health care unit

No. of inpatients: ___________/day
No. of outpatients: ___________/day
No. of beds (total): ___________/day

Type of solid waste produced and estimated quantity
(Consult classification and mark X where waste is produced)

<table>
<thead>
<tr>
<th>Type</th>
<th>Estimated Quantity (for a defined time period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharps</td>
<td></td>
</tr>
<tr>
<td>Pathological waste</td>
<td></td>
</tr>
<tr>
<td>Infectious waste</td>
<td></td>
</tr>
<tr>
<td>Pharmaceutical waste</td>
<td></td>
</tr>
<tr>
<td>Pressurized containers</td>
<td></td>
</tr>
</tbody>
</table>

Waste segregation, collection, storage, and handling
Describe briefly what happens between segregation (if any) and final disposal of:

Sharps __________________________________________

Pathological waste ________________________________
**Infectious waste**

**Pharmaceutical waste**

**Pressurized containers**

---

**Waste segregation, collection, labelling, transport, and disposal**

<table>
<thead>
<tr>
<th>Handling of segregated waste</th>
<th>Sharps</th>
<th>Pathological waste</th>
<th>Infectious Waste</th>
<th>Pharmaceutical waste</th>
<th>Pressurized containers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicate by X the type of waste (if any) that is segregated from general waste stream.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where is the segregation taking place (i.e. operating room, laboratory, among others)?</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>What type of containers/bags (primary containment vessels) are used to segregate waste (bags, cardboard boxes, plastic containers, metal containers, among others)? Describe accurately.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What type of labelling, colour-coding (if any) is used for marking segregated waste? Describe.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who handles (removes) the segregated waste (designation of the hospital staff member)? Is the waste handler using any protective clothing (gloves, among others) during waste handling? Yes/No.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What type of containers (plastic bins, bags, cardboard boxes, trolleys, wheelbarrows, safe boxes, metal containers, among others) are used for collection and internal transport of the waste? Describe.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where is the segregated waste stored while awaiting removal from the hospital for disposal? Describe.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe briefly the final disposal of segregated waste (taken to municipal landfill, buried on hospital grounds, incinerated (external incinerator, own incinerator), open burned, removed from premises, among others) and whether the disposal adequately meets EHS requirements for the Project.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If removed from premises; who is responsible for removal? Health facility/self, private collector, State Environmental protection Agency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If removed from premises; what form of transport is used? Enclosed waste track, open waste track, open pick-up, among others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often is the waste removed from site?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 – 4 times per week</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 – 2 times per week</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once a week</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every two weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once a month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less often</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is safety clothing issued to staff involved in medical waste collection, i.e. gloves, aprons, among others?

Y  N

If yes, please list the safety clothing/items issued to medical waste collectors and the frequency of issue:

<table>
<thead>
<tr>
<th>Items issued</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>As Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aprons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gloves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety shoes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overhauls</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Which of these waste collection, handling, transport and disposal activities are undertaken by Health-care staff and which are outsourced? List the party responsible for that activity, where the activity is outsourced and the start and end dates of the contract entered into:

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>RESPONSIBLE PARTY (self/facility, Environmental Protection Agency, Private collector, among others)</th>
<th>NAME OF THE RESPONSIBLE PARTY/PRIVATE COLLECTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Handling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incineration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Personnel involved in the management of Health-care waste**

Designation of person(s) responsible for organization and management of waste collection, handling, storage, and disposal at the hospital administration level.

____________________________________________________________________________

Has he/she received any training on hospital waste management?

Yes  No

If yes, what type of training and of what duration?

____________________________________________________________________________

____________________________________________________________________________
ANNEX 9: SEXUAL EXPLOITATION AND ABUSE/SEXUAL HARASSMENT PREVENTION AND RESPONSE ACTION PLAN

Introduction

Somalia is currently on a path of political stabilization and reconstruction, after more than twenty years of conflict. Since the collapse of the Siad Barre government in 1991, cycles of conflict have fragmented the country, destroyed legitimate institutions and large segments of the economy, displaced millions of people, and hence created widespread vulnerability to external shocks, such as pandemics and droughts. The adoption of the Provisional Constitution in 2012, peaceful presidential elections in 2012 and 2017, and a broader regularization of Somalia’s political processes represent important milestones. The Somali economy has been recovering at a modest pace there is a high degree of susceptibility to shocks where the COVID-19 pandemic expected to result in a recessionary impact.

The Recurrent Cost Reform Finance (RCRF) Project became effective in 2014; a second phase RCRF 2 became effective in July 2015 and is currently expected to close in June 2022. The Project Development Objective (PDO) of the RCRF is to support the Federal Government of Somalia and Eligible Federal Member States to strengthen resource management systems, the inter-governmental fiscal framework, and service delivery systems in health and education. This project will cover all of Somalia.

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

Definition of terms

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

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

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

Why is addressing GBV/SEA/SH related risks important?
Gender-based violence (GBV) is a global pandemic that affects 1 in 3 women in their lifetime. Most recent global estimates suggest that 35% of women worldwide have experienced either physical and sexual intimate partner violence (IPV) or non-partner violence, and over 200 million girls and women have undergone Female Genital Mutilation.\(^6\)

GBV is recognized as a major obstacle to gender equality, peace and development. It affects women’s and girls’ health, educational attainment, economic productivity, and capacity to care and provide for themselves and their families. In both public and private settings, GBV limits women’s and girls’ mobility, agency and empowerment, and inhibits economic and social development. Addressing GBV is therefore critical to achieving many of the Sustainable Development Goals (SDGs).

In providing financial and technical support to the Federal Government of Somalia, the World Bank Group pays close attention to risks that can undermine development impact of its assistance. A set of policies and procedures have been developed to address specific risks such as fiduciary (the risk that the financing could be misused) and negative social and environmental impacts.

Gender-based violence (GBV), and in particular sexual exploitation and abuse and sexual harassment, is one of the most pernicious types of risk that the WBG is deeply concerned about worldwide and is stepping up its efforts to address these in its operational environment. This concern is also relevant for this project focusing on Health and Education sectors where there is a high representation of women and girls who may be at risk of varying types of GBV, including sexual violence, sexual exploitation and abuse, sexual harassment, denial of services and psychological abuse if preventive and risk mitigation measures are not put in place by the government.

In 2019, the World Bank’s Somalia Country Team conducted a risk assessment of the portfolio to assess GBV, sexual exploitation and abuse (SEA), and sexual harassment risks across the country investment portfolio. The consequences of gender-based violence therefore calls for structured and systems that are cross sectoral effective prevention and response interventions. This review highlighted key challenges across the portfolio as well as risks across projects.

**Country Context Risks:**
GBV is a major challenge in Somalia and is considered to be an obstacle to gender equality and peace, as well as hindrance to achieving the sustainable development goals in the country and the Bank’s twin goals of shared prosperity and poverty eradication. Available evidence indicates GBV is common in the lives of women and girls across the life course in Somalia, with some forms of GBV endemic. FGM/C has in the past been near universally practiced. Intimate partner violence and sexual violence, the most prevalent types of GBV globally, are both commonplace in the lives of Somali women and girls.

Conflicts, disasters and insecurity have in the past, and continue to, exacerbate risks associated with varying forms of gender-based violence. The effects that displacement has on increasing GBV risks and rates among internally displaced and refugee communities globally is increasingly recognized and evidence points to a similar escalation of violence against women catalyzed by conflict and climate-related displacement and associated stressors; displaced women and girls are among the most vulnerable to experiencing some form of GBV in Somalia. Conflict and disaster-related displacement magnify in particular sexual violence risks for women and girls. Women and girls are at amplified risk of sexual assault during movement to new areas and once settled in displaced settings. Unsafe environments, eroded protection mechanisms and social cohesion,

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6 World Bank (2019) brief on gender based violence

and a lack of safe livelihoods options all increase the incidence of opportunistic sexual violence perpetrated in and around displaced settings when women and girls are collecting water, firewood and other resources, and when in public spaces and accessing public facilities.  

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

There have been significant efforts to promote gender equality objectives through Federal Government legislative and policy initiatives, as integrated, for example, in the Provisional Constitution (2012), the National Gender Policy (NGP) and National Development Plan (NDP). At the same time, progress in translating these initiatives into substantive equality for women has been limited, and there have been few changes to the gendered dynamics of social institutions and power structures, meaning that realization of progress towards gender equality and towards addressing GBV continues to be a challenge. There is a need for sustained investment in gender equality initiatives and programs within government and civil society and a need to galvanize commitment to gender issues within government into action.

**Identified Project-related GBV Risks**

Complementary to identification of existing contextual risks is a need to identify and understand the project-specific risks that may exacerbate or create new risks of sexual exploitation and abuse, sexual harassment and other forms of GBV. Identified risks are substantial specific to RCRF III include:

- **Abuse of power, including sexual exploitation and abuse and bullying, in hiring, employment, and retention practices.** Public sector recruitment processes can distort power relations and lead to opportunities for abuse. For example, hiring and employment practices that seek to increase the number of women in different employment positions – from skilled labour in Ministries to community health workers – can expose women to incidents of sexual exploitation, harassment, or violence, either because they are pressured to exchange “favours” for jobs, or because the working environment legitimizes and allows harassment and exploitation. SEA/GBV risks in the office and workforce can lead women to remove themselves – or be removed – from the workforce; exacerbating a continuing culture of SEA/GBV.

- **Lack of integration of GBV, SEA and sexual harassment related policies in the training, recruitment and supervision of health and education personnel.** With limited or lack of information, staff may have no /limited knowledge in identifying, supporting and reporting GBV, SEA and SH related cases as such may cause more harm than good.

- **Resistance and backlash against women’s entry into the workforce can lead to increased risks of SEA/SH or GBV at both the household level as well as in workspaces.** Women entering workforces traditional dominated by men can be seen as “taking a man’s job” or “taking a man’s place,” sparking backlash and, potentially, exposing women to increased levels of harassment or GBV. Studies also show that domestic violence, or IPV, can increase when women upset traditional gender norms, for example, by leaving off household duties to join the workforce. It can lead to increased risks of domestic violence or IPV – forms of violence that have shown to have costly economic and public health impacts. Research shows that IPV/DV is, in many countries, one of the most common reasons

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10 Human Rights Watch (2014)
for women to either miss work or leave the workforce; costing the economy and related health systems significant money and important contributions.

- **Women and girls can face high risks related to limitations on their mobility during outreach or supervision, leading to potential exposure to GBV/SEA when implementing FHW duties.** For example, traveling long distances to reach communities and/or service sites work sites can increase targeting, exploitation and harm from non-partner individuals, including armed groups/forces/individuals.

- **Limited or incomplete training for key personnel (health and education), as well as a lack of competent, survivor-centered primary, secondary and tertiary services, can increased risk of harm.** Other risks include violence or death for survivors of GBV and women, girls and other groups (such as people with disabilities and people of minority ethnic/tribal groups). Survivors of GBV who choose to seek services and disclosure their experience. It can be in a primary care setting, to FHWs or education personnel (in the case of young people), or at designated clinical management of rape services. Such survivors may experience more violence and harm by providers or health personnel who do not observe survivor-centered principles – namely safety, confidentiality, non-discrimination and informed consent – or who do not abide by safe and ethical operating procedures for referrals to specialized services. Breaks in confidentiality or breaks in considerations for a survivor’s safety and choices could lead to a slew of consequences including retaliation by perpetrator(s), intimate partners or family members, social isolation, targeted physical attack and death. Additionally, an inability to recognize or respond appropriately to the signs of trauma from survivors can lead first responders such as FHWs or “trusted adults” (such as educators, if they are) to inadvertently exacerbate stigma, trauma, and/or survivors ability to access safe, appropriate, services.

- **Community conflict resolution approaches can lead to more harm against survivors who report GBV/SEA experiences.** Community or social governance resolution processes might reinforce gender inequality pushing for resolutions that widen inequalities, are not survivor-centered and may lead to impunity and more harm to a survivor (through marriage to a perpetrator, re-victimization or other consequences).

### Existing Risk Management Systems/Gaps

#### Regulations and Policies

The **Civil Servant Act** of 2017 provides the legal and administrative framework for effective work. It includes overall management and organization of a politically neutral and impartial Civil Service; the terms and conditions for appointment to the Civil Service; working conditions; the rights and obligations of staff; personal conduct; and Career progression of Civil Servants.

Prohibitions have been highlighted such as accepting or soliciting gifts in cash or kind, favours of any sort, or rewards from any internal or external sources for discharging civil service functions, or from commercial firms or individuals doing or seeking to do business with the [FMS] State of Somalia or any of its Ministries or agencies.

On matters of disciplining and dealing with misconduct, there is a need to develop mechanisms to address specifically SEA/SH, including a grievance mechanism with separate channels to manage GBV related complaints and the procedure for disciplinary actions on matters on GBV/SEA/SH.

Therefore, the project needs to take into consideration the potential risks emanating due to limited training of personnel, limited or lack of understanding of survivor-centered approach, and lack of integrated policies providing a protective environment free from GBV, SEA, and SH. If not well managed, these factors can lead to further harm to the workers and community members.

The project will put in place necessary mechanisms to address SEA/SH. The proposed mitigation measures as per the risk level in the current project is as follows:
• GBV requirements and expectations included in the procurement process (such as the procurement of IEC materials) and the signing of the Code of Conduct by all the project staff to cultivate an environment free from GBV, SEA/SH.

• The hiring of a GBV specialist to support the project implementation as well as guide the operation while continuously identifying potential risks and mitigation measures to be adopted.

• Materials developed for the stakeholders providing information, education, and communication to indicate that the project and/area is a GBV free zone as well as provide information on GBV response services (such as hotline numbers and where to seek services when needed).

• Develop an effective Grievance Redress Mechanism (GRM) with separate channels to manage GBV-related complaints identified and integrated into the GM to enable reporting in a safe, confidential, and survivor-centric manner.
Table 5: GBV ACTION PLAN

<table>
<thead>
<tr>
<th>Objective:</th>
<th>To increase awareness and enhance response systems for GBV, SEA and SH incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity to Address SEA/SH risk</td>
<td>Steps to be taken</td>
</tr>
<tr>
<td>1. Review the IA’s capacity to prevent and respond to GBV/SEA/SH;</td>
<td></td>
</tr>
<tr>
<td>a) Recruit GBV specialist to support the project and supervise the implementation of the GBV action plan</td>
<td>Recruitment of GBV specialist</td>
</tr>
<tr>
<td>b) Review existing acts and regulations on GBV/SEA prevention and response:</td>
<td>Review civil service acts and regulations to include commitment to maintaining a protective environment free from GBV/SEA/SH</td>
</tr>
<tr>
<td>a. Human resource manuals and staff capacity.</td>
<td></td>
</tr>
<tr>
<td>b. Existing GBV/SEA Policies and procedures.</td>
<td></td>
</tr>
<tr>
<td>c) Codes of Conduct signed and understood.</td>
<td>Review CoC for provisions/clauses that guard against GBV/SEA/SH</td>
</tr>
</tbody>
</table>
|   | Develop and conduct GBV/SEA orientation training for all project staff, including PIU | Develop a training plan  
Develop training materials for respective sectors and civil servants  
Conduct training for project staff/PIU | Within the first 3 months of project effectiveness  
Retraining during project implementation. | MOF | MOH/MOE, GBV specialist and WB | Number of trainings conducted for project staff  
Number of staff trained | 67,400 |
|---|---|---|---|---|---|---|---|
| d) | Develop M&E programme | Develop a comprehensive M&E plan to monitor GBV action plan implementation  
Promotion of high level commitment on monitoring the implementation of GBV action plan in order to supports efforts to provide multi-sectoral support to GBV survivors.  
Monitor SEA/SH action plan | Maintained throughout Project implementation. | GBV/SEA Specialist-MOF | MOH/ MOE | M&E framework in place  
. | N/A |

2. **Inform project stakeholders about GBV/SEA/SH risks**

|   | Establish partnerships with key stakeholders (Community members, Students, Parents, teachers, FHWs, PIU staffs, Government and NGO services providers such as health, psychosocial support, safety and security-related services, legal and justice-related services and economic empowerment opportunities etc.) | Identify and officially inform the stakeholders on the components of the projects and project-related risks of GBV/SEA  
Engage stakeholders including citizens engagement and feedback component regularly and conduct joint meetings | Within the first 3 months of project effectiveness  
Maintained throughout Project implementation. | MOF | MOE/MOH | Number and types of stakeholders engaged | N/A |
### b) Develop information dissemination strategy

Develop a strategy to
- Identity the methods to disseminate the information
- Disclosure of information to stakeholders through multimedia outlets

Within the first 3 months of project effectiveness
Maintained throughout Project implementation.

<table>
<thead>
<tr>
<th>MOF</th>
<th>MOE/MOH</th>
<th>A GBV/SEA communication strategy in place</th>
<th>Covered under IEC material development</th>
</tr>
</thead>
</table>

### c) Identify, train and establish project social focal point for GBV/SEA

Establish a trained, dedicated and committed network of project social focal persons including for education and health components

Within the first 3 months of project effectiveness
Maintained throughout Project implementation.

<table>
<thead>
<tr>
<th>MOF</th>
<th>MOE/MOH</th>
<th>No. of social focal points identified and trained</th>
<th>Cost covered under the orientation of all project staffs</th>
</tr>
</thead>
</table>

### d) Develop relevant IEC materials for community engagements

Conduct assessment on the effective IEC materials to be used community
Develop relevant GBV IEC materials that targets everyone without discrimination and easy to comprehend.
IEC materials to include information on GBV response services (such as hotline and where to get help).

Within the first 6 months of project effectiveness
Maintained throughout Project implementation.

<table>
<thead>
<tr>
<th>MOF</th>
<th>MOE/MOH</th>
<th>No and type of GBV/SEA IEC material developed</th>
<th>15,000</th>
</tr>
</thead>
</table>

### f) Conduct outreach information and sensitization campaigns with female health workers and teachers on the risks of GBV/SEA

Develop GBV /SEA information guide integrated into the health and education materials for outreach teams

Within the first 6 months of project effectiveness
Maintained throughout Project implementation.

<table>
<thead>
<tr>
<th>MOE /MOH</th>
<th>Health actors and education actors</th>
<th>Number of community sensitization conducted</th>
<th>15,000</th>
</tr>
</thead>
</table>

### 3. Mapping of service delivery for GBV/SEA prevention and response
<table>
<thead>
<tr>
<th></th>
<th>Develop and/or/update a multisectoral GBV/SEA referral pathway(s)</th>
<th>On the basis of mapped GBV/SEA prevention and response service providers, develop/update a GBV/SEA referral list of preferred service providers. Identify key gaps where remedial measures may be required (e.g. training staff on psychosocial first aid) Regular quality assurance and evaluation</th>
<th>Within the first 3 months of project effectiveness Maintained throughout Project implementation.</th>
<th>MOE/MOH</th>
<th>Referral pathway developed/updated Number/type of GBV/SEA preventive and response services available.</th>
<th>30,000</th>
</tr>
</thead>
</table>

4. **GBV/SEA sensitive channels for reporting in GRM**
|   | Develop/Review GRM for specific GBV/SEA/SH procedures | Undertake internal review of GRM for GBV/SEA reporting channels. Identify and integrate GBV/SEA entry points within the GRM with clear procedures and tools for management of related complaints. Develop and regularly update the information sharing protocol to enhance who is receiving information and how best it is used. Develop and update disclosure and reporting guidelines / protocol for GBV/SEA/SH with a provision for victim protection and assistance. Create reporting pathways that include support systems and accountability mechanisms including how to handle SEA/SH allegations properly. Develop simple, anonymous and confidential tracking system that community health workers /teachers /or identified social focal points can use to document when they observe/support and refer GBV incidents to service providers. | Within the first 3 months of project effectiveness | MOF | GRM with GBV/SEA procedure integrated In the GRM Number of guidelines and protocol on GBV/SEA/SH developed | N/A |
b. **Identify and train GM operators and GBV/SEA/SH social focal points within the GRM, who will be responsible for GBV/SEA cases and referrals as defined in the referral pathway.**

- Identify and select GBV/SEA focal persons within the GRM to manage SEA/SH/GBV related complaints
- Clarify the role of the GM operators and social focal points in GBV/SEA as referral points
- Train the social focal points and all GRM operators on GBV/SEA basics, survivor-centered approach and the referral pathways

Within the first 6 months of project effectiveness
Retraining during project implementation.

<table>
<thead>
<tr>
<th>MOF</th>
<th>MOE/MOH</th>
<th>GM operators and GBV social focal points identified and trained</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>9,200</td>
</tr>
</tbody>
</table>

c. **Review GRM reports/logs for GBV/SEA sensitivity**

- Review logs for GBV/SEA documentation to ensure it follows standards for documenting GBV/SEA cases
- Identify and review culturally appropriate community based reporting mechanism to facilitate reporting.

During project implementation.

<table>
<thead>
<tr>
<th>MOF</th>
<th>MOE/MOH</th>
<th>Number of GBV/SEA cases documented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number of referrals of SEA/SH incidents to the project GRM/ by other service providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of GBV/SEA/SH complaints not resolved by type</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of cases closed, and the average time they were open</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

| Number of SEA/SH complaints not resolved by type | Number of cases closed, and the average time they were open | Number of referrals of SEA/SH incidents to the project GRM/ by other service providers | Number of GBV/SEA cases documented | N/A | 9,200 |