THE GOVERNMENT OF SOMALILAND

THE MINISTRY OF HEALTH DEVELOPMENT

IMPROVING HEALTHCARE SERVICES IN SOMALILAND (P172031)

ENVIRONMENTAL AND SOCIAL MANAGEMENT FRAMEWORK (ESMF)

Updated October 2023

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ACRONYMS AND ABBREVIATIONS

AFRO	Regional Office for Africa
ANC	Antenatal care
ARAP	Abbreviated Resettlement Action Plan
ARI	Acute Respiratory Infection
CBO	Community-based organization
CERC	Contingency Emergency Response Component
CHC	Community Health Committee
CHS	Community Health and safety
CoC	Code of Conduct
CPF	Country Partnership Framework
CPR	Contraceptive prevalence rate
CSO	Civil society organization
DG	Director General
E&S	Environment and Social
EHS	Environmental Health and Safety
EHSGs	Environmental Health and Safety Guidelines
ESMF	Environmental Management Framework
EMRO	Regional Office for the Eastern Mediterranean
EPHS	Essential package of health services
ESCP	Environment and Social Commitment Plan
ESF	Environment and Social Framework
ESIA	Environmental and Social Impact Assessment
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Assessment and Management Plan
ESS	Environment and Social Standards
FCV	Fragility, Conflict & Violence
FGM/C	Female genital mutilation/circumcision
MoHD	Ministry of Health Development
GBV	Gender-based Violence
GDP	Gross Development Project
GFF	Global Financing Facility
GIIP	Good International Industry Practice
GIS	Geographic Information System
GM	Grievance mechanism
GOSL	Government of Somaliland
HCI	Human Capacity Index
HSSP	Health Sector Strategic Plan
ICWMP	Infection Control and Waste Management Plan
IDPs	Internally displaced person
IP	Implementing Partner
IPF	Investment Project Financing
IPV	Intimate partner violence
IVAs	Independent Verification Agents JHNP
JHNP	Joint Health and Nutrition Programme

LMP	Labour Management Procedures
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
MIS	Management Information System
MTR	Medium Term Review
NDP	National Development Plan
NGO	Non-governmental Organization
NSAs	Non-state actors
OHS	Occupation health and safety
OHSE	Occupation health and safety and Environmental
OOP	Out-of-pocket
PAPs	Project affected persons
PDO	Project Development Objective
PFM	Public Financial Management
PHC	Public Healthcare
PIU	Project Implementation Unit
PLWDs	People living with disabilities
POM	Project Operational Manual
PWDs	Persons living with disabilities
RCRF	Recurrent Cost and Reform Financing (WB funded project)
RMET	Resource Mapping and Expenditure Tracking
SBA	Skilled Birth Attendants
SEAH	Sexual Exploitation, Abuse and Harassment
SecMF	Security Management Framework
SecMP	Security Management Plan
SEP	Stakeholder Engagement Plan
SHDS	Somaliland Health and Demographic Survey
TA	Technical Assistance
TBAs	Traditional Birth Attendants
TFR	Total Fertility Rate
ToR	Terms of Reference
TPM	Third Party Monitoring Agent
TTL	Task Team Leader
WB	World Bank
WHO	World Health Organization
WM	Waste Management

EXECUTIVE SUMMARY

1. Somaliland, officially known as the Republic of Somaliland, is an unrecognized *de facto* sovereign state in the Horn of Africa, still considered internationally to be part of Somalia. Somaliland lies in the Horn of Africa, on the southern coast of the Gulf of Aden. It is bordered by Djibouti to the northwest, Ethiopia to the south and west, and Somalia to the east. Its claimed territory has an area of 176,120 square kilometers, with approximately 5.7 million residents as of 2021. The capital and largest city is Hargeisa. The Government of Somaliland regards itself as the successor state to British Somaliland, which, as the briefly independent State of Somaliland, united from 1960 to 1991 with the Trust Territory of Somaliland (the former Italian Somaliland) to form the Somali Republic.

2. Somaliland came into being following the ouster of the Siad Barre regime in 1991 and is among the poorest countries in the world. Somaliland has the fourth lowest GDP per capita in the world, and there are huge socio-economic challenges for Somaliland, with an unemployment rate between 60 and 70% among youth, if not higher. According to ILO, illiteracy exists up to 70% in several areas of Somaliland, especially among females and the elder population. Fiscal capacity remains low, with the government relying mainly upon tax receipts and remittances from the large Somali diaspora, which contribute immensely to Somaliland's economy, in the absence of inflows from Overseas Development Assistance.

3. Somaliland is transitioning towards increased stability through institutional and political reforms, which begun with the adoption of a constitution in 2000. The Constitution of Somaliland is the supreme source of national law of Somaliland and was adopted by the Houses of the Parliament of Somaliland on April 30, 2000, following a national plebiscite. It is notable that Somaliland does not operate within Somalia's Federal system since it declared its independence in 1991, following the referendum that was held on a draft constitution that affirmed Somaliland's independence from Somalia. Today, while significant development has been witnessed in Somaliland on account of the prevailing relative peace, yet the territory's enhanced development is hobbled by weak service delivery capacity, fiscal capacity constraints, and continual humanitarian crises that occur against a backdrop of climate change.

4. Despite some progress, Somaliland's human capital (HC) is likely among the world's lowest. The Human Capital Index (HCI)[1] developed by the World Bank has yet to be calculated for Somaliland due to lack of data on educational outcomes. However, Somaliland's HC level likely lags behind neighbouring countries. Underperforming human capital indicators underline the need to invest in the quality and coverage of services for human development. Improvements in HC are demonstrated to accelerate sustainable growth and prosperity in countries.

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

6. Somaliland's Ministry of Health Development is at the nascent stage of establishment and is now building its capacity to manage health services, including contract management. The Ministry's stewardship, leadership, and managerial functions are still developing. The Government's role in health service delivery is

[1] The HCI measures how much human capital a child born today can expect to attain by age 18, given the risks of poor health and poor education prevailing in the country where they live.

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

limited, and is by law mandated to oversee the development of National Health Policy, which guides the health service delivery approach of implementation of the Essential Package of Health Services. The ministry is also in charge of ensuring that operational and technical policies are developed for all relevant areas of health services, including human resources development, reproductive health, communicable diseases control, among others.

7. As a result of the systemic weaknesses of the ministry, most healthcare services are financed and delivered by NGOs. This also means that key ministry functions including planning, budgeting, finance and governance are not fully developed. Further, the MoHD is highly reliant on external support for its operations. Just like in Somalia, only a small portion of health workers' whose salaries are directly financed from the Exchequer; the remainder of the staff are donor financed and are primarily contracted on short-term basis. While the MoHD has leadership structures and some policies and procedures in place, its decision-making process and management systems are not fully defined, and capacity to manage programs independently of partners is limited. Overall, gains have been made in improving health outcomes, particularly in the areas of reproductive health, maternal, neonatal and child health, and capacities of public institutions have improved. However, health systems challenges remain, including, financial constraints, human resource capacity, limited infrastructure, donor dependency and fragmented health systems. In addition, recurring drought results in malnutrition and there is an inadequate focus on the prevention of non-communicable diseases (NCDs).

8. Out-of-pocket payments (OOP) as a percentage of per capita health expenditure in Somaliland are high at 46 percent. Average annual household OOP on health is estimated at US$6 per capita out of a total of US$13 (2019) and varies substantially between the richest and the poorest quintile, indicating that households are accessing healthcare services based on the ability to pay instead of their healthcare needs, resulting in health inequities.

Project objectives and components

9. The 'Improving Healthcare Services in Somaliland Project', also known as **'Damal Caafimaad'** in Somali language[3] is expected to run from **November 1st 2023 to 30th May 2025** in selected geographical areas in Somaliland. The central problem that the project seeks to address is improving Somaliland's poor healthcare system which has been exacerbated by recurrent extreme droughts and floods, and subsequent food insecurity, and lack of operational and technical capacity by the MoHD, to effectively deliver healthcare services to the population.

10. The Project Development Objective (PDO) is to improve coverage of essential health and nutrition services in project areas and strengthen stewardship, governance, and accountability of the MoHD. The project seeks to expand the coverage of essential services for health and nutrition services to underserved populations in selected areas through performance-based contracting of non-state actors (NSAs) and private sector networks to deliver health services, and direct support to state actors.

11. The project will specifically develop the capacity of the MoHD in health information and management systems (HMIS), contract management and broader public financial management, support to the private sector to provide health services, organizational capacity development, and development of policy and regulatory frameworks. In addition, the project also seeks to support the day-to-day management of the planned activities through the development of monitoring and evaluation (M&E) and coordination mechanisms, and provide an emergency fund for epidemics and outbreaks during the project implementation period.

12. The project, to be implemented over a 4-year period (2023 – 2025), has five components as summarized in Table E1.

Table E1: Project components and sub-components

[3] Damal is a Somali word that refers to *Acacia stenocarpa*, sometimes also known as *Vachellia seyal,* which grows in Somaliland. Caafimaad in Somali means *"health."*

Component	Sub-component
Component 1: Expanding the coverage of a prioritized Essential Package of Health Services (EPHS) in selected geographic areas	
Component 2: Developing government stewardship and management capacity to enhance service delivery	2.1 Health Management Information System (HMIS)
	2.2 Public Financial Management (PFM), Contract Management and Resource Mapping and Expenditure Tracking (RMET)
	2.3 Private Sector Development and Regulatory Reforms
	2.4 Organizational Capacity
Component 3: Project Management	
Component 4: Contingency Emergency Response Component (CERC)	

13. The Project will also retain a proportion of the project funds to contribute to the achievement of the Project's PDO in Somaliland. The disbursement of the funds for Somaliland will be contingent on: (i) the pending resolution of the implementation modalities for Somaliland including clarity on flow of funds; (ii) agreement on the specific project activities; and (iii) completion of relevant fiduciary requirements, as well as the preparation and disclosure of necessary ESF documents. If an agreement on the disbursement of the funds will not have been attained by the time of the Project's Mid-Term Review (MTR), the allocated funds will be cancelled from the total project cost or reallocated based on the agreement reached at that point.[4]

14. The expected key project results include: (i) improvement of coverage of essential health and nutrition services in project locations; (ii) strengthened stewardship, governance, and accountability of and ministries of health; (iii) expansion of the coverage of essential health and nutrition services to underserved populations in the project locations; (iv) enhanced delivery of quality health service by and ministries of health; and (v) provision of emergency fund to and ministries of health in case of epidemics and outbreaks during the project implementation period.

15. Due to the complex and vastness of this project, the ESMF is presented in 5 major sections: (a) Background Information; (b) Environmental and Social Management Framework (ESMF); (c) Grievance Mechanism; (d) Gender-Based Violence (GBV) Action Plan; and (e) Infection Control and Waste Management Plan. This presentation allows the stakeholders to access and reference specific sections.

Environmental and Social Management Framework

16. This document presents the Environmental and Social Management Framework (ESMF) for the proposed Improving Healthcare Services in Somaliland (sometimes also referred to simply as "the Project" or by use of the Somali name for the project, *Damal Caafimaad*). The ESMF focuses on identifying and characterizing the relevant environmental and social risks and impacts the project is likely to face, including labour issues, stakeholder engagement, healthcare waste, exploitation of natural resources, pollution prevention, community health and safety, occupational health and safety, social exclusion and gender-based risks. The ESMF and associated instruments, including the Labour Management Procedures (LMP) and Security Management Framework (SecMF), will be included in all bidding and other contractor management related documents at project implementation.

17. Additionally, this document provides a guideline for environmental and social screening and assessment of activities and interventions that are to be funded within the framework of the proposed project. The ESMF ensures that the project activities scheduled for implementation are compliant with the relevant

[4] Somaliland were initially engaged in a fully collaborative project preparation process, including the joint revision of the EPHS and leadership of a GFF-supported country platform meeting. However, before project pre-appraisal, -Somaliland collaboration was challenged as a result of broader political circumstances between the Somalia and Somaliland. However as of today, the Somaliland Ministry of Health Development is currently fully engaged with the World Bank, and Somaliland's project preparation process is ongoing.

requirements of national[5] policies, regulations and legislations (including primary healthcare, EPHS standards, waste management procedures, among others) as well as requirements of the World Bank Environment and Social Standards (ESSs) and Environment Health and Safety Guidelines (EHSGs). The Framework has also highlighted existing weaknesses in environmental and social risk management at the level of the ministries responsible for health matters at both levels of government, and provides an action plan for mitigating these structural weaknesses.

18. This ESMF not only sets out the principles, rules, guidelines and procedure to assess the environmental and social impacts of interventions to be funded by the project, but also highlights the various responsibilities of the various actors in the project. The ESMF, therefore, directly applies to those activities that will be financed by the project or which are associated or implemented as a result of project interventions. It also highlights the appropriate World Bank's Environment and Social Standards and relevant existing Somaliland environmental and social development laws which project activities and sub-projects financed by, or related to, the project has to conform to.

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

20. **Project Environmental Baseline.** The project will likely be implemented in a number of locations in Somaliland. The final selection of target areas will be agreed by project appraisal. The criterion for geographic selection is based on objective criteria, including population size, accessibility (based on 2019 polio program accessibility data), poverty data from the Somali High Frequency Survey (SHFS), health service delivery data from the Somaliland Health and Demographic Survey (undertaken in 2020)[6], and current partner support.

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

22. **Project Social Baseline**. There has not been an official census conducted in Somaliland since the Somalia census in 1975, while the results from a 1986 census were never released into public domain. A population estimate was conducted by UNFPA in 2014 primarily for the purpose of distributing United Nations funding amongst the regions and to offer a reliable population estimate in lieu of a census. This population estimate puts the combined population of the regions of Somaliland at 3.5 million. The Somaliland government estimates that there are 5.7 million residents as of 2021. Somaliland in addition has an estimated 600,000 to a million strong diaspora, mainly residing in Western Europe, the Middle East, North America, and several other African countries.

23. The main clans of Somaliland are as follows: Isaaq (Garhajis, Habr Je'lo, Habr Awal, Arab, Ayub), Harti (Dhulbahante, Warsangali, Kaskiqabe, Gahayle), Dir (Gadabuursi, Issa, Magaadle) and Madhiban. Other smaller clans include: Jibraahil, Akisho, and others. The clan groupings of the Somali people are important social units and have a central role in Somali culture and politics. Clans are patrilineal and are often divided into sub-clans, sometimes with many sub-divisions.

24. While 40.5% of households in Somaliland have access to improved water sources, almost a third of households lie at least an hour away from their primary source of drinking water. Approximately 1 in 11

[5] Government of Somaliland

[6] Please see a copy of this study at https://somalilandcsd.org/wp-content/uploads/2021/08/SLHDS2020-Report_2020_signed-copy.pdf

children die before their first birthday, and 1 in 9 dies before their fifth birthday. The UNICEF multiple indicator cluster survey (MICS) in 2006 found that 94.8% of women in Somaliland had undergone some form of female genital mutilation; in 2018 the Somaliland government issued a fatwa condemning the two most severe forms of FGM, but no laws are present to punish those responsible for the practice. In addition, Somaliland remains a low-income country with clear disparities between regions, urban and rural communities, and the poorest and the relatively rich classes. Consequently, 49.9% of the urban population are categorized as poor (living below the poverty line), whereas 62.9% of the rural population and 55.3% of internally displaced persons live below the poverty line. Life expectancy at birth is 51.6 years for males and 55 for females. Despite the collapse of health systems during the civil war in 1988, Somaliland has been relatively peaceful and politically stable for almost three decades, and the government of Somaliland has successfully re-established the national health system with partially functioning primary and secondary services with limited finance. The Somaliland government is committed to improving coverage, access, staffing and service delivery. [7]**Policy, Legal and Institutional Frameworks.** The project is required to meet the health sector laws of Somaliland, as well as environmental and social management systems in place in the country. The key legal instrument for management of environmental affairs in Somaliland is the Constitution, The Constitution of Somaliland enshrines matters that relate to the environment and natural resource management thus, providing the keystone to the National Policy on Environment - especially, Article 18 ("Environment and the Relief of Disaster"), Article 31 ("The Right to Own Private Property"), Article 12 ("Public Assets, Natural Resources and Indigenous Production").

25. Article 18: The Environment and the Relief of Disaster, the state shall give a special priority to the protection and safeguarding of the environment, which is essential for the well-being of the society, and to the care of the natural resources. Therefore, the care of and (the combating of) the damage to the environment shall be determined by law. The state shall undertake relief in disasters such as famine, storms, epidemics, earthquakes, and war.

26. Article 31: The Right to Own Private Property**,** every person shall have the right to own private property, provided that it is acquired lawfully. Private property acquired lawfully shall not be expropriated except for reasons of public interest and provided that proper compensation is paid. The law shall determine matters that are within the public interest, which may bring about the expropriation of private property.

27. **Article 12: Public Assets, Natural Resources and Indigenous Production.** Today, as the GoSL institutional capacities are growing, the legislative and policy processes are also evolving. The Republic of Somaliland Constitution of 2001 declare that the land is a public property commonly owned by the state and the state is responsible for it. Article 12: Public Assets, Natural Resources and Indigenous Production states:

i. The land is a public property commonly owned by the nation, and the state is responsible for it.

ii. The care and safeguarding of property, endowments and public assets is the responsibility of the state and all citizens; and shall be determined by law.

iii. The Government shall have the power to own and possess movable and immovable property; and to purchase, sell, rent, lease, exchange on equivalent value, or otherwise expend that property in any way which is in accordance with the law.

iv. The central state is responsible for the natural resources of the country, and shall take all possible steps to explore and exploit all these resources which are available in the nation's land or sea. The protection and the best means of the exploitation of these natural resources shall be determined by law.

v. Where it is necessary to transfer the ownership or the benefits of a public asset, the transfer shall be effected in accordance with the law.

[7] This section is based on this report: https://www.thet.org/wp-content/uploads/2020/11/UKPHS_Somaliland-Priority-Document.pdf

28. There are no standing environmental and/or social safeguards in terms of legislated and or drafted regulations. However, Article 18 and 31 also affirms that the 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.

29. The Government of Somalia developed the third National Development Plan (NDP) covering the period from 2023-2027. Chapter 12 is dedicated to the health and nutrition sector, with a vision clearly enunciated that all people in Somaliland should get access to improved health services. The policy identified six priority areas for the health sector namely: Leadership and Governance; Health Information System; Health workforce; Medicine and Technology; Infrastructure; and Health Financing.

30. The Government of Somaliland has developed the second Health Sector Strategic Plan (HSSP III). The HSSP, which covers the period between 2022-2026, provides the guiding framework and strategic direction for the detailed planning and implementation of health sector activities. It guides various health stakeholders to direct their efforts and initiatives towards the attainment of the national health priorities, including Universal Health Coverage (UHC) and the Sustainable Development Goals (SDG), particularly SDG 3. Furthermore, the Somaliland National Drug Policy and Essential Medicine List was developed, and endorsed in 2014. The National Medicines Supply Chain Masterplan for Somaliland was finalized in 2015, while the National Medicines Regulatory Authority established in 2016.

31. The project is also structured to meet the requirements of the Somaliland-WHO Country Cooperation Strategy where MoHD- committed with WHO on those priorities.[8] In particular, the project interventions will contribute to the achievement of:

- Strategic Priority 1 ("Communicable Diseases"): through implementing activities that will reduce the burden of communicable diseases, and by way of child health services (routine immunization; micronutrient supplementation) that are planned in the project;
- Strategic Priority 2 ("Non-Communicable Diseases"): this will be achieved through planned investments in primary healthcare, knowledge and documentation activities, and strengthening the capacity of Somali authorities to prevent and manage NCDs and their risk factors;
- Strategic Priority 3 ("Health through the Life Course"): the proposed project has significant focus on maternal, newborn, and child health; the project also proposed to strengthen coordination between participating entities and development partners on maternal, neonatal, and child health; and

32. Strategic Priority 4 ("Health System and People-Centred Healthcare Services"): The proposed project has a focus on strengthening the existing weak health systems by infusing both technical (personnel) as well as policy and regulatory frameworks in order to ensure greater well-being of the people of Somaliland. **Environmental Risks and Risk Rating.** The environmental risk classification for the project is Substantial under the World Bank ESF, mainly because of the risks linked to the management of biomedical waste but also because of the risks linked to small scale renovation and of health facilities. In addition, health and safety risks also need to be taken into account given the limited capacity of the PIU on these issues. The main environmental impacts of health activities supported under this project may come during the rehabilitation and operational phases of the project from the possible heavy consumption of energy and water resources, pollution, possible greenhouse gas emissions, use and disposal of toxic chemicals, and production of wastes and wastewater and their disposal.

33. In addition, possible heavy consumption of energy and water resources is anticipated. As a result, soil, air and water pollution will likely occur, in addition to possible greenhouse gas emissions. The disposal of toxic chemicals and other healthcare wastes and wastewater will likely be a significant challenge. The various

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

typologies of healthcare wastes envisaged include infectious waste (waste that may contain pathogens, including used dressings, swabs and other materials or equipment that have been in contact with infected patients or excreta; may also include liquid waste such as faeces, urine, blood and other body secretions, pathological wastes (human tissues including placentas, body parts, blood and foetuses), sharps (needles, infusion sets, scalpels, blades and broken glass), pharmaceutical waste (expired or no longer needed pharmaceuticals, items contaminated by or containing pharmaceuticals), chemical wastes (waste containing chemical substances such as laboratory reagents, film developer, disinfectants that are expired or no longer needed, and solvents), waste with high content of heavy metals, including batteries, broken thermometers, blood-pressure gauges, etc.

34. The project activities with environmental risks proposed under the project include construction activities, such as possible small-scale rehabilitation and/or refurbishment of health centres, as well as lifecycle infection control and the possible use of designated waste disposal pits or medical incinerators (especially in large urban centres) or other waste management facilities for medical waste disposal. Generally, there are no waste management and disposal systems in public health facilities in Somaliland that meet international standards. As a result, improper disposal of bio-medical waste by health centres, hospitals, primary health centres, community health centres and diagnostic centres pose a health hazard to the general public. Other environmental risks include Occupational Health and Safety (OHS) risks and community health and safety risks, including possibilities of exposure to communicable diseases.

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

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

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

38. **Overall Risk Rating**. The Ministry of Health Development's ability to apply World Bank environmental standards is limited, due to absence of experienced technical capacity for environmental and social safeguards at the ministry. In addition, there are also extensive social risks identified during the project preparation and consultations. Therefore, the overall environmental and social risk rating (ESRR) is "**Substantial**" under World Bank's Environmental and Social Risk Classification system (ESRC).

39. **Applicable Environmental and Social Standards.** Due to the dearth of applicable environmental laws and regulations at both national and regional levels in Somaliland, the project will apply the World Bank

Environment and Social Framework[9], and will, therefore, not rely on Somaliland's national environment management frameworks. The following environmental and social standards will be relevant to the activities implemented under the project:

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

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

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

- less pollution loads due to improved solid waste management;
- greater improvements in social welfare of the Somaliland population, given the investments in package of healthcare services;
- increased legitimacy of State authorities in Somaliland as they pioneer in the rendering of health services to the population;
- availability of employment opportunities for young people, including both skilled and unskilled personnel;
- an uptick in economic activity in the areas traversed by project interventions;
- greater capacity for Somaliland authorities in managing social risks, including enhancement of capacity to conduct stakeholder consultations with poor and marginalized sections of the community;
- enhanced capacity for environmental management at the participating health facilities.

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

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

- Stakeholder Engagement Plan (SEP), which will set out effective and transparent management of consultation, communication and information disclosure processes to guide the health sector reforms process;

[9] For better understanding of the World Bank's ESF, please visit https://projects.worldbank.org/en/projectsoperations/environmental-and-social-framework/brief/environmental-and-social-standards

- An Environment and Social Commitment Plan (ESCP), which will summarize the Borrower's commitments and obligations to adopt and implement the environmental management measures specified in this document for project implementation;
- This ESMF, Grievance Mechanism (GM), Gender –Based Violence (GBV) Action Plan and Infection Control and Waste Management Plan (ICWMP);
- Contractor Environmental and Social Management Plan (C-ESMP), to be developed and implemented by the contractors running the health facilities, and which will be structured to cover environmental risks and impacts during both the (minor) construction and operational phases of the healthcare facilities. The C-ESMPs will meet contractual EHS requirements; • Labour Management Procedures (LMP); and
- Security Management Framework (SecMF).

44. **Public Consultations and Disclosure.** The World Bank Environment and Social Standards require 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. The details of stakeholder engagement are presented in the Stakeholder Engagement Plan (SEP). The World Bank's Safeguards team have also closely engaged with the ministry officials in and by way of constant on-net communications. Feedback was received from stakeholders consultations on 22nd of August 2023, including discussions on issues, such as, information disclosure, coordination and clarity on the project, labor and security risks, socio-cultural believes, GBV, OHS, among others. This input is reflected in this updated version of the ESMF.

45. **Cost Implications of the ESMF.** Low capacity within the implementing team risks undermining the ability of the project team to roll out in a timely and effective manner the interventions proposed in the ESMF. To mitigate this risk, the project will contribute to developing capabilities of the Ministry of Health Development to oversee the execution and delivery of the mitigation measures proposed in the ESMF.

46. Technical capacities for environmental and social risk management in the MoHD are limited; as such, an external third party may be appointed to support the ministry to administer the bulk of project activities on behalf of the government, which will be contracted at the start of the project. Definitive and discrete measures will need to be taken to enhance safeguards capacity to improve E&S performance during project implementation; this will include safeguards training for PIU members. The ESMF includes an action plan for engendering and enhancing E&S risk management at the two levels of management. The indicative budget proposed to implement the ESMF (including other ESF instruments, trainings, salaries, and cost for commissioning Security Management Company, among others) over the life of the project is USD 1,315,650 (*see Sec 7.5, Table 14*).[10]

47. The existing policies, legislation and institutional frameworks on social services, including policies on social, heath and civil service sectors, and World Bank's ESF provide a framework that can facilitate the implementation of social safeguards for the project. The existing labour laws are aligned to the provisions stipulated in Environment and Social Standard 2 (ESS2) although the key challenge in Somaliland is lack of enforcement. The Provisional Constitution (2021) makes provisions that guarantee human rights of all people including the disadvantaged and vulnerable groups and the right to healthcare and other social services. The Somaliland Health Sector Strategic Plan (HSSP) 2022-2026 takes a pragmatic approach to the provision of essential package of health services (EPHS) including community-based health services across regions of Somaliland but the EPHS' implementation is limited to some regions due to funding gaps and insecurity.

48. Multiple mechanisms are outlined on how to mitigate the potential social risks including: (i) ensuring that all the specific risks are identified and addressed in the ESMPs of all the contractors and implementing partners; (ii) stakeholders are actively involved in the project as guided by the Stakeholder Engagement Plan (SEP); (iii) the LMP, Inclusion Plan and GBV Action Plan are fully implemented (note that the Inclusion Plan is

[10] This is to be validated by the MoHD.

part of the SEP and while the GBV Action Plan is part of this ESMF); (v) the grievance management (GM) procedures developed for the project is operationalized; and (v) there is robust monitoring through a third party. In addition, a SecMF will be prepared by the project team to address all issues related to security of the project workers, users of health facilities, equipment and materials. High level mitigation measures will include: strong involvement of authorities throughout project preparation; effectively using the Global Financing Facility (GFF) supported country platform for improved coordination among stakeholders; and closely engaging with the MoHD, to better manage - relationships.

Inclusion Plan

45. This plan addresses the risk of exclusion of disadvantaged and vulnerable people in the intervention areas. These groups include: minority castes and groups;[11] internally displaced people (IDPs); people who live in remote rural areas or areas characterized by violence and conflict and are bereft of social services and amenities; nomadic pastoralist communities; people living with disabilities (PWDs); and female headed households including vulnerable orphans and unaccompanied minors. The project will also endeavor to involve men since they are often left out in health projects, yet their commitment and influence is essential for women and children to access services, as well as the need for general community commitment to the project for successful implementation, and security and conflict management. Measures will be put in place to ensure that disadvantaged and vulnerable groups are engaged in project consultations in the sub-project design, development of the ESMPs, project implementation and monitoring.

Gender-based violence (GBV)/Sexual exploitation and abuse (SEA)

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

Grievance Mechanism

47. For the **'Damal Caafimaad'** project, the MoHD will have the responsibility to resolve all issues related to the project in accordance with the laws of Somaliland and the World Bank ESSs through a clearly defined GM that outlines its process and is available and accessible to all stakeholders (the GM is outlined in the SEP and the ESMF). The mechanism will amongst other things:

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

48. The entry point for all grievances will be the social specialist who will receive grievances by phone, text or email to publicized mobile phone lines and email addresses, ensuring confidentiality and sensitivity in handling them to avoid any retaliation or harm to the complainant. The social safeguards specialist will acknowledge, log, forward, follow-up grievance resolution and inform the complainant of the outcome. The complainants have the right to remain anonymous, in which case their identifying details will not be logged. The social specialist will carry out training of social officers and contractors on complaints handling and reporting. The LMP will outline a separate GM for workers although they too will have access to the broader project GM.

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

Cost of implementing the ESMF

49. The estimated cost for this Framework is USD 1,398,873. The cost will cover the implementation of the SEP, LMP, GBV Action Plan, development and implementation of SecMF, security risk assessments and security management plans (SecMPs), orientation workshops for implementing partners and third-party monitor (TPM) and other contractors on ESF requirements before bidding and capacity building on social risk management (SRM). The costs of contractors implementing their ESMPs will be contained in their contracts

Management of the Project and implementation of the ESMF

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

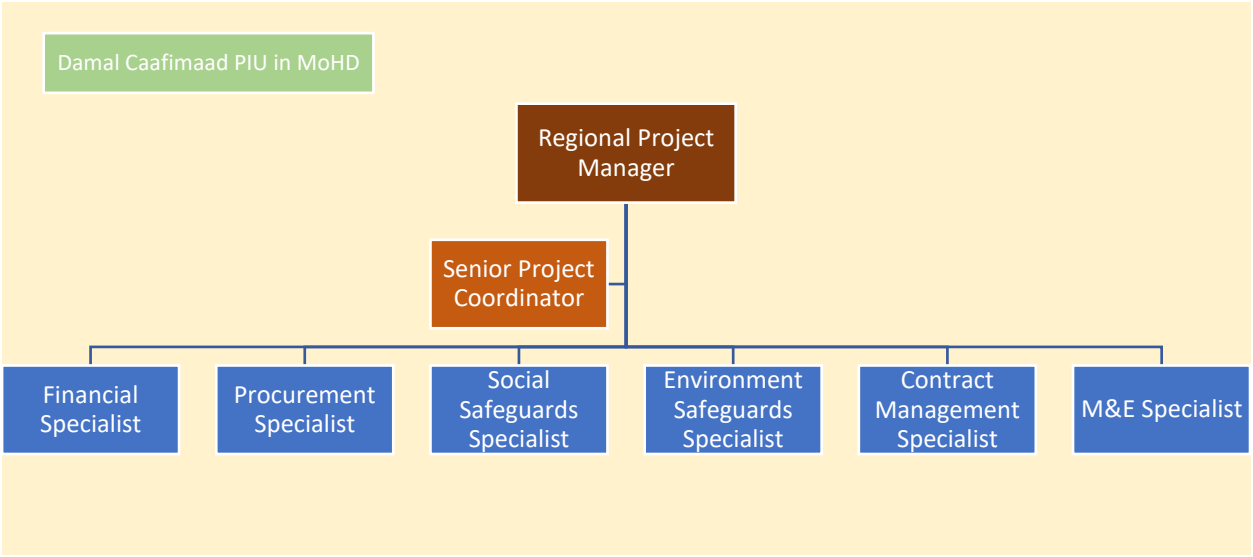

Figure E1: Institutional diagram of PIU at MoHD

SECTION 1: INTRODUCTION AND PROJECT CONTEXT

1.1. Project Context

50. Somaliland, officially known as the Republic of Somaliland, is an unrecognized *de facto* sovereign state in the Horn of Africa, still considered internationally to be part of Somalia. Somaliland lies in the Horn of Africa, on the southern coast of the Gulf of Aden. It is bordered by Djibouti to the northwest, Ethiopia to the south and west, and Somalia to the east. Its claimed territory has an area of 176,120 square kilometers, with approximately 5.7 million residents as of 2021. The capital and largest city is Hargeisa. The government of Somaliland regards itself as the successor state to British Somaliland, which, as the briefly independent State of Somaliland, united from 1960 to 1991 with the Trust Territory of Somaliland (the former Italian Somaliland) to form the Somali Republic.

Figure 1: Map of Somaliland[12]

51. Somaliland has experienced prolonged conflict since the ouster of the Siad Barre regime in 1991 and is among the poorest countries in the world, with a per capita Gross Domestic Product (GDP) of US$876.99 in 2020[13]. An estimated 69 percent of the Somali population lives in poverty (below US$1.90 per day, 2018 estimate) with many more people living just above the poverty line. The situation is further compounded by a high population growth rate with an annual economic growth rate of approximately 2.8 percent between 2016 and 2020. Due to the COVID-19 pandemic and associated disruptions of economic activity, the economy was anticipated to contract by 1.5 percent in 2020. Fiscal capacity remains low, with a government

[12] https://en.wikipedia.org/wiki/Geography_of_Somaliland
[13] World Economic Outlook, 2020.

expenditure to GDP ratio of 12.4 percent (2020), underlined by nascent tax mobilization systems with a tax-to-GDP ratio of 2.5 percent (2020), which further constrains service delivery[14].

52. Somaliland is transitioning towards increased stability through institutional and political reforms, which begun with the referendum on secession from the Republic of Somaliland. The collapse of the unified Somali state under General Mohammed Siad Barre in 1991 after protracted civil war resulted in death and destruction and the collapse of governance. Even as chaos in southern and central Somalia continued, the northwest region of Somaliland has been defined by a long period of relative peace and calm and the development of an emerging set of state institutions. Somaliland has developed its own structures and systems of governance, drawing on elements of a kin-based system that provided a basis for organizing and restructuring institutions.

53. Despite some progress, Somaliland's human capital (HC) is likely among the world's lowest. The Human Capital Index (HCI)[15] developed by the World Bank has yet to be calculated for Somaliland due to a lack of data on educational outcomes. However, Somaliland's HC level likely lags behind neighbouring countries. Underperforming human capital indicators underline the need to invest in the quality and coverage of services for human development. Improvements in HC are demonstrated to accelerate sustainable growth and prosperity in countries.

54. Somaliland is faced with two critical challenges of creating sustainable internal peace and constructing a path for shared economic growth and prosperity. Among the most critical sectors for the emerging state is the health sector. However, as a result of limited regulatory capacity, the private sector is largely unregulated. Due to Somaliland's nascent health sector regulatory capacity, there are inadequate quality standards and weak functional regulatory bodies for health services or pharmaceutical products. As a result, providers can operate without any oversight and provide services and products of unknown quality. This limits the full potential of the private sector, as formal private sector investment requires functional regulations to be effective. Somaliland has very high prevalence of communicable and non-communicable illnesses, and some of the lowest health indicators in the world, according to the World Health organization (WHO, 2018).

55. Somaliland's lagging health outcomes reflect the country's insecurity, vulnerability, and deep-rooted poverty, limiting opportunities for people to access basic social services, including education and health. As seen in Table 1, Somaliland's health indicators remain among the worst in the world, with an average life expectancy of 66 years. Other indicators lag behind those in the World Health Organization (WHO) Regional Office for Africa (AFRO) region as well as most indicators in select, comparable Fragility, Conflict, and Violence (FCV) impacted countries in WHO's Regional Office for the Eastern Mediterranean (EMRO) region, of which Somaliland is a part[16]. While most health outcomes in Somaliland improved from 2006 to 2019, some indicators such as fertility and stunting have declined since 2016.

Table 1: Somaliland's Key Health Indicators

Indicator	2011	2016[17]	2020	WHO AFRO Regional Average (2016)[18]
Maternal Mortality Ratio (per 100,000 live births)	1044 (MICS 2011)	732	396	536 (2017)

[14] World Bank, (2020). Somaliland Economic Update, June 2020: Impact of COVID-19-Policies to Manage the Crisis and Strengthen Economic Recovery.

[15] The HCI measures how much human capital a child born today can expect to attain by age 18, given the risks of poor health and poor education prevailing in the country where they live.

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

[17] The World Bank: http://data.worldbank.org.

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

Indicator	2011	2016[17]	2020	WHO AFRO Regional Average (2016)[18]
Neonatal Mortality Rate (per 1,000 live births)	35-48 (MICS 2011)	38.8	20.7% (SLDHS 2020)	26
Infant Mortality Rate (per 1,000 live births)	72 (MICS 2011)	90	70	51
Under-five Mortality Rate (per 1,000 live births)	90 (MICS 2011)	137	93	80.5
Total Fertility Rate (no. of births per woman)	8 (MICS 2011)	6.7	5.7	N/A
Stunting (age-for-height among children under five years of age)	42% (UNICEF 2009)	N/A	21%	29%

56. The country's overall morbidity and mortality remain very high, particularly women and children. Somaliland currently has the world's highest child mortality rate. For Somaliland Infant Mortality Rate (IMR) stands at 72/1000 live births and Under Five Mortality (U5MR) 91/1000 live births One out of seven Somalilander children die before the age of five. Somalilander mothers experience the sixth highest maternal death risk in the world, with 47% of ever-married women aged 15-49 who had a live birth in the five years preceding the SHDS (2020) received Antenatal Care (ANC) from a skilled health provider. The average Somalilander woman has 5.7 children, the one of the highest fertility rate in the world (Somaliland Health and Demographic Survey). Despite the immense challenges, the country's health sector is emerging from the crises and is forging a path forward. The country is re-establishing health governance structures, rebuilding health institutions, re-engaging with development partners, and adopting a decentralized health governance system through MOHD at the national and regional levels. According to SARA report 2016, nationally, there is less than 1 health facility per 10,000 population (0.76 facilities per 10,000 population) which indicates the country is 38% of the way towards achieving the facility density target of two health facilities per 10,000 population.

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

58. Government expenditure on health is 6.14 percent out of the total national budget (National Budget 2021). According to World Bank's Resource Mapping and Health Expenditure Tracking (RMET, 2020) around 75% Somaliland's total health expenditure is donor financed. The high proportion of off-treasury donor resources has limited the Government's involvement in many aspects of health sector programming, constraining the ability to increase efficiency in spending and Government leadership in the sector.

59. Out-of-pocket payments (OOP), as a percentage of per capita health expenditure in Somaliland, are high and twenty-nine percent of households spend less USD 50; 25 percent spend USD 50 to 99, 19 percent spend USD 100 to 199, 7 percent spend USD 200 to 299 and 20 percent spend USD 300 or more on health. Forty-eight percent of families pay for their health expenses from their income towards medical expenses, while 18 percent receive it from their relatives or friends and 16 percent borrow. Households are less likely to receive money to cover health related expenses from insurance at 2 percent, savings at 2 percent and proceeds from sold fixed assets at 9 percent.

60. There are currently 46 major health facilities in Somaliland including 10 referral health centers, 20 district hospitals, 279 maternal and child health centers and 131 primary health units. The Government of Somaliland has acknowledged the poor state of the health sector and is engaging development partners in an effort to improve health outcomes for its people. In 2013, for the first time, the MoHD developed the Health Sector Strategic Plan with the latest finalized in 2022 (HSSP, 2022-2026). This was

an important step towards building the Government's capacity to improve access to health services for the people of Somaliland (Government of Somaliland, 2016).

1.2. Gender and Equality

61. 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 396 deaths per 100,000 live births and a high fertility rate of 5.7 (as of 2020).

62. Despite recent successes, the representation of women in political positions, such as parliament remainslow. Efforts to codify a gender quota in electoral legislation has been unsuccessful. Women are more vulnerable to physical insecurity in the form of GBV such as rape and domestic violence. While these behaviors are still taboo, the combination of high rates of male unemployment and khat addictions have contributed to increased instances of these forms of violence against women. Women have become primary breadwinners in many households yet they are still predominant in the small and petty trade sectors. In the Somaliland civil service, women make up only 26 percent of the federal workforce[19].

63. Female Genital Mutilation/Cutting (FGM/C) is a deeply entrenched, near universal[20], cultural practice in Somaliland. Ninety-eight percent of women between the ages of 15-49 have undergone FGM/C according to the 2020 SHDS. The survey also found that 56% of women aged between 15 and 49 years believe that FGM/C is a religious obligation and 53 percent would like it to continue. FGM/C contributes to obstetric complications such as obstructed labour, obstetric fistula and infections, which dramatically impact maternal health in Somaliland. FGM/C violates the rights of women and girls, and the prevalence of FGM/C is compounded by socio-cultural barriers to reporting GBV and few quality GBV response services. Behaviour change is challenging and will require in-depth understanding of the socio-cultural context and past experiences of individuals and communities, to develop effective and innovative ways to work with opinion influencers including religious and traditional leaders, female role models and traditional circumcisers and TBAs.

64. Somaliland's maternal mortality ratio (396/100,000) is among the highest in the world but is lower than some comparable countries. Only 20 percent of women receive four antenatal care (ANC) visits and 47% percent receive a first ANC visit. Forty percent of births are attended by skilled birth attendants (SBA), which is notably higher than births at a health facility (33%), in a context where there are cultural preferences and geographic constraints that increase home births. Only 19 percent of women and 17 percent of newborns receive post-natal care (PNC). Thirty-nine percent of women described permission from their male partners to access services as a barrier to service access. Thus, community engagement and outreach activities should include efforts to engage men in the health activities.

65. Socio-cultural factors play a significant role in the health seeking behaviours and status of women in Somaliland. Responsibility for decisions related to health seeking, such as when to get treatment at a clinic, resides primarily with men and contributes to care seeking delays. According to the 2020 SHDS, 39 percent of women report needing permission to access services as a barrier to healthcare during pregnancy. Further, early marriageis prevalent and a significant contributor to early first pregnancies, high fertility rates and the high maternal mortality ratio. The high prevalence of female genital mutilation/circumcision (FGM/C) in Somaliland contributes of early marriages and poor health among women of child bearing age). Overall, 12

19

https://csi.govsomaliland.org/site/downloadfile/file/MjAyMi8wMS8yMDIyLTAxLTE4LTA4LTE4LTE4LTE3OC0xNjQyNDkzODk4LnBkZg%3D%3D/view/1

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percent of women aged 25-49 married by age 15, 39 percent by the time they were 20, while 52 percent were married by the age of 22. Average age at first marriage is 20 for women and 25 for men. Women, especially pregnant women and those in rural areas, find it difficult to access proper healthcare due to its absence in the areas they live in and/or due to poor infrastructure.

1.3. Improving Somaliland's Health Sector

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

13. Somaliland's 3rd National Development Plan sets key priorities for improving health access and outcomes, including:

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

14. The Plan calls on Somaliland to coordinate with development partners to ensure better health service coverage. Specifically, the NDP III pledges that the government will partner with non-state providers to rehabilitate or construct health clinics, and to increase distribution of Essential Package of Health Services (EPHS). Towards this, in 2019, Somaliland became a GFF country, and this will go a long way in reducing health sector fragmentation and strengthen the Government's stewardship role.

15. Basing his recommendations on the 2013 Somali Joint Health and Nutrition Programme (JHNP),[21] overseen by UNICEF and the Health Consortium for Somali People, Warsame (2014), in his seminal study on "opportunity for health systems strengthening in Somaliland", calls for interventions in six distinct areas:

a. strengthening leadership and governance;
b. increasing health workforce quality and quantity;
c. delivering equitable health services through functioning health facilities;
d. developing a nationally financed and locally prioritized health financing system;
e. ensuring provision of appropriate and sufficient health products; and
f. establishing a comprehensive M&E system.[22]

[21] For more details on this programme, please see http://www.unicef.org/Somaliland/reallives_13941.html.
[22] Warsame, A. 2014. Opportunity for health systems strengthening in Somaliland. The Lancet, Vol. 2, Issue 4. Available at https://doi.org/10.1016/S2214-109X(14)70010-5.

1.4. Improving Healthcare Services in Somaliland Project

16. The 'Improving Healthcare Services in Somaliland Project', also known as **'Damal Caafimaad'** in Somali language[23] is expected to run from **November 1st to 30th May 2025** in selected geographical areas in Somaliland. The central problem the project seeks to address is improving Somaliland's poor healthcare system which has been exacerbated by recurrent extreme droughts and floods, and subsequent food insecurity, and lack of operational and technical capacity by the MoHD to effectively deliver healthcare to the people.

17. The Project Development Objective (PDO) is to improve the coverage of essential health and nutrition services in project areas and strengthen stewardship, governance, and accountability of the MoHD. The project seeks to expand the coverage of essential services for health and nutrition services to underserved populations in selected areas through performance-based contracting of non-state actors and private sector networks to deliver health services, and direct support to state actors to deliver services.

18. The project also seeks to strengthen the capacity of MoHD in order to enhance quality health service delivery across the country. The project will specifically develop the capacity of the MoHD in health information and management systems (HMIS), contract management and broader public financial management, support to the private sector to provide health services, organizational capacity development, and development of policy and regulatory frameworks. In addition, the project also seeks to support the day-to-day management through development of M&E and coordination mechanisms, and provide an emergency fund for epidemics and outbreaks during the project implementation period.

19. The project will be implemented by the MoHD, Somaliland. The mission of the Ministry is to "ensure the provision of quality essential health and nutrition services for all people in Somaliland, with a focus on women, children, and other vulnerable groups." The Ministry also seeks to "strengthen the national and local capacity to deliver evidence-based and cost-effective services based on the EPHS and Primary Healthcare (PHC) approach."[24] The Ministry adopted the EPHS framework in 2009 and has tried to implement it in the country with the support of the JHNP, supported by multiple donors and UN organizations.

20. The proposed project is in line with the Somaliland National Development Plan's Pillar 4 ("Social Development"), which calls for investments to achieve outcomes related to "improved health", "improved social protection," and "governance strengthening." In the long-term, the project will also help in the achievement of peace and stability, as the interventions will help develop confidence in national institutions (including the MoHD) and its enhanced capacity to deliver PHC outcomes for the people of Somaliland.

1.5. Project Scope

21. The project will have four components as described in brief below.

22. ***Component 1: Expanding the coverage of a prioritized EPHS in selected geographic areas:*** This component will finance the delivery of an essential package of health and nutrition services in selected geographic areas. Somaliland's EPHS will focus on the provision of basic maternal and child health, primary healthcare, and health preparedness. Two delivery platforms are envisaged for extension of EPHS to Somalilanders:

- In urban areas, the project envisages to contract private sector players to deliver the EPHS; and
- strengthening government service delivery system to expand service coverage: this is likely in Maroodi Jeex region, where there is existing government service delivery capacity.

[23] Damal is a Somali word that refers to *Acacia stenocarpa*, sometimes also known as *Vachellia seyal,* which grows in Somaliland. Caafimaad in Somali means *"health."*

23. ***Component 2: Strengthening Government's stewardship to enhance service delivery***: through this component, the project will support the development of government stewardship capacities to enhance quality service delivery. The activities will be implemented under four sub-components:

- *Sub-component 2.1: Health Information and Management Systems (HMIS) and Data Use for Decision Making:* In this sub-component, the project will finance interventions meant to improve data timeliness, quality, and use. The project will also initiate the Logistics Management Information System (or LMIS in short) framework to contribute to the long-term goal of ensuring a high-functioning health information system producing regular, quality, reliable data that are used for routine decision making.
- *Sub-component 2.2: Public Financial Management (PFM), Contract Management, and Health Financing:* The project will support the implementation of recently developed Public Finance Management (PFM) roadmap by funding short-term activities including the development of contract management quality control guidelines, contract management capacity development and support, PFM technical assistance and capacity development for planning and budgeting as well as budget execution capacity.
- *Sub-component 2.3: Private Sector Development and Regulatory Reforms***:** The project will map private sector providers and networks to inform organizational development/capacity building interventions. Interventions under this sub-component will also support the building of the organizational capacities of selected private providers and their networks. The project will establish public-private dialogue mechanism and building dialogue capacity on health matters.
- *Sub-component 2.4: Organizational Development:* This sub-component will finance activities aimed at the development of systems and process for decision making, internal information sharing, internal communication, external communication, and information management. The project will also enhance the capacity for planning, learning and review including development and implementation of systems and processes for regular review and learning.

24. ***Component 3: Project Management, M&E, Knowledge Management, and Learning:*** This component will support day-to-day project management including coordination, administration, communication, management, procurement, M&E, and dissemination of project activities. To this end, the component will finance the following activities: (i) conducting rigorous monitoring evaluations by a Third Party Monitoring (TPM) firm, contracted by the Government, to draw timely lessons on what works, costs, and how activities can be scaled up; (ii) facilitating learning and knowledge sharing across and within and ; and (iii) supervising, coordinating, and providing oversight for project implementation. The component will also support technical and administrative staff for the Project.

25. ***Component 4: Contingency Emergency Response Component*****:** This component is included in the project, in accordance with the World Bank's Investment Project Financing (IPF) Policy, paragraphs 12 and 13, for situations of urgent need of assistance. There is a high probability that during the life of the Project, the country will experience an epidemic or outbreak of public health importance, or other disaster, which causes a major adverse economic and/or social impact (e.g., Ebola), which will result in a request to the World Bank to support mitigation, response, and recovery in areas affected by such an emergency. To trigger this component, the Government needs to declare an emergency or provide a statement of fact justifying the request for the activation of the use of emergency funding. The Government may request the World Bank to re-allocate undisbursed Project funds to support response and reconstruction. An Emergency Response Operations Manual will be prepared by the Government as a condition of disbursement and annexed to the Project's Operations Manual (POM). The Project will also retain a proportion of the project funds to contribute to the achievement of the Project's PDO in Somaliland. The disbursement of the funds for Somaliland will be contingent on: (i) the pending resolution of the implementation modalities for Somaliland including clarity on flow of funds; (ii) agreement on the specific project activities; and (iii) completion of relevant fiduciary requirements, including disclosure of necessary ESF documents. If an agreement on the disbursement of the funds will not have been attained by the time of the Project's Mid-Term Review (MTR), the allocated funds

will be cancelled from the total project cost or reallocated based on the agreement reached at that point.[25] Both the POM and the Emergency Response Operations Manual will detail the SRM measures for all aspects of the project. Revised environment and social (E&S) instruments will be required for the CERC as a condition of disbursement.

1.6. Project Beneficiaries

28. The direct beneficiaries of the project will be the Somali public, specifically the residents of the localities where the project activities will be implemented. The project will specifically target the following groups: mothers, children, women of reproductive age and persons living in project target regions, including disadvantaged and vulnerable groups including minority groups and castes, hard-to-reach populations, IDPs and nomads. There will also be concerted effort to engage men who are often side-lined in health interventions and buy-in is critical for project success and social risk management.

29. The following have been identified as likely project regions: Maroodi Jeex region, particularly in Hargeisa District, Baligubedle District and Gabiley District**.** Other beneficiaries of project will include government institutions, specifically the MoHD will benefit from the capacity building component of the project. Consultants who are employed under the project to assist the MoHD in the project implementation and NGOs to be contracted to deliver health services in the project locations will also benefit from the project.

Figure 2: Regions of Somaliland including Maroodi Jeex where the Project is initially taking place

1.7. The Project Expected Results

30. The expected key results of the project include:

[25] Somaliland were initially engaged in a fully collaborative project preparation process, including the joint revision of the EPHS and leadership of a GFF-supported country platform meeting. However, before project pre-appraisal, -Somaliland collaboration was challenged as a result of broader political circumstances between the Somalia and Somaliland. Today, the Somaliland Ministry of Health Development is re-engaged with the World Bank, and Somaliland's project preparation process is ongoing.

a. Improvement of coverage of essential health and nutrition services in project locations;
b. Strengthened stewardship, governance, and accountability of Somaliland's MoHD
c. Expansion of the coverage of essential health and nutrition services to underserved populations in the project locations;
d. Enhanced delivery of quality health services by MoHD; and

Provision of emergency fund to MoHD in case of epidemics and outbreaks during the project implementation period.

SECTION 2: SCOPE AND METHODOLOGY OF THE ESMF

2.1. Purpose and Scope of the ESMF

31. The purpose of the ESMF is to ensure that the activities executed under the Improving Healthcare Services in Somaliland project (also identified throughout this ESMF as "the project") address and identify measures to avoid and minimize environmental and social impacts, as much as possible. Where these cannot be avoided, the impacts are adequately identified, assessed and necessary mitigation measures designed and implemented following relevant, existing environmental and social legislation of Somaliland and the World Bank's Environmental and Social Standards.

32. The Ministry of Health Development is expected to prepare, validate, and disclose this ESMF in all the participating regions of Somaliland in order to obtain valuable input from Somalis and to enrich the entire process of environmental and social risk management.

2.2. ESMF Justification

33. The Environmental and Social Management Framework (ESMF) clarifies appropriate environmental and social standards, processes, and mitigation principles, organizational arrangements and design criteria to be applied to subprojects, which are likely to be financed under the overall *Damal Caafimaad* project. These standards, principles, instruments and other documents are to be applied during project implementation by the PIU, the MoHD and by the contracted partners supporting the implementation and monitoring of the project.

34. The project PIU, based at the Ministry of Health Development, will use and refer to this ESMF during implementation of the project. Where appropriate, Environmental and Social Management Plans (ESMPs) will be prepared during project implementation following guidelines that are made clear in this ESMF. It remains the responsibility of the Safeguards focal person with the PIU managing this project to ensure that the necessary mitigation plans are developed and adhered to by the project actors.

35. The specific objectives of this ESMF are:

- To ensure that the implementation of the project will be carried out in an environmentally and socially sustainable manner.
- To provide information about scope of adverse environmental and social risks and impacts expected during activities planning and operation;
- To describe the approach to mitigation and monitoring actions to be taken, and their cost implications.
- To clarify the roles and responsibilities of the MoHD, the project PIU and participating private sector contractors and other stakeholders with regard to environmental due diligence, management of risks and impacts, and monitoring.
- To provide the project implementation team with an environmental and social screening process and risk management procedures that will enable them to identify, assess and mitigate potential environmental and social impacts of project activities, including through the preparation of a site-specific Environmental and Social Management Plans (ESMPs) where applicable.

2.3. ESMF Principle

36. This ESMF will guide the PIU in Somaliland in implementing the project in line with World Bank's overall Environmental and Social Framework and the Somaliland government's environmental and social management standards, including the newly developed National Environmental Policy.

2.4. METHODOLOGY

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

38. **Desktop review of policy environment**. In close coordination with the World Bank, the project preparation team in Somaliland undertook a review of relevant national legislation, policies, and guidelines on the health sector in Somaliland. The team also reviewed the applicable World Bank ESSs related to this project.

39. **Consultations with stakeholders**. Consultation with key stakeholders was conducted from March 2020 to April 2020 (see Table 2 for key deliberations. Following these consultations, this ESMF was developed for the project. The ESMF was validated and finalized through public consultations conducted in Somaliland on the 22nd of August 2023, together with other ESF instruments (the SEP, GBV Action Plan, SecMF and the LMP). Key points discussed during this meeting included, but were not limited to: Perception about the project and its implementation; Exclusion during project implementation; Labor-related risks; Security issues and conflict; Socio-cultural beliefs; Grievance Mechanism; Gender-based violence (GBV); Occupational health and safety; and recommendations for mitigation. Details of the consultations are described in Annex 2.

Table 2: Deliberations undertaken in the preparation of this ESMF

Location	Nature of consultations undertaken	Participants met (number, description)	Summary of the deliberations and agreements
	Health sector reforms	The Ministry of Health Development has conducted a number of consultation meetings.	Consultative meetings have been held for the purpose of preparing this ESMF. The stakeholder meetings were conducted virtually on diverse dates, including December 14, 2020, January 21, 2021, February 3, 2021, and finally on March 24, 2021. The meetings were attended by stakeholders in the health sector in Somaliland. Input was received from INGOs operating in the health sector in the country, especially on medical waste management and placement of placenta pits.

SECTION 3: POLICY, LEGISLATIVE AND INSTITUTIONAL FRAMEWORKS

3.1. OVERVIEW

40. This section describes the existing policy, legislative and institutional framework that will be important for consideration in the design, implementation, monitoring and evaluation of the Improving Healthcare Services for Somaliland project. The section begins with the existing framework in the Government of Somaliland.

41. The project will be implemented by the Ministry of Health Development, Somaliland. The mission of this ministry is to "ensure the provision of quality essential health and nutrition services for all people in Somaliland, with a focus on women, children, and other vulnerable groups, and strengthen the national and local capacity to deliver evidence-based and cost-effective services based on the EPHS and Primary HealthCare Approach."

42. **Policy, Legal and Institutional Frameworks.** The project is required to meet the health sector laws of Somaliland, as well as environmental management systems in place in the country. The Government of Somaliland has its National Development Plan (NDP) III that has a component dedicated to the health and nutrition sector, with a vision clearly enunciated that all people in Somaliland should get access to improved health services.

3.2. Somaliland National Laws, Policies and Legislations

43. **Institutional framework in Somaliland.** In Somaliland, the institutions at the national, regional and district levels responsible for the implementation and monitoring environmental compliance include the following:

44. **The Ministry of Environment and Rural Development (MoERD).** The main responsibilities of the MoERD include (i) determining the policy to manage, protect the use of the environment; (ii) preparing policies, strategies, objectives and standards for environmental management; (iii) coordinating environmental management issues. The ministry is by law, under Article 6 of the Somaliland Environmental Management Law No. 79 of 2018, required to establish the Sustainable Development Advisory Committee with the following main functions: (i) proposing guidelines and coordinating environmental policies; (ii) liaison with the ministry and local stakeholders; (iii) recommending to the Minister policies and strategies for managing the environmental and biodiversity protection as well as the utilization of the country's resources.

45. **Environmental Licensing Procedures:** The environmental licensing process in Somaliland is regulated by the Ministries. The key principle is that the MOERD (Somaliland) grants EIA licenses. Every license shall be subject to such conditions as may be specified therein. The minister or any person authorized by him/her may at any time cancel or suspend any license granted by or on behalf of the ministry, the holder of which has been on reasonable grounds suspected by the minister or such other authorized person, to have infringed any of the conditions upon or subject to which said license has been granted, and may at any time vary the conditions of any such license. Any person aggrieved by any order under this Article may appeal to the MOERD for Somaliland whose decision shall be final.

46. **Somaliland National Environmental Management Act:** the general principle of environmental management is to ensure all people living in Somaliland have the fundamental right to an environmental adequate for their health and wellbeing, enjoying appropriate natural resource management in dealing with land degradation and reclaiming degraded ecosystems. So as promote equitable access to environmental resources and take into account the functional integrity of ecological systems to ensure the sustainability of the systems and to prevent harmful effects, this Act is the primary organic law for management of environmental risks. The Somaliland Environmental Management Law No. 79 of 2018 provides in Section V for

an Environmental Impact Assessment to be carried out for a series of projects, detailed in Appendix 2 of the Act, and all the procedures to be followed are provided in the Act. A Standards Implementation and Review Committee shall be established at the ministry with the following main tasks (i) advise the ministry to develop a water quality measurement system; (ii) suggest the quality level of water different types (drinking water, industrial water, water used for agriculture, water used for recreational purposes); (iii) establish measures to protect fish and wildlife; (iv) establish rules for sustainable both marine and freshwater fishing; (v) advise the ministry on issues related to the study of water pollution and its impact on the environment, humans, plants and animals; (vi) establish a system for detecting water quality and pollution.

47. Furthermore, Article 25 establishes that no one may be allowed to emit liquid waste without a permit and the payment of legal fees. In Somaliland in consultation with regional authorities, the civil society and communities, the ministry is empowered to establish the Regional Watch Councils (REWC). The minister, in consultation with the Parliamentary Environment Committee and civil society organizations working in the environment sector, shall establish Environmental Watch Councils at National level (NEWCs). The MoERD in consultation with the Local Government Councils and District Governor, local Community-Based Organizations (CBOs) and the community at large, shall establish the District Environment and Environment Watch Council (DEWC). The members of the Council shall come from both genders and should be Somaliland citizens in good standing in the community and are environmentally conscientious. The council shall serve five-year terms at a time and can be re-appointed.

48. **Somaliland's National Climate Change Policy (NCCP).** The overall aim of the Somaliland's National Climate Change Policy (NCCP) is to enhance the resilience and improve adaptive capacity of the country as whole, and in particular, the vulnerable communities and the ecosystems on which they depend, to the adverse effects of climate change, whilst equally, pursuing a path of economic growth that uses natural resources in a sustainable manner. This policy is intended to guide the development policies and operations of those concerned with development matters in Somaliland, including government institutions, non-governmental international and local organisations, with the intention of enhancing coping and recovery mechanisms of the Somaliland citizens to the risks of climate change.

49. **Somaliland National Gender Policy:** The overall objective of the National Gender Policy is to facilitate the mainstreaming of the needs and concerns of women and men, girls and boys in all areas for sustainable and equitable development and poverty eradication. Policy refers to guiding principles to a course of action arrived at by decision-makers to address a particular issue or issues. The following are the 9 priority areas, (i) Poverty Reduction and Economic Empowerment (livelihoods), (ii) Education and Training, (iii) Health and Reproductive Health, (iv) Nutrition Security, (v) Water Resources And Supply, (vi) Employment, (vii) Political Participation And Decision- Making; (viii) Democratic Governance And Human Rights and (ix) Sexual and Gender Based Violence (SGBV). The ultimate objective of this sector is to ensure that opportunities for education and training for all citizens, male as well as female, are guaranteed so that they may develop their individual potentials to the optimum and that they may be able to play a more meaningful role as productive and upright citizens.

50. **Somaliland National Environment Policy (NEP)** provides a framework for the sustainable management of the territory's environment and natural resources. The policy seeks to ensure that the territory's natural resource assets retain their integrity to support the needs of the current and future generations. This policy, developed in 2015 by the Ministry of Environment and Rural Development, addresses the nexus between poverty alleviation, food security and national development objectives. The policy emphasizes on the need to establish new prospects for the improvement to the standard of living, which enable people to become self -sufficient and realize their own potential without damaging the environment. The policy seeks to catalyze the implementation of sustainable environmental, social and economic development initiatives for equitable benefits sharing. The policy advocates for community participation, information dissemination, environmental education and awareness raising and gender equality in order to fully harness the Somaliland's "latent capacity" in this regard.

51. The guiding principles of the NEP state that "EIAs [are] necessary to ensure that public and private sector development options are environmentally sound and sustainable and that any environmental consequences are recognized early and taken into account in project design, and implementation." The project is expected to incorporate EIA as an essential tool in aid of development programs and projects.

52. **The environmental licensing procedures in Somaliland** is relatively straightforward. Ministry of Environment and Rural Development control the licensing procedures. The Ministry of Environment and Rural Development has the powers to grant any of the licenses sought. Every license shall be subject to such conditions as may be specified therein during the issuance stage. The minister (or any person authorized by him or her) may at any time cancel or suspend any license granted by or on behalf of the minister: Grounds for cancellation include suspicions of infringement of any of the conditions upon which said license has been granted. The minister may, at any time, also vary the conditions of any such license. Any person aggrieved by any order under this clause may appeal to the minister whose decision shall be final.

53. Somaliland Health Sector Strategic Plan. The Government of Somaliland has developed its Health Sector Strategic Plan. The strategic plan is based on the NDP, and follows the same goals and targets, and provides broader interpretation of the actions that needs to be taken. Furthermore.

54. **Somaliland Labour and Employment Law (2021).** The Somaliland Labour and Employment Law is the organic act governing all aspects of labour and working conditions for non-civil servants in Somaliland. The law covers the contract of employment, terms and conditions, remuneration, and OHS, trade unions and labour authorities. This Law applies to all project workers. The law is broadly consistent with the ESS2, although there is a significant gap in the enforcement aspects of the legislation. The Law stipulates that remuneration must be adequate in view of the quality and quantity of the work delivered, and must be non-discriminatory in regard to age, gender and other aspects.

55. **Somaliland Civil Servants Law No. 7/96** is the main law that governs the conditions of employment of civil servants. This Law, which was issued under the 1993 Somaliland National Charter and is based on the 1962 Civil Service Law. The 1962 law was subsequently amended many times and the last pre-1991 Somali Republic Civil Service Law was Law No. 5 of 2/2/1980 which purported to cover all public employees (including public industrial workers) and which was no longer applicable to Somaliland. The 1996 Somaliland Civil Service Law covers permanent civil servants and does not apply to local government employees and to members of the armed forces or the police and corrections corps (see section 2). The law No. 7/96 has been recently amended and approved by the Cabinet and Parliament with the support of CSSP.

56. Local Government Employees: Section 59(4) of the Regions and Districts Law (Law No. 22/2002, as amended) states that local government (and water agencies) employees shall have a separate law which shall be prepared by the Ministry of Interior and approved by the "Councils". The last pre-1991 Regulations, which specifically addressed separately local government employees, were the Local Government Regulations 1973 - Decree No. 4 of 15 July 1973, which were slightly amended by Decree No. 116 of 5 September 1974. The Somaliland I997 Interim Constitution and the final 2000 Constitution both included a provision which allowed the continued use of pre-1993 Somali Republic laws, which are not in conflict with the Somaliland Constitution, fundamental human rights and freedoms and Sharia until new laws are promulgated.

57. The project is also structured to meet the requirements of the Somaliland-WHO Country Cooperation Strategy.[26] In particular, the project interventions will contribute to the achievement of:

- Strategic Priority 1 ("Communicable Diseases"): through implementing activities that will reduce the burden of communicable diseases, and by way of child health services (routine immunization; micronutrient supplementation) that are planned in the project

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

- Strategic Priority 2 ("Non-Communicable Diseases"): this will be achieved through planned investments in primary healthcare, knowledge and documentation activities, and strengthening the capacity of Somali authorities to prevent and manage NCDs and their risk factors
- Strategic Priority 3 ("Health through the Life Course"): the proposed project has significant focus on maternal, newborn, and child health; the project also proposed to strengthen coordination between participating s and development partners on maternal, neonatal, and child health
- Strategic Priority 4 ("Health System and People-Centred Healthcare Services"): The proposed project has a focus on strengthening the existing weak health systems by infusing both technical (personnel) as well as policy and regulatory frameworks in order to ensure greater well-being of the people of Somaliland.
- **Somaliland National Development Plan (2023-2027).** Launched in March 2023, the new Third Somaliland National Development Plan (NDP III) focuses on six pillars of economic development, good governance, climate change, economic infrastructure, social development and justice. It is envisaged that Somaliland will become a nation with a sophisticated telecommunication system by 2030. A good communication network is essential for the development of a modern e-economy, e-government and e-learning, which are required if Somaliland is to transform itself to a middle-income country by 2030. The NDP III includes a health policy focusing on the provision of essential healthcare services. The Plan also calls for investment in improved capacity building and regulation of the health workforce, as well as implementation of the long-term Medicine and Supply Plan to secure delivery of essential health supplies. The Plan focuses on strengthening institutional and management capacity at all levels through a 'Health in all Policies' approach. All these interventions are aimed at creating a sustainable health financing system and an effective health management information system.
- The NDP III succeeds the defunct NDP II, which had set three main priorities for improving health access and outcomes:
    - institutional oversight and strengthening, which includes setting the legal and oversight frameworks at the Ministry of Health, and at the level of state and municipal government health bodies.
    - focusing on most pressing health challenges, including maternal and early childhood health, reducing malnutrition and childhood stunting, and greater access to clean water and sanitation (in homes as well as in health facilities).
    - focusing on the most vulnerable, especially rural citizens along with Internally Displaced Persons (IDPs).

58. **Waste Management and Urban Sanitation Law No.83 of 2018.** This Law, applying to the management of solid, liquid, and sanitary waste in the cities of Somaliland and consisting of 64 articles, aims to (i) have clean cities that are safe for public health, and improve their beauty, hygiene, and sanitation; (ii) promote all the social services related to environmental sanitation to strengthen and enhance the availability of a clean environment in which to live; (iii) have a law to strengthen the capacity of the Urban Sanitation and Waste Management; (iv) enable the development of the National Plan for Solid Waste, Liquid, and Sanitation and translate it into national plans; (v) establish a collaborative framework for collaboration between all stakeholders in the development of waste management and sanitation; (vi) encourage the Public-Private Partnership (PPP) system in the sector.

59. The services related to hygiene and sanitation are the responsibility of the local governments whose duties are detailed in Article 5. While the role of the Ministry of Health, mainly of support, training, and guidance, is dealt with in article 6. Other concerned ministries, whose tasks are indicated in the following articles, are the Ministry of Environment and Rural Development, the Ministry of Water Resources Development, the Ministry of Trade, Industry and Tourism, and the Ministry of Livestock and Fisheries

Development. The Law deals with the companies responsible for the services related to the waste management and in particular, with (i) waste companies (Article 11); (ii) slaughterhouse companies (Article 12); (iii) waste development and recycling companies (Article 13). As for the sub-sectors, the Law considers the following (i) household waste (Article 17); (ii) commercial waste (Article 18); (iii) industrial waste (Article 19); (iv) hazardous waste produced by health facilities (Article 20); (v) waste produced in public areas, such as road, schools, markets, fishery-related fields, building. Waste management includes storage and separation, collection, and disposal which are the object of Articles 28 - 31. Regarding the garbage dumps, article 33 establishes that they have to be placed where the local government and the relevant government agencies have checked that it is appropriate. The waste management business shall be organized through a license and contracts system (art. 34) and with the payment of fees, as provided in article 35.

60. Part IV regards the liquid waste management and it is organized according to the following subsectors (i) business areas (Article 39); (ii) housing sites (Article 40); (iii) industrial areas (Article 41); (iv) Health Centers (Article 42); (v) liquid waste in dairy products (Article 43); (vi) liquid waste for dyeing clothing (Article 44); (vii) liquid waste from vehicles and industry (Article 45); (viii) from abattoirs (Article 46); (ix) in reservoirs and sewers (Article 47). Section V regards the hygiene rules in the following (i) household and personal; (ii) food places; (iii) hotels; (iv) animal slaughterhouses; (v) food products. Article 61 is dedicated to sanitation and the prevention of threats at ports, airports, and borders. Meanwhile, the Municipal Council of Hargeisa collects transports and disposes waste materials from the city. Waste management differs in the urban areas from that of the rural area, as there are more people in the rural area in comparison to the city. This is done in order to minimize harm to individual's health as well as the environment. In Somaliland there is no distinction of the nature of waste; whether solid, liquid or any other form; waste will be considered as waste and dumped in the dumping sites.

3.3. World Bank Environment and Social Standards

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

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

62. ESS10 ("Stakeholder Engagement and Information Disclosure") More details on the ESSs and how they apply to the project are enumerated in Table 3.

Table 3: Summary of applicable World Bank Environment and Social Standards (ESSs)[27]

Standard	Relevant?	Explanation on application
ESS 1 Assessment and Management of Environmental and Social Risks and Impacts	Yes	This Standard sets out the Ministry of Health Development's (Somaliland) responsibilities for assessing, managing and monitoring environmental and social risks and impacts associated with each stage the project in order to achieve environmental outcomes consistent with the Environmental and Social Standards (ESSs). The project envisages small-scale construction works, which may entail the refurbishment of existing health facilities, installation of equipment including x-ray facilities, as well as the development of sanitary facilities, and development and operation of medical waste management facilities, such as waste pits, which may adversely affect the health of ecosystems and people through air pollution, generation of leachate, and contamination of groundwater. During the construction phase, there may be significant quantities of construction waste generated, in addition to dust, noise and air pollution. During the operational phase of the project, there will likely be generation of moderate quantities of medical and other waste that is generally expected, for the most part, to be non-toxic and non-hazardous. The composition of waste produced may be in the form of sharp objects (including needles, syringes, disposable scalpels and blades), waste contaminated with blood and other bodily fluids (e.g., from discarded diagnostic samples), cultures and stocks of infectious agents from laboratory work or waste from patients with infections (e.g. swabs, bandages and disposable medical devices). Other wastes may include chemical wastes, such as solvents and reagents used for laboratory preparations, disinfectants, sterilant and heavy metals contained in medical devices (e.g., mercury in broken thermometers) and batteries, as well as pharmaceutical wastes (including expired, unused and contaminated drugs and vaccines), and old medical equipment such as X-ray machines and laboratory testing equipment. As a result, this ESMF has been prepared, in conjunction with other, appropriate environmental and social risk management instruments, including: • Infection control and waste management plan (ICWMP) • Labour Management Procedures • Stakeholder Engagement Plan • Grievance Mechanism • GBV Action Plan • Environment and Social Commitment Plan Substantial social risks are expected from the project. The risks will be mitigated according to the measures outlined in the ESF and ESMF for this project. The project-wide GBV Action Plan also identifies actions to prevent GBV among staff and patients and ensure separate, survivor-centric and confidential procedures for dealing with grievances and provision of services for survivors.

[27] More details at http://www.worldbank.org/en/projects-operations/environmental-and-social-framework/brief/environmental-and-social-framework-resources

Standard	Relevant?	Explanation on application
		The social risks and impacts are various and will depend on locations and may vary over time. These include: a. The risk of project benefits not reaching disadvantaged and vulnerable groups including: nomads, IDPs, minority groups, men, people with disabilities, women who have experienced GBV, people who leave in remote areas both in terms of siting of services and accessibility, and how services are provided including the attitude and make up of health work force and social cultural and religious considerations; b. The risk of diversion of project benefits in hard-to-reach areas such as those controlled by armed groups; c. Ensuring health services are acceptable and accessible to women particularly when delivered by men and the potential risks of SEAH in delivery or uptake of health services (including of midwives or female mobile health outreach workers); d. Potential risks of increased social tension in the community for example, around the types of services delivered (e.g. child spacing, vaccination, maternal health, female genital mutilation/cutting (FGM/C) or survivor centric GBV services), particularly when in competition with traditional provision, social cultural practices or against the recommendations of religious leaders or others and how services are provided (by whom or how discretely due to the taboo around GBV/SEAH), or siting of services; a. Labour risks including OHS risks, security risks to staff, SEAH, and other forms of GBV that may occur in recruitment or retention of skilled female health workers (see also ESS2 and ESS4 sections below). Risks also exist around delayed payments and conditions (hours of work) and access or use of a GM (due to lack of trust and confidentiality in complaints handling); b. Exclusion and selection bias: recruitment of health professionals and consultants may be influenced by nepotism, clannism and gender whereby people from minority groups, IDPs, women and PWDs are excluded; c. Elite capture of project benefits, especially recruitment and contracting of implementing partners, private healthcare providers and suppliers, may limit project quality and reinforce exclusion; d. Contextual risks of operating in a conflict zone where effective and inclusive community consultations, stakeholder engagement, and community participation and safety of staff is challenging; e. Challenges in developing effective GM due to difficulty in accessing rural areas, and the collective nature of traditional complaints handling and the difficulty of disadvantaged and vulnerable groups raising complaints; f. For component 2, HMIS and Information Management will include data privacy and confidentiality requirements as outlined in the ESMF and Labour Management Procedures; and Policy developments will need to be in line with the requirements of the ESF including effective stakeholder consultations.
ESS2 Labour and Working Conditions	Relevant	The following are the labour-related risks expected during the implementation of the project: <u>For direct workers:</u> (i) Discrimination and exclusion: Direct workers from disadvantaged and vulnerable groups may be deliberately excluded from employment opportunities under the project due to clannism, nepotism and gender considerations. People in

Standard	Relevant?	Explanation on application
		senior positions at the MoHD and relevant government agencies may set higher employment qualifications which may exclude disadvantaged and vulnerable groups including women, minority groups, IDPs, and PWDs; and (ii) Labour disputes over terms and conditions of employment: Like any other project, labourrelated disputes are likely to occur in the "Damal Caafimaad" project. Labour-related disputes might emerge between health professionals (and consultants) and the MoHD (or contracted agencies) over labour wages rates, working hours, payment delays, health and safety concerns in the work environment and deplorable working conditions. In turn, there is also a risk that employers may retaliate against workers for demanding legitimate working conditions, or raising concerns regarding unsafe or unhealthy work situations, or any grievances raised, and such situations could lead to labour unrest. <u>For all workers:</u> (i) OHS risks: The primary risk to worker safety is due to the potential exposure to infectious diseases such as Covid-19. Lack of personal protective equipment (PPE) and safe workplace practices may put the workers at risk. In addition, physical structures from which workers provide services to the community may not cater for female workers, which may limit their functionality and thus accessibility of services for women. There is also a risk of HIV/AIDS due to labour influx that will be occasioned with the recruitment of staff for the various facilities. - SEAH: this will mainly affect female workers during recruitment or retention process given men dominate the hiring management in most government offices and NGOs. Insecurity: Ensuring security for project operations, including project workers at the regional and district-level health workers and the potential for increased contestation due to the drought or floods, will remain a challenge.
ESS3 Resource Efficiency and Pollution Prevention and Management	Yes	There are environmental impacts of health systems supported under this project associated with the possible heavy consumption of energy and water resources in support of health centre operations. It is also envisaged that there are possible greenhouse gas emissions, use and disposal of toxic chemicals, and production of waste and wastewater and their disposal. The generation of some solid and liquid wastes in the health centres to be supported under this project will require well-prepared disposal facilities. The waste disposal options open to the project include waste pits located within health centre footprints. It is also possible that health centre waste may be routed to uncategorized landfills (some form of open dumping or lightly managed dumps). This ESMF covers management of both onsite waste pits as well as transportation to and management of medical waste into nearby uncategorized landfills (*see ICWMP in Section F*).
		The project will screen activities in order to ensure efficiency of resource use and minimize pollution and build local capacity to manage resource use efficiency during implementation. Care will be taken to ensure that the medical and other waste disposal system selected will be context-appropriate, given the low-capacity levels existing in Somaliland.

Standard	Relevant?	Explanation on application
		In addition, the World Bank's EHS Guidelines including the General, Healthcare Facilities, Healthcare Facilities will be applicable and used for screening and ES assessment of these disposal facilities. The project team will be trained in life-cycle infection control, with a focus on segregation, packaging, disinfection of infectious or dangerous healthcare waste. Waste pits sited within the health centre footprint will be the first point for consideration in waste disposal for the project-supported health centres. The incineration of waste may also occur as a step prior to medical waste disposal. Incineration may involve the generation of climate-relevant emissions, which are mainly CO_2 (carbon dioxide) as well as N_2O (nitrous oxide), NO_x (oxides of nitrogen), NH_3 (ammonia) and organic C, measured as total carbon. CO_2 constitutes the chief climate-relevant emission of waste incineration. However, the generation of greenhouse gas emissions is limited in the context of the proposed project: the incineration of 1 Mg of waste in incinerators is associated with the production and release of about 0.7 to 1.2 Mg of carbon dioxide (CO_2 output). The climate-relevant CO_2 emissions from waste incineration are determined by the proportion of waste whose carbon compounds are assumed to be of fossil origin: in the project context, again this is likely to be limited. On the other hand, inadequate incineration or the incineration of unsuitable materials may result in the release of pollutants into the air and in the generation of ash residue. Incineration of heavy metals or materials with high metal content (in particular lead, mercury and cadmium) can lead to the spread of toxic metals in the environment. To mitigate this, the project will prepare a Medical Waste Management Plan to address aspects such as regulatory framework, planning issues, waste minimization and recycling, handling, storage and transportation, treatment and disposal options, and training. In the preponderance of health centres, locally sourced, non-commercial incinerators can provide sufficient heat to incinerate properly, with the caveat the medical waste has been sorted adequately prior to incineration. However, a final determination of the final incinerator type to be used will be made during the environmental assessment process of the project. In addition, subject to the findings of the environmental assessment undertaken, the project will explore the use of alternatives to incineration such as autoclaving, microwaving, steam treatment integrated with internal mixing, which minimize the formation and release of chemicals or hazardous emissions. These should be given consideration in localities where there are sufficient resources to operate and maintain such systems and dispose of the treated waste.
ESS4 Community Health and Safety	Yes	The disposal of untreated healthcare wastes in waste pits or uncategorized landfills can lead to the contamination of drinking, surface, and ground waters if not properly constructed, posing danger to human health and community wellbeing. Communities are also likely to be exposed to health problems arising from ineffective infection control and inappropriate healthcare waste management, as well as inappropriate sanitation facilities. To mitigate this, the project will strive to achieve universal access, ensuring that the rehabilitation of healthcare facilities will provide unimpeded access for people of all ages and abilities in different situations and under various circumstances. An awareness raising campaign will be undertaken to sensitize local communities against the reuse of needles, medicine bottles, and other used or expired medical supplies. In addition, rehabilitation and/or refurbishment of health facilities may pose a danger to construction crews. Where the project interventions include civil works, there are community health and safety challenges that can arise. Therefore, the project team will prioritise training of the contractors and their workers on structural safety issues. Due care

Standard	Relevant?	Explanation on application
		will be taken to minimise exposure of the beneficiary communities arising from poor infection control through investing in emergency preparedness and response mechanisms: this will address incidents associated with infection control as well as environmental and health incidents arising from medical waste management facilities. The PIU will conduct a full EHS audit of each existing HCF facility under their jurisdiction and supply the results of the audit to prospective contractors. This will be important for the bidders and prospective contractors to properly understand the existing HCF conditions (including all existing EHS liabilities). With the benefit of this audit and their own understanding, bidders can properly and adequately include in their bids (both technical measures and their implementation costs) all needed EHS measures (including medical waste management, water supply, waste water management, indoor air quality, hazardous materials management, waste management, requirements related ESS4 and healthcare infrastructure and equipment design and safety of services). This EHS audits will cover both construction but more importantly the HCFs' operational phase. In addition, the Ministry of Health Development and the PIU will design, construct, operate, and decommission the structural elements of the healthcare centres in accordance with the requirements established in the Bank's EHSGs and other GIIP, taking into consideration safety risks to third parties and affected communities. The health facilities' structural elements will be designed and constructed by competent professionals. Structural design will take into account climate change considerations, as appropriate. The PIU will ensure that in the usage of the health facilities, the concept of "universal access" is implemented, meaning that all persons, irrespective of background and age, will be given unimpeded access to the facilities. Security challenges will be addressed by the SecMF, which has been prepared for this project
ESS6 Biodiversity Conservation and Sustainable Management of Living Natural Resources	Yes	• While a few locations in a few municipalities may contain some land with inherent environmental sensitivity relevant to ESS6, the subproject screening process in the ESMF will exclude such sensitive areas. • The ESMF includes specific measures to avoid or minimize negative impact on critical or protected areas if the sub-project screening process does not otherwise exclude these areas.
ESS8 Cultural Heritage	Yes	• There is the potential for chance find of cultural or archaeological significance during construction or rehabilitation of healthcare facilities, and the existence of some historic buildings in the neighborhood of the HCFs that could potentially be impacted from the construction. The ESMF has been updated to comply with ESS8, and the subproject specific ESMPs will address these issues through the inclusion of chance find procedures.
ESS10 Stakeholder Engagement and Information Disclosure	Yes	A Stakeholder Engagement Framework (SEF) has been prepared prior to appraisal as part of preparing Safeguards Instruments for the parent Project of Somalia, which was recently embedded in the overall ESMF, thus recasted and adopted for the context of Somaliland. This updated ESMF outlines how appropriate representation and participation of various groups of stakeholders will be carried out, including their viewpoints and suggestions in improving project documentation, including this ESMF. Once project sites are known, specific and costed stakeholder engagement plans will be prepared by the different

Standard	Relevant?	Explanation on application
		implementing agencies and, approved, implemented and monitored by the MoHD throughout the different phases of the project cycle. As part of the information disclosure arrangement, the main environmental instrument (this ESMF) will be disclosed publicly on the MoHD website. Meaningful and inclusive consultations with relevant stakeholders will be conducted before the appraisal stage, and its results adequately recorded and disclosed.

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

3.4. World Bank Group EHS Guidelines

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

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

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

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

3.5. GAP Analysis

68. The activities as proposed in this project will need to comply with both existing Somali laws and regulations and World Bank Environment and Social Standards. This sub-section compares the national public sector environmental management rules, regulations and standards to World Bank's Standards. The main

objective of this assessment is to help implement this ESMF more effectively at the government level in Somaliland through an understanding of existing gaps.

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

Table 4: GAP analysis for Environmental and Social Standards – Improving Healthcare Services in Somaliland – June 2020, updated for Somaliland in March 2023

Scope	Bank Standard	Government of Somaliland policies, regulations	Gaps identified	Gap-filling measures
ESS1 ("Assessment and Management of Environmental and Social Risks and Impacts")				
Environmental and Social risks and impacts assessment instruments and protocols	Range of instruments to satisfy the Bank include EIAs, regional or sectoral EIAs, ESMPs, etc.	Instruments for E&S assessment have not been delineated adequately, and are absent in Somaliland.	EIAs not incorporated into laws, and are missing in Somaliland	ESMF and the instruments highlighted in the mitigation plan for the project to guide the borrower
Environmental and social impact screening	Screening procedures developed for projects involving sub-projects, as is likely to be the case in the *Damal Caafimaad* project	There are no clear procedures for screening under the statutes of Somaliland	Screening procedures are absent in Somaliland	ESMF to guide the borrower
Public consultations	The Bank requires the Borrower to initiate consultations with project affected persons and other interested parties including civil society	Procedures for public consultations not explicitly stated	Procedures for public consultations not explicitly stated	SEP to guide the borrower
Monitoring of environmental and Social data	Bank requires regular monitoring of E&S data (including volumes of medical and other healthcare wastes generated, etc.) to evaluate the success of the mitigation plan and to foster corrective measures at the earliest possible juncture	There are no procedures provided in regulations in the country on the conduct of monitoring activities in the collection of E&S data	There are no procedures provided in regulations in the country on the conduct of monitoring activities in the collection of E&S data, especially volumes of solid waste likely to be generated in this project and the medical and other pathological wastes	ESMF and the accompanying ICWMP to guide the borrower
Institutional arrangement	Requirement by the Bank for specific description of institutional arrangement and implementation schedule for monitoring and mitigation measures	MoHD is the project implementing partner to be responsible for oversight of environmental matters	MoHD has capacity for technical implementation of project interventions but will require Safeguards support	MoHD-based PIU to work with the respective ministries and agencies responsible for management of environmental matters as the focal points for administration of this ESMF

Scope	Bank Standard	Government of Somaliland policies, regulations	Gaps identified	Gap-filling measures
			for coordinating institutional responses under this ESMF, and the institutional information is not available, and its remit is unknown, as is its technical capacities	
ESS2 ("Labour and Working Conditions")				
Management of different types of project workers	The Bank puts emphasis on the identification and characterization of different types of workers (project workers, direct workers, contracted workers, community workers, primary supply workers) to manage different types of labor risks.	Labour Code of Somaliland is the specific labor law governing all aspects of labor and working conditions, which covers the contract of employment, terms and condition, remuneration, and OHS, trade unions and labor authorities. The provisions of the Labour Code apply to all employers and employees in all project municipalities. The Labour Code is applicable to all project workers of the Somaliland health project.	The Labour Code is broadly consistent with the ESS2, while there is a significant gap in the enforcement aspect of the legislation. More details are presented in the LMP.	ESMF and the Labour Management Procedures (LMP) to guide the borrower.
Labour standards	Several provisions made under ESS2 to safeguard the healthcare workers and other project workers, promote safety at work and ensure that they have a viable means of communicating grievances and receiving redress.	Article 20 (Work, Trade, and the Welfare of Employees), Article 7 (Rights of Civil Servants) Article 10 (Basic Labour rights of Citizens) stipulates that all workers, particularly women, have a special right of protection from sexual abuse, segregation and discrimination in the workplace. The Rape and Sexual Offences Act (Law No. 78/2018) lays out protection, prevention and criminalization of rape.	The implementation of the existing articles in practice may not be very strong.	The Project will not allow any forced and child labor. It will hold all contractors liable to the implementation of the LMP. The PIU will have overall responsibility to monitor the implementation of the LMP.

Scope	Bank Standard	Government of Somaliland policies, regulations	Gaps identified	Gap-filling measures
		prohibits sexual harassment. Act No: 101/2021 (*Prevention and Suppression of Trafficking In Persons and Smuggling of Migrants*) PART II: OFFENCES OF TRAFFICKING IN PERSONS AND SMUGGLING OF MIGRANTS (6)Trafficking in Persons, 1) Any person who recruits, transports, transfers, harbours, or receives another person for the purpose of exploitation by means of threat or use of force or other forms of coercion, abduction, fraud or deception; abuse of authority, or power of the position of vulnerability; financial or other inducements or benefits to obtain the consent of a victim of trafficking; or giving or receiving payments or other monetary benefits, or benefits in kind, to obtain the consent of a person having control over another person commits an offence. 2) The recruitment, transportation, transfer, harbouring, or receipt of a child for the purposes of exploitation shall be considered "trafficking in persons" even if it does not involve any of the means set out in subsection (1) of this act. 3) Any person convicted under sub-articles (1) and (2) of this article shall be imprisoned for five years to 20 years. 4) The consent of a victim of offences set out in sub-article (1) and		The Project will fully comply with WB ESS 2.

Scope	Bank Standard	Government of Somaliland policies, regulations	Gaps identified	Gap-filling measures
		(2) of this article shall not have the legal effect of justifying the accused.		
ESS3 ("Resource Efficiency and Pollution Prevention and Management")				
Pollution prevention and management	This ESS requires the Borrower to undertake a health and safety risk assessment of potential for pollution generation at supported health facilities, which may affect communities, workers and the environment.	No known national waste management standards No known designated landfills for medical wastes by municipalities. No guidelines nationally known to support operation of incinerators No known national statutes in support of periodic environmental audits. No national pollution standards known at the time of developing this ESMF.	There are no supporting legislative frameworks for pollution prevention and management.	ESMF to guide the Borrower on pollution prevention and management Separate ICWMP to guide the Borrower in managing medical waste. Individual health centers to develop ESMPs for the assessment of the environmental impact of medical waste incinerators or any other framework used for management of medical waste.
Management of hazardous wastes	The bank requires the Borrower to undertake specific measures to manage both hazardous and nonhazardous wastes. Specific emphasis is given in this ESS with respect to transportation and disposal, obtain chain of custody documentation to the final destination. Approved disposal sites are required for this ESS.	No known national legislation or policies on management of hazardous wastes	There are no approved hazardous waste disposal sites in Somaliland	ESMF and the ICWMP to guide the Borrower on the management of both hazardous and nonhazardous wastes, including pathological and medical wastes from the health centers.
ESS4 ("Community Health and Safety")				
Security personnel	This ESS postulates that when the Borrower retains security personnel to safeguard workers and property (including high value medical assets), it will assess risks posed by these security	District police will likely provide security services in the implementation of the project. The civil servants in Somaliland are governed by and Civil Service Law (Law Number 7/96).	While the security protocols guiding their deployment and use of force are broadly unknown, the project will coordinate with the law enforcement authorities in	The project to be guided by the ESMF and relevant provisions of ESS4 on the deployment of security personnel to support project activities. Further delineation of security

Scope	Bank Standard	Government of Somaliland policies, regulations	Gaps identified	Gap-filling measures
	arrangements to those within and outside the project site.		each municipality to manage associate risks.	operations to be provided in the SecMP of the project.
	The Borrower will not sanction any use of force by direct or contracted workers in providing security except when used for preventive and defensive purposes in proportion to the nature and extent of the threat.	However, there are no security protocols guiding their deployment, and there is possibility of violence meted out on civilians or workers or even the possibility of rent-seeking.		
Universal access	The ESS4 is emphatic on the right to access to services, especially on the concept of "universal access."	The service charter of the Ministry of Health Development is silent on the issue of "universal access."	The concept of universal access is not widely acknowledged in the policies	The project will be guided by the provisions of ESS4 on unimpeded access for people of all ages and abilities in different situations and under various circumstances, as set out in GIIP.
ESS6 ("Biodiversity Conservation and Sustainable Management of Living Natural Resources)				
Ecosystem restoration	In accordance with the mitigation hierarchy provided in ESS1 and with the requirements of this ESS, Borrower is required to ensure that biodiversity expertise is utilized to develop and implement a Biodiversity Management Plan.	Somaliland has developed National Biodiversity Strategy and Action Plan (NBSAP), which calls for action to be taken to manage the 40+ identified biodiversity hotspots.	However, no draft management plan is provided in Somaliland's NBSAP.	The project to be guided by the ESMF and relevant provisions of ESS6 on biodiversity restoration where the project interfaces with biodiversity and other environmentally sensitive areas
ESS10: Stakeholder engagement and information disclosure				
Meaningful engagement of stakeholders in the project activities from planning to implementation levels	The World Bank anticipates that the project will establish a systematic approach to stakeholder engagement that will help Borrowers identify stakeholders and build and maintain a constructive relationship with them, in particular project-affected parties. Further, the project will promote	Currently, there is no specific law in Somaliland which stipulates that every person has the right of access to information held by the Government. However, in Somaliland Labour Law workers have a right to get access information held.	The law on the right of access to information currently only exists scattered.	The Project will implement stakeholder consultations throughout the lifetime of the project, as per the SEP. The contractors will develop sub-project SEPs in line with the project SEP, which will be reviewed and cleared by the MoH and the World Bank.

Scope	Bank Standard	Government of Somaliland policies, regulations	Gaps identified	Gap-filling measures
	and provide means for effective and inclusive engagement with project-affected parties throughout the project life-cycle on issues that could potentially affect them. The project affected persons should be provided with accessible and inclusive means to raise issues and grievances.			The PCIU will ensure that a GM for the project is in place, in accordance with ESS10 as early as possible in project development to address concerns from project affected persons. The contractors will outline their workplace GMs in their subproject SEPs including confidential channels for GBV/SEAH reporting.

3.6. Action Plan for Capacity Enhancement in E&S Risk Management

45. The Damal Caafimaad project is projected to be implemented by the Ministry of Health Development, in Somaliland. Based on a preliminary assessment of existing capacity at the Ministry of Health Development, the World Bank's ESF team (both environment and social) have taken note of the low capacity for social and environmental risk management. As a result of the aforementioned observation, the Bank's E&S specialists assigned to the project have worked very closely with the Somaliland government counterparts from the Ministry of Health Development in the updating of environmental and social instruments required for the implementation of project activities in Somaliland, in many cases participating in the drafting and updating of the instruments. These documents include:

- Environmental and Social Commitment Plan (ESCP);
- Environmental and Social Management Framework (ESMF);
- Security Management Framework (SecMF); and
- Labour Management Procedures (LMP).

46. The project's implementation unit (PIU) is required to undertake the tasks outlined in Table 5 on environmental risk management on implementation.

Table 5: E&S capacity assessment per phase

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

47. Based on the assessment it is expected that the Ministry of Health Development team in the Somaliland government implementing the project will require substantive assistance in meeting the World Bank's ESF requirements.

48. Longer-term, this action plan will be the first step in the MoHD and the Somaliland government in establishing their own E&S risk management systems.

49. This E&S risk management capacity action plan has been prepared to directly aid the environmental specialists attached to the Ministry of Health Development and who will be responsible for supporting the Damal Caafimaad project, this will be updated once staff and implementing partners are on board as guided by the draft TOR for E&S capacity assessment in Annex 16.

50. This draft plan has been discussed with the counterparts in the MoHD, Somaliland, who have had their input and accepted this plan as part of the overall project design for the Somaliland health project.

51. Once staff and implementing partner are in place, a capacity assessment and development plan will be updated as per the TOR in Annex 16.

52. Before the bidding process, potential organizations will be oriented on the E&S requirements and reference documents. In their bids, contractors will be required to provide plans for E&S implementation

including for E&S assessment and management plan and staffing plan as part of their bids which will be reviewed by WB safeguards staff and no objection provided. Once contracted, the contractors will develop the E&S assessment plan including a SEP, inclusion plan, GBV Action Plan, labour management plan and area specific SecMPs, which will be informed by stakeholder consultations in line with the E&S instruments. The plan will be reviewed by the MoHD and will be submitted to the World Bank for clearance. Clearance will be obtained before implementation of activities.

53. The E&S specialists will guide and monitor the implementation of plans and ensure remedial measures are taken including providing capacity building support to the implementing partners and contractors. Once the E&S specialists and the implementing partners are on board, this capacity assessment and implementing plan will be updated. Given there are very few experienced E&S safeguards specialists in Somaliland, it is likely that capacity will have to be developed from scratch. Thus, a training and capacity building plan will be developed to be facilitated by World Bank consultants and other government specialists and consultants. The capacity building plan may need to be developed and implemented by an independent SRM capacity building specialist and will include sessions on collaboration and synergy with other World Bank funded projects. The capacity building process will consist of practical virtual sessions as shown in Table 6.

Table 6: Capacity building plan

Session	Timeframe	For whom
E&S requirements for implementing partners/contractors	Once requests for proposals are issued	Potential implementing partners. All organizations working in health delivery in the targeted regions could be invited.
E&S requirements for MoHD and action planning	Once staff are in place.	PIU staff including E&S specialist, GBV advisor, security management specialist, communication specialists.
GM	Month 1	All direct workers including E&S specialist, GBV advisor, security management specialist, communication specialists
GBV	Month 2	All direct workers including E&S specialist, GBV advisor, security management specialist, communication specialists
LMP and code of conduct	Month 3	All direct workers including E&S specialist, GBV advisor, security management specialist, communication specialists
Medical waste management	Month 4	All direct workers including E&S specialist, GBV advisor, security management specialist, communication specialists
Inclusion plan	Month 5	All direct workers including E&S specialist, GBV advisor, security management specialist, communication specialists
E&S reporting	Month 6	E&S specialists
Monitoring of E&S requirements	Month 7	E&S specialists
Virtual tools for E&S monitoring	Month 8	E&S specialists
Other sessions as required	To be offered based on the needs assessment and project demands.	

Table 7: Environmental risk management plan

Activity	Year 1	Year 2	Year 3	Year 4	Responsibility	Resources
In-depth capacity needs assessment of MoHD's institutional set-up for env. risk management					World Bank MoHD	
Sourcing for capable in-country -environmental specialists					MoHD	WB to work with PIU in drafting TORs
Training I: E&S risk management and ESF in general for focal points					World Bank	
Training II: introduction on HCF emergency preparedness and response					World Bank	
Training III: implementing the Infection Control and Waste Management Plan					World Bank	
Training IV: conducting follow-on EHS audits and use of MSDS[28] at HCFs					World Bank	
Training V: monitoring EFS compliance at s					World Bank	
Evaluation of performance of env. focal points					PIU World Bank	
Study tour for ESF focal points to other Bank-funded projects					World Bank	
Twinning of MoHD Environmental Risk Management (ERM) focal points with other Bank projects					World Bank	
Training on E&S risk reporting					World Bank	
Transition: towards establishing own E&S risk management system					MoHD	

[28] Material Safety Data Sheets

SECTION 4: PROJECT'S BIOPHYSICAL AND SOCIOECONOMIC SETTINGS

4.1. Overview

52. This section focuses on the existing biophysical and socio-economic environments in the proposed states. Physio-geographically, Somaliland a country of limited contrasts, but for the purposes of the Damal Caafimaad project, this ESMF will cover the project activities to be implemented in Maroodi Jeex, in particularly:

- Hargeisa District
- Gabiley District
- Baligubadley District

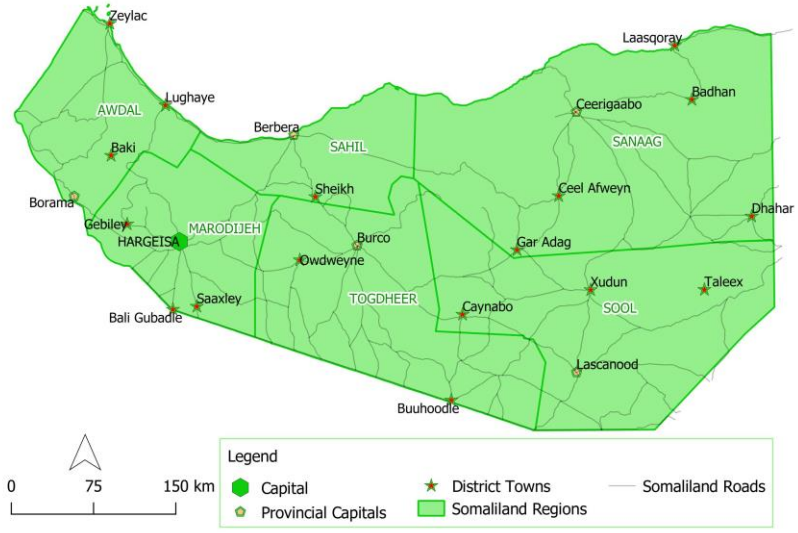

Figure 3: Map of Regions and Districts in Somaliland

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

4.2. Introduction

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

55. Many of the aforementioned species are categorized as Critically Endangered (CR), Endangered (EN) or Vulnerable (VU) in international conventions, or are under preparation, and agreements, such as the World Conservation Union's Red List of Threatened Animals[29][41]. Considering the mixed urban-and-rural environment settings of the proposed the Somaliland health subprojects, it is unlikely that project interventions will affect

[29] See http://www.animalinfo.org/country/Somaliland.htm

such species. As a precaution, it will be critically important for the PIU to engage with communities, contractors, civil society and other government MDAs to ensure that the project does not affect existing biodiversity.

4.3. Climate

56. Somaliland lies north of the Equator and has a dry climate, with most regions designated as arid, with a few, smaller, areas as semi-arid. The temperatures in the highlands range from around 20–24 °C (68–75 °F). The landscape is notably varied, with approximately 740 kilometers of coastline – mostly along the Gulf of Aden. Though the majority of the rest of the region is elevated and hilly (altitudes reach more than 2000m above sea level), with the Awdal and Maroodi Jeex being particularly fertile and teeming, other areas – including Togdheer and the Guban – offer semi-desert conditions. Its geology was largely formed during the process that created both the Red Sea and the Gulf of Aden – the separation of the Arabian plate from Nubia.

57. Overall, its climate follows a fairly typical monsoon pattern, though with four distinct seasons that comprise the spring rains of April to June, a dry summer from July to September, the autumn rains of October and November and a dry winter from December to March. Temperatures vary as one would expect, with the colder months having a range of approximately 15-26° and the summer averaging 26-32°, though temperatures do fluctuate, reaching 0° in the highlands during colder months (December to February) and climbing to 45° during the hotter months (particularly July) on the coastal plain that lines the Gulf of Aden. Varying across climates and seasons, humidity ranges widely and reaches up to 85% in some places.

58. Inevitably, given the range of Somaliland's climates, rainfall varies very widely, ranging from extremes of as little as 50-150mm to as much as, in the highlands and some coastal areas, 900mm. A largely coastal climate with significant mountainous territory, Somaliland's weather patterns are produced by the unpredictable interactions of those landscapes as well as the southwest and northeast monsoons, though because of its northerly position relative to the rest of Somalia the latter, which lasts from December to March, has more influence.

59. Annual potential evapotranspiration (PET) is high, exceeding 2,000 mm in the northern basins and can be as high as 3,000 mm in the Gulf of Aden. Over the dry period, the vegetation is sustained mainly through the shallow aquifers found along the dry riverbeds (*tog* or *wadis*) across the country.

4.4. Ecosystems

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

- The dominant xeric grasslands and shrub-lands,

Somaliland* montane xeric woodlands.

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

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

4.5. Socio-Economic Environment

61. **Geography, landmass and population**. Population numbers are difficult to come by. Somaliland, with a landmass of about 284 899 km^2, has a population estimated to be 4.5 million[6]. Estimates show that, out of the total population 4,968,526 people in 2018 are living in urban centers. This accounts for a relatively highly urbanized society (standing at ~33 percent). The population density in Somaliland is estimated at 24 persons per km^2, one of the lowest in East Africa.

62. The median age in Somaliland is estimated to be 16.6 years. The population's livelihoods are connected to either livestock husbandry, smallholder dryland agriculture, itinerant commerce or remittances from diaspora. Somaliland is reportedly the world's fourth-most remittance dependent country, which makes up about 20-50 percent of local economy[30].

63. **Poverty in Somaliland**. The United Nations classifies Somaliland as a least developed country. The socioeconomic situation of the country is described as "very poor" in the National Development Plan (2017-2019)[31], with approximately 69 percent of Somalis reportedly living below the poverty line. Poverty cuts across sectors, location, group and gender, and its forms and causes vary. An understanding of Somaliland's geography, recent trends in its economy and consequences of the civil strife is important to determining the nature and extent of its poverty. There is more stability in the northern regions (Somaliland and Puntland), and consequently less poverty. Poverty in Somaliland is more pronounced in the IDP camps, where is it estimated to be 88 percent, followed by rural areas with 75 percent and urban areas with 67 percent.

64. **Agriculture, livestock and livelihoods**. Only about 10 percent of Somaliland's land can be described as arable and suitable for crop production. Somaliland's agricultural sector, which accounts for 65 percent of the GDP and employs 45 percent of the active workforce (Somaliland Agriculture Report, 2018), relies on the state of health of the country's natural capital (vegetation and water resources). It is worth nothing that the livestock sub-sector alone accounts for between 80 to 90 percent of agricultural GDP and contributes about US$2.4 billion (or about 40 percent of total GDP) and more than 90 percent of export earnings (*ibid*), and grows 6 percent annually.

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

66. **Gender**. UNDP Somaliland reports that Somaliland has one of the highest gender inequalities in the world, at 0.776, which ranks fourth in the world. The country has an extremely high maternal mortality, rape, female genital mutilation and child marriage rates, and violence and SEA/GBV against women and girls is common. The participation and roles of women in politics and decision-making is minimal, which perpetuates limited female roles and inequality. While in Somaliland and Puntland women's rights are ostensibly protected in their respective constitutions, however implementation of these provisions is lagging behind.

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

68. In Somaliland, the women are significantly involved in trading and commerce, from micro-enterprises to large-scale businesses. While the women butcher and sell small ruminants (goat and sheep), they however make up most of the fruits and vegetables vendors. The women are also engaged in the sale of local imported goods (e.g., rice, sugar, wheat, sorghum, etc.). The project will likely make a positive impact for women in the

[30] See https://en.wikipedia.org/wiki/Economy_of_Somaliland

[31] See http://extwprlegs1.fao.org/docs/pdf/som169866.pdf for a copy of the Plan –

rural areas and smallholder farmers in terms of improving their health prospects (medical care, ante- and post-natal care, etc.). Environmental and social risks mitigation should also ensure women's needs are addressed.

SECTION 5: CONSULTATIONS AND PUBLIC DISCLOSURE

5.1. Introduction

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

70. The MoHD-based PIU needs to develop a robust grievance redress mechanism (GRM) that allows general public in the areas across the project-supported areas, affected communities or individuals to file complaints and to receive responses in a timely manner. The system will also record and consolidate complaints and their follow-up. This system will, be designed for handling complaints perceived to be generated by the project or its personnel. It may also include disagreements about quality of health services offered or received at the health centres improved under this project.

71. Stakeholder consultations for Somaliland were conducted August 22,2023. More details on the stakeholder engagement (including consultations conducted for project preparations and RM) and information disclosure are presented in the SEP for the project and presented in Annex 1 of this ESMF.

SECTION 6: POTENTIAL ENVIRONMENTAL AND SOCIAL RISKS AND IMPACTS AND MITIGATION MEASURES

6.1. Introduction

72. **Potential Environmental and Social Benefits of the Project.** The implementation of sub-projects under the project as proposed will have some environmental benefits. These include:

- less pollution loads due to improved solid waste management;
- greater improvements in social welfare of the Somaliland population, given the investments in package of healthcare services;
- increased legitimacy of authorities in Maroodi Jeex in Somaliland as they pioneer in the rendering of health services to the population;
- availability of employment opportunities for young people, including both skilled and unskilled personnel;
- an uptick in economic activity in the areas traversed by project interventions;
- greater capacity for Somaliland authorities in managing social risks, including enhancement of capacity to conduct stakeholder consultations with poor and marginalized sections of the community; and
- enhanced capacity for environmental management at the participating health facilities.

73. **Overview to E&S Social Risks and Impacts.** This section highlights the generalized E&S risks and impacts along with generalized associated mitigation measures for the expected potentially deleterious E&S risks and impacts linked to proposed project activities, especially medical waste issues and other operational impacts. It also provides proposed mitigation and management measures proportionate to the level of identified E&S risks and impacts. These management measures are based mainly on requirements of WB's ESF, WBG's EHSGs (incl. GIIP), and pertinent local laws and regulations, such as National Environmental Policy and Labour Code.

74. Additionally, this Section outlines means of monitoring and responsibilities thereof, throughout life cycle of the Project, as well as key steps for screening sub-projects envisaged under the Project's components against possible high E&S risks and impacts.

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

76. The project will entail, among other things, possible installation of incinerators or other waste management equipment, strengthening and expanding of existing government health centres, and possible upgrading and installing of sanitary facilities. This may result in an expansion of the environmental footprint of the existing health centres. The absence of adequate biohazard and biological waste management procedures in health institutions may allow for uncontrolled outbreaks of contagious diseases and is a threat to public health. In particular, studies show that there is no adequate incineration system in place in the majority of the health facilities in Somaliland.

77. In addition to the foregoing and based on stakeholder consultations and an examination of the project's description of activities, it is envisaged that the project will have substantial environmental impacts. In addition, the potentially positive environmental benefits that may be registered as a result of this project are also described.

6.2. Environmental Risks and Impacts

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

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

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

79. The environmental risk classification for the project is Substantial under the World Bank ESF, mainly because of the risks linked to the management of biomedical waste but also because of the risks linked to small scale renovation of health facilities. Other potentially significant risks and impacts that contribute to this classification include wastewater disposal problems, indoor air quality issues, and worker and community health and safety exposure. In addition, health and safety risks also need to be taken into account given the limited capacity of the PIU on these issues.

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

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

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

83. The use of medical waste incinerators requires trained operators, monitoring of waste segregation, appropriate waste transportation to site, and ash residue disposal. There are few trained operators in the country, and there is limited experience generally with modern medical waste management systems. The project's PIU will support the health facilities in designing and establishing SOPs based on WHO and WB standards, including WB ESHS guidelines. The following Table 8 summarizes environmental related risks and impacts of the Project.

Table 8: Project components and envisaged environmental risks and impacts

Component	Project activities	Environmental risks
Expanding the coverage of a prioritized EPHS in selected geographic areas	Child health services: maternal and neonatal health services including testing and interventions during ANC visits; disease surveillance (strengthening and maintaining disease surveillance and response as well as preparedness and response to disease outbreaks; Procurement of drugs, incl. contraceptives, and other specialized medical equipment, basic facility refurbishment, medical supplements, vaccines, testing kits, etc.	Medical wastes, other wastes (pathological, hazardous, expired drugs, etc.), e-waste Pollution risks – soil, air, water GHG emissions Outbreaks of infectious diseases
Strengthening government's stewardship to enhance service delivery	Capacity enhancement activities, contract management, regulatory reforms	Occupational health and safety risks for contracted workers, including healthcare staff
Project management, M&E, knowledge management, and learning	Day-to-day project management including coordination, administration, communication, management, procurement, M&E, and dissemination of project activities.	Benign

84. **Environment, Health and Safety Audits.** The PIU will conduct a full EHS audit of each existing HCF facility under their jurisdiction and supply the results of the audit to prospective contractors. This will be important for the bidders and prospective contractors to properly understand the existing HCF conditions (including all existing EHS liabilities). With the benefit of this audit and their own understanding, bidders can properly and adequately include in their bids (both technical measures and their implementation costs) all needed EHS measures (including medical waste management, water supply, waste water management, indoor air quality, hazardous materials management, waste management, requirements related ESS4 and healthcare infrastructure and equipment design and safety of services) as part of their project level ESMPs. This EHS audits will cover both constructions, but more importantly the HCFs' operational phase.

85. In addition, subsequent EHS audits, post HCF contracting, will serve other functions, including:

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

86. The Prevention of infectious disease transmission will complement other World Bank supported projects, including the Somaliland Crisis Recovery Project (SCRP), which includes a Contingent Emergency Response Component (CERC) support for COVID-19 coordination and monitoring, surveillance, contact tracing, risk communication, laboratory support, infection prevention and control, and case management, as well as essential health services to complement the Government's and other partners' emergency response

efforts. In the medium term, the project will strengthen health preparedness capacity such as Critical Care Units (CCUs) in a few major hospitals nationwide, as well as surveillance and laboratory capacity for pathogen detection (including COVID-19). Therefore, the overall environmental risk rating is "**Substantial**" under World Bank's Environmental and Social Risk Classification system (ESRC).

6.3. Environmental Risks and Impacts Envisaged

87. The main environmental impacts of health activities supported under this project may come during the rehabilitation and operational phases of the project from the possible heavy consumption of energy and water resources, pollution, possible greenhouse gas emissions, use and disposal of toxic chemicals, and production of wastes and wastewater and their disposal. The project activities with environmental risks proposed under the project include construction activities, such as possible small-scale rehabilitation and/or refurbishment of health centres, as well as lifecycle infection control and the possible use of designated waste disposal pits or medical incinerators (especially in large urban centres) or other waste management facilities for medical waste disposal. Generally, there are no waste management and disposal systems in public health facilities in Somaliland. As a result, improper disposal of bio-medical waste by health centres, hospitals, primary health centres, community health centres and diagnostic centres pose a health hazard to the general public.

88. The project activities will produce hazardous waste, such as mercury-containing items (thermometers) contaminate the environment; ash residue, which, if not properly disposed of, can contaminate groundwater at unlined waste disposal pits. On the other hand, significant amounts of pathologic waste with high moisture content requires significant energy to combust properly etc. Due diligence will be carried out to ensure that the siting, design and operation of waste management pits do not exacerbate environmental risks and impacts, however it is anticipated that they will be within existing health facilities. The use of medical waste incinerators requires trained operators, monitoring of waste segregation, appropriate waste transportation to site, and ash residue disposal. There are few trained operators in the country, and there is limited experience generally with modern medical waste management systems. The project will support the health facilities in designing and establishing SOPs based on WHO and WB standards, including WB ESHS guidelines.

6.4. Social Risks and Risk Rating

89. The social risks from this project are rated Substantial, taking into consideration the following key social risks and impacts: (i) potential exclusion of disadvantaged and vulnerable groups from project benefits and elite capture; (ii) potential risks of increased social tension in the community (for example, on types or how services are delivered, or siting of services); (iii) conflict and security risks for project workers, patients and the community. Potential security risks include: targeting of health workers, facility users and project staff by parties involved in the conflict; risks to health workers and other project staff due to conflict; and inability to access project areas for both providers and users, due to conflict; (iv) labour risks, including OHS risks during small-scale refurbishment of HCFs typical to general civil works, sexual exploitation and abuse (SEA), sexual harassment (SH), and other forms of gender-based violence (GBV) that may occur in recruitment or retention of skilled or unskilled female workers and the delivery of services; (v) contextual risks of operating in a conflict zone and a complex social context where effective and inclusive community consultations, stakeholder engagement, and community participation and safety of staff are challenging. Consequently, the GV/SEAH risk of the project is also assessed as substantial.

90. Potential risks are those related to labour and working conditions, such as work-related discrimination, sexual harassment and other forms of GBV, OHS and security risks. To address labour-related risks, a LMP will be prepared and the GBV/SEAH risks will be addressed in a GBV Action Plan presented in Annex 11. The LMP will set out the Project's approach to meeting national requirements as well as the objectives of ESS2 and ESS4 on Community Health and Safety. It will include procedures on incident investigation and reporting, recording and reporting of non-compliance, emergency preparedness and response procedures and continuous training and awareness to workers. The LMP will include a CoC for project workers who will receive an orientation on the same.

91. The Project will include civil servants, direct workers (members of the PIU), direct contracted and primary supply workers. As such, the Borrower will prepare the LMP while the implementing partners and contractors will develop Labour Management Plans as part of their bids. The LMP establishes that:

- Civil servants are bound by their labour contracts, but the Project will also ensure they meet ESS2 requirements regarding principles on non-discrimination, equal opportunity, and the establishment of workers' organizations, child labour, forced labour, OHS and access to the project GM;
- All workers must meet the national requirements regarding child labour, forced labour and OHS, as well as measures to establish written labour management processes and ensure proper working conditions, non-discrimination, equality of opportunities, and the right to form workers' organizations;
- A project specific Occupational, Health, Safety and Environmental (OHSE) plan will be developed and implemented as part of the ESMP, in line with World Bank Group's EHS Guidelines and Good International Industry Practice (GIIP) to ensure health and safety of workers.
- The Project will include a GM for labour-related complaints, based on national laws and procedures, as well as the requirements of ESS2;
- The Borrower will incorporate the requirements of ESS2 into contractual agreements with contractors together with appropriate noncompliance remedies;
- Once on board, contractors will prepare labour management plans to set out the way Project workers will be managed in accordance with the requirements of national laws and ESS2;
- OHS risks and impacts will continually be assessed following ESS2 requirements; and
- Regular monitoring and project reports will include information on labour management.

92. Although accessibility was one of the criteria for the selection of targeted districts, the security situation in Somaliland is stable. A district may be deemed as relatively secure but there is always potential for pockets of insecurity through flare ups of local community interests and non-state actor initiatives. Thus, a SecFM will be developed for the project before the bidding process begins. Expressions of interest by potential implementing partners will demonstrate internal security capacity and policies and due diligence directly managed by a competent activity Security officer.

93. Once the project becomes effective, an internationally certified security risk management firm will be contracted by the PIU and will carry out security risk assessments, in accordance with international standards, for the project and target regions. The firm will produce a project wide and regional Security Risk Assessments and SecMPs. The contracted implementing partners will ensure they publish and manage activity site security plans under the supervision of the PIU and the security risk management firm. Security and activity management plans will ensure workers, health facilities, equipment and materials are secure and serious incidents are prevented. Where security incidents occur, these shall be reported to the PIU, who shall report formally in writing to the World Bank within five days of the incident occurring. Particular attention will be paid to security providers to direct or contracted workers in the project. The risks posed by these security arrangements within and outside the project sites will be assessed, and measures will be implemented in line with the WB Good Practice Note on Assessing and Managing the Risks and Impacts of the Use of Security Personnel.

94. The stakeholder engagement risk is also rated Substantial. The current context in Somaliland, characterized by lack of trust between key groups in society, and accompanying high levels of contestation, presents a high risk for the Project in relation to the stakeholder environment. There may also be contestation on the types of services to be provided by the project including child spacing that could be opposed on religious and cultural grounds. Fragmented donor support in the health sector also contributes to intensifying such political divisions within the Government. For this reason, the selection of the project target areas and subsequent project funds allocation may be highly contentious and lead to a backlash from some. Key mitigation measures will include strong involvement of both and authorities throughout project preparation;

effectively using the GFF-supported country platform for improved coordination among stakeholders and; closely engaging with Office of the Prime Minister (OPM) in addition to the MoHD, to better manage - relationships. Moreover, the project's GM will help manage grievances from communities and enhance feedback.

95. The World Bank ESSs require continuous public consultation with affected groups and other stakeholders about the project E&S impacts, in order to take on their suggestions and inputs to improve project implementation. It also outlines the need for a trusted and functional GM that is accessible to all PAPs including disadvantaged and vulnerable individuals and groups.

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

97. Developing effective and trusted GMs is complicated by difficulties in accessing rural areas and the collective nature of traditional complaints handling processes. Social risks have been detailed in this SocMF and mitigated through the preparation of a SEP, a Social Management Framework (including a GBV Action Plan), LMP, as well as Environmental and Social Management Plans (ESMPs) for applicable sub-project activities. Lastly, the service providers' implementation capacity in complying with environmental and social safeguards guidelines may be varied from one organization to another. The contractor selection process will require bidders to demonstrate their capacity in implementing E&S safeguard measures. In addition, the Project's PIU will include a part-time Environmental and another full-time Social Safeguard consultant in Somaliland, and a full-time Social and GBV consultant, to monitor and support the safeguard implementation. The Table 9 below details social impacts based on proposed Project components.

Table 9: Project components and the associated social risks

Social Area	Risks and Impacts
All the project components (all project activities)	
Conflict and Security Risks	• Deteriorating security conditions in the project locations may hinder access and the ability to implement activities and also affect the security and well-being of workers and communities. • During the implementation of all project activities flare-ups of clan conflict in the project location Maroodi Jeex is particularly unlikely and security threats are minimal in Somaliland in general.
Exclusion and Selection Bias	• Recruitment of project staff, health professionals and consultants can be influenced by nepotism, clannism, corruption and elitism where women, people from minority groups, IDP groups, and PWDs are excluded, particularly at higher levels. • Elite capture of project benefits, especially recruitment and contracts for supplies and of private healthcare providers is possible. • Access to health facilities, once established and running, may be hindered due to clannism and other barriers (e.g. religious and cultural factors).
Sexual Exploitation Abuse and/or Harassment (SEAH)	• Female healthcare workers (whether civil servants or consultants) may be subject to GBV/SEAH in the recruitment or retention process since men dominate the hiring processes in most government and NGO offices. • Women may also be excluded from employment due to clan dynamics specially if they are married to a clan that is not dominant in the project area or if they are from minority

Social Area	Risks and Impacts
	groups. There is an acute lack of integrated policies providing a protective environment free from GBV/SEAH. • Women and girls from the community may be subjected to GBV/SEAH if they seek services from the health facilities.
Implementation of labour procedures	• The LMP will reinforce the need to implement policies and comply with ESS2 for project workers. • There may be discrimination in the workplace based on minority groups, IDP status, disability and gender considerations. • Women are often discriminated against as health workers and only widely engaged at the community level. • While official government policy is to allow for female employees to take maternity leave and have access to time off for breastfeeding, women are vulnerable to losing their jobs after pregnancy since these policies are not adhered to fully.
Occupational Health and Safety (OHS)	• In health facilities, physical structures from which workers provide services to the community may not cater to females, in terms of distance or appropriate facilities including for female workers. • Health workers may be exposed to infectious diseases such as coronavirus and HIV/AIDS, especially if they are not well trained on prevention and they do not have adequate personal PPE. • There is a risk of GBV/SEAH at the workplace. • During the delivery of an essential package of health and nutrition services in selected areas, health workers and staff may be directly targeted by violence for their affiliation with the government. This a particular threat for those working in areas outside of government control, and where people congregate e.g. health centres or public spaces during meetings.
Socio-cultural beliefs	• During the delivery of the essential package of health and nutrition services, socio-cultural beliefs may affect the health-seeking behaviour of some community members. For example, since decision-making at the household is invested in men, there could be delays in seeking medical assistance at health centres for women, particularly for certain medical procedures or by particular groups. • Clan structures and cultural practices are believed to have major impacts on the utilization of formal healthcare services and health practices of individuals and groups. Clan based health seeking behaviour may also limit access. • Most communities in Somaliland often prefer traditional medicine (use of herbal medicinal products) due to its perceived value over conventional medicines and cost. This has affected the popularity and the use of conventional medicines in many parts of Somaliland, including vaccinations. The predominance of cultural practices e.g. FGM and perception of GBV/SEAH also affects health seeking behaviour. • There could be tension and conflict between the communities and the health system due to opposition to some of the proposed interventions including FP and addressing FGM.
Component 1: Expanding the coverage of a prioritized EPHS in selected geographic areas	
Gender-based Violence (GBV)	• Female health workers may face GBV/SEAH during recruitment and delivery of healthcare services, especially when they have to travel to work alone and/or on foot in the evenings or at night to provide health services. • Limited training for key personnel providing services to GBV survivors, cultural perceptions, lack of confidentiality as well as lack of information on who provides what can increase harm, violence, and death. • Due to limited understanding of survivor-centred approaches, reinforcement of community conflict resolution in some cases may cause harm to women and girls including re-victimization, stigma, and marriage to the perpetrator. • The form of health services (e.g. FGM and child spacing) may lead to GBV against the users and providers.

Social Area	Risks and Impacts
Traditional healthcare providers and other sources of healthcare	• The focus of support exclusively to formal healthcare may marginalize TBAs who are the primary providers of pre- and post-pregnancy care, as well as other traditional healers who may influence health seeking behaviour of the target populations. • The community health outreach strategies will encourage engagement and collaboration with traditional health providers including encouraging TBAs to refer women for antenatal care.
Ownership of facilities or land or eviction of occupants in leasing of new facilities	• The health facility mapping will screen health facilities for any ownership conflicts or possible forced eviction of occupants in case new buildings are leased. In which, case abbreviated resettlement action plans (ARAPs) or government mediated land agreements will be developed.
Disputes over terms and conditions	• Disputes may emerge over labour wages, working hours, payment delays, health and safety concerns in the work environment and working conditions. • Retaliation against workers for demanding legitimate working conditions, or raising concerns regarding unsafe or unhealthy work situations. • Such situations could degenerate into labour unrest and resultant disruptions in service provision and damage to project property.
OHS	• During refurbishment of HCFs/PHUs and associated civil works though limited, there will be exposure to a variety of workplace hazards, including moving equipment and heavy machines, noise, vibration, welding, chemical hazard, working environment temperature, working at height and safety and hygiene in worker camps, as well as exposure to highly infectious diseases. • During transport, installation, and operation of solar power generating and SDD cold chain equipment there will be additional risks and impacts, including physical injuries, electrical shocks, and exposure to refrigerants.
Child/forced labour	• During limited civil works at HCFs/PHUs suppliers and contractors are expected to engage child labour within different types of field works, as this is quite common in the country. • Child/forced labour is also expected during transport and installation of planned solar power and cold chain equipment, including carrying heavy equipment to the site, preparing foundation and/or wiring, among others.
Component 2: Developing government stewardship and management capacity to enhance service delivery	
Investments in institutional capacity building with a significant focus on public financial management	• The training/capacity building activities may discriminate against low cadre staff, or staff from particular clans, those with disabilities and/or women.

6.5. E&S Risks Screening

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

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

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

- reconnaissance of the subproject areas (including the siting of the medical waste incinerators or waste pits[32]) and their surroundings, as well as understanding characteristics of beneficiary communities, by way of field visits to all the sites;
- identification of the major subproject activities taking place;
- preliminary assessment of the impacts of these activities on the social, ecological, physicochemical and the larger biophysical environment of the subproject surrounding areas;
- periodic environmental health and safety audits (as described in Section 6.1) above. The PIU will use the audits, during the operational phase of the project, to verify and record the effectiveness of prevention and control of exposure to occupational hazards, and maintaining accident and incident investigation reports on file for a period of at least three years, as per the recommendations of the World Bank's EHS Guidelines.

101. A template form for E&S screening for sub-project activities is presented in Annex 4. This will be reviewed and updated as needed during the process. Key E&S risks identified as crosscutting for the project include OHS risks, community health and safety, and waste management issues. If, for any reason, the PIU encounters substantially more complex E&S risks, an environmental and social impact assessment (ESIA) is recommended. Annex 15 provides the TORs for such an exercise.

6.6. Preparation of Environmental and Social Assessment Instruments

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

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

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

- Stakeholder Engagement Plan (SEP), which will set out effective and transparent management of consultation and information disclosure processes: the SEP will include a Grievance Redress Mechanism (GRM) as a key component;
- An Environment and Social Commitment Plan (ESCP), which will summarize the Borrower's commitments and obligations to adopt and implement these measures during project implementation; and
- The Labour Management Procedures (LMP), which also highlight occupational health and safety risks and procedures for minimising them.
- The SecMF which outlines the security risks and mitigation measures;

[32] Final decision on waste disposal type pending

- HCF Environmental Health and Safety (EHS) audits, which will examine how far the project funded healthcare facilities in Somaliland comply with the applicable World Bank and regulations apply to the facility.
- Environmental Health and Safety Management Plans (EHSMPs) for each of the HCF to be upgraded and operated under this project. The EHSMPs would include a more complete list of potential impacts and risks due to HCF operation activities, and an updated list of potential and needed mitigation measures, monitoring and indicators. This will be done when project implementation starts. The standard EHSMP should include ESS requirements, good practice for HCF EHS management, and ICWMP. The standard EHSMP will be used as part of the subproject screening process and can be modified as key issues are identified. The HCF contract bid package will then include the standard EHSMP and key issues which can be used by selected contractors as a base for their development of the Environmental and Social Assessment and Management Plan (ESMP).

6.7. Environmental and Social Mitigation and Monitoring Measures Proposed

105. Much of the expected environmental and social risks and impacts of the project will occur during the implementation of activities as designed under Component 1 ("Expanding the coverage of a prioritized EPHS in selected geographic areas").

106. Tables 10 and 11 present the mitigation measures proposed for negative environmental and social risks and impacts anticipated for the Somaliland health project. The PIU will prepare a more complete list of potential impacts and risks due to the proposed small-scale rehabilitation of HCF, and updated list of potential and needed mitigation measures, monitoring and indicators. This will be prepared prior to the start of project implementation. This updated list will be used as part of the subproject screening process and revised as needed for specific subprojects. This updated version will then be included as standard practice into contract bid packages. If on the other hand the bidding process starts before project effectiveness, the contractors will prepare their sub-project ESMPs and update the risks profile for the project.

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

108. The standard EHSMP will include ESS requirements, good practice for HCF EHS management, and ICWMP. The standard EHSMP will be used as part of the subproject screening process and will be modified as key issues are identified. The HCF contract bid package will then include the standard EHSMP and key issues which can be used by selected contractors as a base for the development of their ESMPs.

Table 10: Environmental and social mitigation and monitoring plan – updated March 2023

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US$)[33]
Construction phase[34]						
Noise and vibration during small-scale refurbishment and construction activities	- Notify the public of any activities that may be perceived of as noisy and intrusive prior to starting. - Establish a GRM for the public to contact the engineers-in-charge (i.e., provide telephone number, email, etc.) and the procedures to handle complaints. - Provide hearing protection gears for use by workers when exposed to noise levels above 85 dB(A). - Put in place controls for high noise equipment and/or noise controls for works near sensitive receptors - Ensure that noise and excessive vibration from construction activities are within permissible levels as per the provisions of World Bank's OHS guidelines: this includes among others adhering to permissible noise and vibration level. Use modern construction equipment, which produces less noise; and - Use of noise shielding screens should be used and the operation of such machinery restricted to when actually required	# complaints received over noise # complaints registered via GRM mechanism # hearing protection and aids provided to workers	Records Field visits Records	Monthly		
Airborne emissions	- Motorised equipment be maintained in good operating condition to reduce exhaust emissions; Construction sites, transportation	# health facility records on respiratory diseases	# Records from nearby health facilities	Monthly	PIU	

[33] The actual costs for the mitigation measures will be established at project effectiveness, and the PIU will update this section accordingly.

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

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US$)[33]
	routes, diversions and materials handling sites to be water-sprayed on dry and windy days to contain dust; - Haulage trucks to be covered or the aggregates sprayed with water before loading; - Health facilities and the associated project areas under refurbishment to be cordoned off to minimize dust migration to nearby facilities by wind; - Staff working in dust generating activities e.g. site preparation, excavation, concrete mixing, stone dressing should be provided with personal protective equipment (PPE) - The use of PPE shall be enforced; and - Avoiding open burning of solid wastes	Visual observations of dust emissions Complaints from community about dust				
Soil and water pollution	- Open stockpiles of onsite construction materials should be covered with tarpaulin or similar fabric during rainy season; - Prevention of the washing away of construction materials, soil, silt or debris into any drainage system; - All machinery and equipment be regularly maintained and serviced to avoid leak oils; - Maintenance and servicing of heavy vehicles, machinery and equipment must be carried out in a designated area (protected service bays); - Oil products and materials should be stored in site stores or in the contractor's yard; - Oil interceptors shall be installed along the drainage channels leading from such areas; All applicable national laws, regulations and standards for the safe use, handling, storage and disposal of hazardous waste to be followed;	# incidents on soil and water pollution reported	# Field reports	Monthly	PIU	

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US$)[33]
	and Implementation of erosion and sediment control measures such as silt fences, where applicable and where resources permit					
Other construction risks associated with minor facility repairs and rehabilitation works and construction safety	- Construction worker first-aid - Community health and safety - Construction equipment handling training - Construction debris management - Provision of PPEs to construction workers - Adhering to ESS4 requirements related to Infrastructure and Equipment Design and Safety, and Safety of Services; - The PIU to ensure coordination and efficient management of significant material suppliers; - Appropriate management of construction waste including construction debris, non-hazardous wastes, hazardous wastes, liquid waste management; - Traffic management at and near site; - If worker camps are established, adequate EHS provisions should be put in place; - Construction works under appropriate national Covid-19 guidance, or international best-practice guidelines in the absence of national guidelines, with strict adherence and regular monitoring by the PIU and reporting	# incidents involving safety of workers	Field reports GRM incident logs	Monthly	PIU	
Operational phase[35]						

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

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US$)[33]
Increased safety and health risks, including exposure of medical personnel and waste handlers to dangerous and infectious health care waste	- Medical staff should be medically screened, briefed and trained on risks; - Regular supervision of health facilities to ensure that safety conditions are met while any deviation from safety regulations is immediately reclaimed following the best practices regarding safety at work; - Develop evacuation procedures to handle emergency situations; - Controlled entry and exit from the health premises; - Post in prominent places informative signage and notices in Somalilander language to inform of safety hazards and controls; - Provision of appropriate Personal Protective Equipment and enforcement of their use; - Hire qualified personnel in all Damal Caafimaad financed sub-projects; and - Adhere to provisions of the World Bank's EHS guidelines	# medical personnel exposed to infectious wastes	# PIU reports	Monthly	PIU	
Poor indoor air quality and risks of contracting communicable diseases in restricted spaces	- Ensure that there is enough ventilation Prohibition of smoking of cigars and related sources of indoor air pollution, with adequate signage posted - Use a dehumidifier and/or air conditioner to reduce moisture, funds allowing	# cases of indoor air pollution reported	HCF records EHS audit findings	Yearly	PIU	
Healthcare wastes and general waste management	- Implement the Infection Control and Waste - Management Plan - Practice waste minimization segregation and proper disposal according to internationally accepted guidelines and (where possible) municipal bylaws	Quantities of wastes generated Quantities of waste disposed of GRM incidents reported on waste disposal	Waste records Field reports	Monthly	PIU	

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US$)[33]
	- Contractors appointed under this project will be required to develop project Environmental and Social Assessment and Management Plans, which will include area specific ICWMPs, capturing waste volumes and categories expected from health centres; - These ESAMPs will highlight the measures designed to ensure the safe and environmentally sound management of healthcare wastes in order to prevent adverse health and environmental impacts from such wastes, including the unintended release of chemical or biological hazards, including drug-resistant microorganisms, into the environment; - The contractors will be responsible for instituting and implementing a simple medical waste tracking system allows for the identification of current waste streams while determining how much waste is being generated from the health facility; - The contractors will be responsible for keeping documentation showing details of interventions put in place for tracking, measuring and optimizing medical wastes and recycling processes as appropriate; - A sample waste tracking system has been provided in Annex 9 of this ESMF, with appropriate guidance notes; - Contractors will be required to (a) disaggregate wastes in terms of typologies (infectious waste, pathological waste, sharps, pharmaceutical waste, genotoxic waste, chemical waste, wastes with high content of heavy metals, pressurized					

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US$)[33]
	containers, radioactive waste, general solid waste and microorganisms), (b) report on volumes of each typology of wastes generated, (c) report on volumes of each typology of wastes collected, and (d) report on available capacity for on-site handling, collection, transport and storage; - Pre- treatment of operation process water before flushing into the existing sewage system or soak pits or into the ecosystem (where there is no built receiving system); - The treated effluent being discharged to the sewer line should conform to the international limits for effluent discharge into public systems; - Minimize entry of solid waste into the wastewater stream by collecting separately urine, faeces, blood, and vomit from patients treated with genotoxic drugs to avoid their entry into the wastewater stream; - Ensure that sewerage discharge pipes are not blocked or damaged; and - Put in place mechanism for wastewater management and disposal, both for sanitary wastewater and wastewater that may contain medical wastes or hazardous wastes					
Water management	- Supported health facilities to obtain water abstraction permits from the municipalities, where these laws exist; - HCFs to ensure that adequate potable water is provided for operations; - Implement, at the supported health facilities, water saving devices for domestic water use e.g. dual flush toilets, automatic shut-off taps,	#Water permits obtained	#Field reports on water use efficiency and water consumption audits	Yearly	PIU	

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US$)[33]
	etc.; Cleaning methods utilised for the cleaning of vehicles, floors, containers, yards etc. must aim to minimise water use; - Practice rainwater harvesting (RWH) by including RWH structures in sub-projects' design and construction; - Conducting of regular audits of water systems to identify and rectify any possible water leakages; - Implementing a system for the proper metering and measurement of water use to enable proper performance review and management; - Regularly test the water through accredited laboratories to ensure the biological and chemical components are as per national water quality regulations					
Increased surface or storm water runoff generation	- No surface water shall be directed into the sewer system to avoid overloading the sewerage system; Harvest rainwater from roof for non-portable uses e.g. cleaning and watering plants as well as cleaning the health facilities	# Flooding events within the health facilities	Field reports	Twice a year	PIU	
Community health and safety, including lapse of confidentiality and possible assault by medical staff worker; unrealistic expectations of level of healthcare or subpar quality or	- Medical staff hired should be experienced, professional and trained - MoHD to prepare adequate procedures on staff hiring requirements, code of conduct and ensure training is made available to health staff Patients are told and aware of the services available and understand procedures offered as well as their consequences - Complaints and grievances aired should be registered and processed	# Proportion of skilled healthcare staff # of training opportunities provided on client management	Hiring reports Training reports GRM records	Yearly	PIU	

Potential negative E&S risks and impacts	Mitigation measures proposed	Indicators for monitoring	Means of monitoring	Frequency of monitoring	Responsibility	Cost (US$)[33]
inefficacy of medical goods procured (drugs, supplies, equipment); or expiration of medicines and unnecessary or improper disposal of medical goods	- All waste storage and disposal sites are adequately cordoned off from the public (see Annex 9) Practice cold chain, storage and transport management system for efficiency in the medical logistics chain for the entire project - Computerized and manual inventory system as well as disposal SOPs for medical logistics.					

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

Potential Social Risks	Mitigation Measures	Monitoring	Person/Agency responsible
Labour-related potential risks: OHS	Abide by OHS requirements as set out in Labour Code, ESS2 (including WBG EHSGs both general and Health Care Facilities) including: - Develop and implement an approved Contractor ESMP, including OHS Management Plan. - Select legitimate and reliable contractor through screening OHS records. - Address adequately OHS risks with non-compliance remedies in procurement documents. - Require the contractor to engage qualified ESHS staffing and apply adequate PPE and safety measures onsite. - Enhance workplace OHS awareness and training. - Conduct routine monitoring and reporting.	Monitor implementation of OHS plans onsite Monitor work related grievances and remedy measures Monitor application of housekeeping measures and PPE use Monitor incidents related to OHS onsite	Contractors and suppliers during construction to implement PIU to monitor and coordinate
Labour-related potential risks: Child/forced labour -	- Include minimum age in procurement documents. - Raise awareness on child protection with contractors and in the communities. - Maintain labour registry of all contracted workers with age verification.	- Monitor implementation of age verification measures by contractors and suppliers - Spot checks on child/forced labour including work agreements (terms and conditions) and age verification	Contractors and suppliers to abide and implement verification measures

Potential Social Risks	Mitigation Measures	Monitoring	Person/Agency responsible
	- Develop remedial procedures to deal with child labor incidents.	- Monitor complaints related to labour during construction and installation of solar power and SDD equipment.	PIU to monitor and coordinate with available labour inspectorates
Exclusion and selection bias	- A LMP will be prepared for the project before the bidding process. - Efforts will be made to promote diversity in staffing – including members of disadvantaged and vulnerable groups including PWDs and women. There may be a need to put quotas for gender and PWDs. - Awareness raising of all project implementers, contractors and primary suppliers on the requirements and implementation of the inclusion plan. - Promote inclusion of disadvantaged and vulnerable groups in consultations and access to project benefits. - Promote diversity in recruitment including all disadvantaged and vulnerable groups, PWDs and women. There may be a need to put quotas for gender and PWDs.	- Monitoring of the inclusion plan. - Awareness raising on the need for inclusion and that complaints can be raised through the project GM.	PIU.
		- For direct workers, contracted workers and primary suppliers any complaints related to recruitment will be channelled through the project GM if they are unable to raise or resolve issues with their immediate supervisors or heads of human resources. - Civil servants under the project will follow the Ministry of Labour. Civil Service Commission Policy to articulate their complaints. - The civil servants will also have access to the project GM to lodge their complaints regarding the project.	Civil Service Commission.
(GBV/SEAH)	The GBV risks are assessed as substantial. The GBV Action Plan (see Annex 11) describes the necessary operational measures and protocols needed to address GBV/SEAH related to the project. Based on the GBV Action Plan, the project will: • Healthcare staff will be made aware of the increased risk of sexual violence faced by minorities, IDPs and PWDs. • identify a full range of actions to mitigate GBV/SEAH risks among staff, patients, and community members. • carry out capacity building and training of relevant stakeholders, including project workers and government partners on GBV/SEAH.	The SEP will ensure regular community awareness on GBV/SEAH issues. The project GM will identify specified channels to allow for the safe, confidential and survivor-centric submission of complaints from citizens related to GBV/SEAH. A GBV Advisor will be employed throughout the project and provide regular reports See Annexes 12 and 13 on the ToRs for the GBV specialists). The LMP will provide for CoCs with clear guidance on GBV/SEAH.	Contracted NGOs and companies Social Safeguards specialists. GBV/SEAH focal point.

Potential Social Risks	Mitigation Measures	Monitoring	Person/Agency responsible
	• Healthcare staff will be trained on safe identification and care of PWDs who have experienced sexual violence, respecting their confidentiality. • Conduct consultations, sensitization and awareness raising activities with communities on GBV/SEAH risks. • develop an effective GM with separate channels to manage GBV-related complaints in order to enable reporting of GBV/SEAH incidents in a safe, confidential and survivor centric manner. • Disseminate policies and protocols to all staff. • Train staff in GBV health care, counselling, referral mechanisms, and rights issues. • Include GBV Action Plan in health and community service contingency planning in case of humanitarian emergency. • Integrate GBV medical management into existing heath system structures, national policies, programs, and curriculum. • Include GBV provisions in all CoCs to be signed by the contractors and project workers.		
Security related incidents.	- Contractors will prepare area specific activity SecMPs which will be reviewed and cleared by the PIU and the World Bank and regularly reviewed and updated, to protect staff, patients and communities and healthcare centres. - These will be regularly monitored by dedicated IP security specialists and any lapses addressed promptly. - Serious security incidents will be reported to the PM within 24 hours and mitigation actions developed and implemented.	- The sub-projects SEPs will ensure buy-in from communities through regular consultations and trust building which will improve security for service provision. - Staff will be required through their CoC to report any security concern and/or incident within 24 hours to the PIU. - The project GM will further allow for submission of complaints from citizens related to insecurity caused by the project. - The project will allow for whistle blowing on all matters affecting any aspects of implementation.	Contracted NGOs and companies. Contracted security (public or private).

Potential Social Risks	Mitigation Measures	Monitoring	Person/Agency responsible
Socio-cultural barriers to uptake of EPHS services, exclusion of disadvantaged groups.	- The E&S assessment and management plan will document the socio-cultural barriers to the uptake of EPHS services including traditional and religious beliefs, and exclusion of disadvantaged groups. - The contractors' E&S assessment and management plan and community outreach plan will identify and address socio-cultural barriers through appropriate awareness raising and engagement with opinion influencers. - Implementing partners will consider socio-cultural beliefs and behaviours as part of their community outreach strategy. - The inclusion plan (Annex 10) will promote services for all groups in the project sites. - The SEP and GM have been developed in order to address these risks. In addition, plans may be developed to target specific groups with information including traditional healers, TBAs and religious leaders given their influence in society. - Measures will be put in place to encourage participation and inclusion of disadvantaged and vulnerable individuals and groups.	- The SEP will ensure that the communities (project beneficiaries) receive information about the services offered by the project and have an opportunity to provide feedback. - The project GM will also allow for submission of complaints from the beneficiaries/communities and use the same channels to provide feedback on the complaints. - Regular community feedback session and monitoring on project.	Contracted NGOs and companies
Social unrest and disputes over properties	Conflict over ownership of facilities or land or foreseeable eviction of occupants in leasing of new facilities	The health facility mapping will screen health facilities for any ownership conflicts or foreseeable eviction of occupants in case new buildings are leased and if necessary an abbreviated resettlement action plan (ARAP) will be prepared or government mediated community land donation will be facilitated.	PIU

6.8. Environmental and Social Monitoring by Contractors

109. The MoHD, through the PIU, will ensure contractors and other parties working on the project directly monitor, keep records and report on the following environmental issues for their activities[36]:

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

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

received since the preceding report and those that were unresolved at the time of that report. Grievance data should be gender disaggregated.

- Major changes to contractor's environmental and social practices.
- Deficiency and performance management: actions taken in response to previous notices of deficiency or observations regarding environmental safeguards performance and/or plans for actions to be taken—these should continue to be reported until municipalities/PIU determine the issue is resolved satisfactorily.

6.9. Environmental Liabilities of Contractors

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

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

SECTION 7: ROLES AND RESPONSIBLITIES OF IMPLEMENTING ENTITIES

7.1. Introduction

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

7.2. Project Coordination and Implementation Unit (PIU)

112. Project Implementation Unit (PIU) at the national level has been established within the framework of the project. The PIU will have the overall responsibility for project management, coordinating project implementation, monitoring and evaluation, and reporting of results to stakeholders and developing environment safeguards frameworks and plans. The capacity in the PIU will be enhanced through on-the-job training and mentoring by the World Bank's technical staff working on safeguards and the task team leader.

113. The PIU will provide overall responsibility for environmental safeguards due diligence, and compliance monitoring. During the meetings with World Bank Safeguards Specialists, the various territorial officials from the different ministries in charge of health were encouraged to appoint persons from within their ranks, who are qualified and up to the task, as environmental safeguards for the project.

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

115. The Environment and Social Commitment Plan (ESCP) outlines responsibilities and timelines. Also, to help navigate project implementation, a Project Operations Manual (POM) will be prepared by the PIU for submission to the World Bank for No Objection within two (2) months of project effectiveness. The POM will describe the project components and activities; implementation modalities for each project component; fiduciary/disbursement and safeguard responsibilities and arrangements; and coordination mechanisms at different levels. The POM will also include monitoring of the project progress according to the Project's results framework and the ESCP. Table 12 presents a summary of the institutional arrangements proposed for the project cycle.

7.3. Roles and Responsibilities of The Ministry of Health Development (MOHD)

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

- Take the lead in screening, scoping, review of draft contractor ESMPs for the government, receiving comments from stakeholders during public hearing of the project;

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

Table 12: Institutional arrangements for E&S

Entity	Responsibility
MoHD (PIU) Implementation	
Senior Health Programme Coordinator (Lead at PIU at -MoHD)	The Coordinator will report to the Project Steering Committee. • Lead the project team and have overall responsibility for the management and oversight of project implementation. • Be responsible for day-to-day coordination activities, manage and track implementation progress, identify opportunities for improvements of project implementation and to solve day-to-day issues that may be slowing down or blocking implementation. • Ensure overall compliance with operational policies pertaining to the project's implementation and management, including for procurement and management of financial resources. • Ensure timely reporting to the Steering Committee and to the World Bank.
Contract Management Sub-unit (Legal Advisor and Security Advisor)	The specialists will report to the PIU Senior Health Programme Coordinator. • Develop TORs, bidding documents, carry out review and due diligence of bids, initiate and execute the procurement of contractors. • Develop a framework (indicators and results framework) on how to monitor performance, monitoring and supervision processes, verify results, payment of all contracts, assessing the security context of project implementation areas, and providing legal advice on all contracts. • Ensure accountability and efficient use of project funds, including tracking of and monitoring requests for financial resources and ensuring accuracy and reliability of financial reports. • Process requisitions, purchase orders, payment requests, and funds withdrawal requests from the MoF, and ensure monthly delivery updates to the project manager on financial delivery performance.
Communication Specialist	The specialists will report to the PIU Senior Health Programme Coordinator. • Develop a comprehensive project communication strategy and plan, provide regular and timely analysis and distribution of Project information to all key stakeholder groups and project beneficiaries. As needed, produce (contribute to the production of) communication materials.
Senior Social Safeguard Specialist	The specialists will report to the PIU Programme Coordinator. • Ensure compliance with World Bank's ESF and other relevant country laws in line with this ESMF. • Oversee the development and updating of social safeguards instruments and inclusion in all project documents and contracts. • Train and orient all project workers on social risk management. • Ensure smooth and efficient implementation of the SEP; ESMF, LMP, SecMF; and sub-project specific environmental and social assessment and management plans. This officer will work closely with the Environment Safeguards Specialist. • Effective review, approval and submission for clearance to the World Bank of the sub-project ESMPs based on the E&S instruments. • Assist contractors to fully comply with World Bank's ESF and other relevant country laws. • Oversee the functioning of the GM and act as the focal person for the GM and secretary for the GRC.

Entity	Responsibility
	• Ensure adequate review and quality of all safeguards reports (quarterly) before sending to World Bank. • Collaborate closely with the GBV Advisor • Seek technical support and guidance where necessary from the World Bank social safeguards specialists. • Collaborate and synergise with social specialists on World Bank projects, especially RCRF and SCRP, which have health components. The terms of reference of the social safeguard specialist is included in Annex 14. Other technical consultants reporting to the Coordinator at the PIU will be hired on need basis, based on the needs of the MoHD.
Senior Environmental Safeguard Specialist	The specialists will report to the PIU Programme Coordinator. • Ensure compliance with World Bank Environment and Social Standards and other relevant country laws as contained in this ESMF; • Support the smooth and efficient implementation of the project, and • Undertake effective preparation, review, approval and implementation of sub-project ESMPs, based on this ESMF. • Prepare and submit for review all contractor ESMPs, reports and documents and will ensure compliance to the World Bank Environment and Social Standards; • Ensure that the sub-project designs, specifications and budget adequately reflect the recommendations of the Contractor ESMPs developed in the project; • Prepare draft EHS requirements for subproject bid packages based upon standard requirements and any subproject specific issues; • Review and approve the Contractor's ESMP using the ESMF as guide; • Co-ordinate application, follow up processing and obtain requisite clearances and approvals from the World Bank for the Contractor ESMPs submitted by the individual sub-projects, after their own review and approval at the onset; • Prepare regular monthly/quarterly/semi-annual progress reports with statutory requirements, including performing onsite supervision/monitoring visits to HCFs, including quarterly ES performance reports for the Bank, in addition to fulfilling ES notification requirements, as per ESCP for the project; • Develop, organise and deliver appropriate environment safeguards related training courses for the PIU staff, contractors, local government/community representatives and others involved in the project implementation; • Liaise with the Contractors and the PIU on implementation of the Contractors ESMPs and all other EHS contractual requirements; • Liaise with various Government agencies on environmental monitoring and management matters; • Continuously interact with relevant NGOs and community groups; • Establish dialogue with the affected communities and ensure that the environmental concerns and suggestions are incorporated and implemented in the project; • Review the performance of the project in terms of environment safeguards, through an assessment of the periodic internal monthly and quarterly environmental monitoring reports; provide summaries of same and initiate necessary follow-up actions; and • Provide support and assistance to the Government MDAs and the World Bank during Project Review Missions. Other technical consultants reporting to the Coordinator at the PIU will be hired on need basis, based on the needs of the MoHD.
GBV Advisor	The specialists will report to the PIU Senior Health Programme Coordinator • Ensure the completion and adoption of the GBV Action Plan.

Entity	Responsibility
	• Draft the ToRs for the GBV Service Provider. • Ensure the implementation of the provisions in the GBV Action Plan. • Support the training of project workers on GBV in close coordination with the GBV Service Provider. • Monitor the management of GBV reporting on the GM (both workplace and project-based). • Collaborate closely with the Social Safeguards Specialist for the project. • Seek technical support and guidance where necessary from the World Bank GBV advisors. • Collaborate and synergies with the social and GBV specialists on World Bank projects, especially RCRF and SCRP, which have health components. The terms of reference of the GBV Advisor are included in Annex 12. Other technical consultants, who will report to the Project Coordinator at the PIU, will be hired on need basis, based on the needs of the MoHD.
Third Party Monitoring Agent	The TPM Agent will report to the PIU and while reporting to the MOHD and the WB, the TMP agent will provide monitoring support to the project throughout the project cycle; including on community feedback and E&S implementation. Generally, the TMP agent will: • execute and report on all monitoring activities outlined below; • develop and disseminate quarterly health service bulletins/interactive dashboard and annual report; and • developing Government capacity for monitoring design and oversight; data analysis and dissemination; and data use for decision making. There will be an annual survey and balanced scorecard (beneficiary feedback) including the following indicators: o GBV FGM/C services; • Community satisfaction/community information; • Community satisfaction, perceptions of health service quality, perceptions of different types of services offered at facilities; • Community knowledge of and feedback on GM; • Health seeking behaviour of community members; • Assessment of health system effectiveness in terms of access to and utilization of health services and level of satisfaction by different wealth quintiles / socio-economic groups; • Fertility desires, beliefs (influences / barriers), and child spacing knowledge; and • Utilization of health services by disadvantaged and vulnerable groups including minority groups, IDPs, the poor, and people from remote areas, etc.; • Patient satisfaction, perceptions of quality, and experiences of different types of services offered at facilities. The TMP will use approaches that will facilitate the participation of the disadvantaged and vulnerable members of the target communities including one-on-one interviews, group discussions (while observing the Covid-19 protocols) and use of local leadership structures. Reports generated should capture information on disadvantaged and vulnerable individuals and groups.
Additional Technical Support	
World Bank	• Provide technical support on all aspects of the project and as requested by the MoHD. • Review and clear E&S instruments and plans. • Assess the implementation of the ESMF and other instruments and recommend additional measures for strengthening the management framework and implementation performance, as necessary. • Review and approve the ToRs for contractors, TMPs and consultants recruited for the project. • Approve the reporting framework, screening procedures and preparation of management and mitigation plans with the PIU at the MoHD during the early part of project investment identification stage before disbursement.

Entity	Responsibility
	• Hold review meetings and provide timely feedback to the PIU at MoHD.

7.4. World Bank Roles and Responsibilities

117. During implementation and operation of the Project, the World Bank will:

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

7.5. Budget for Implementing the ESMF

118. To effectively implement the environmental management measures suggested as part of the ESMF, resources will be required, to the tune of US$988,000[37]. An indicative budget has been provided in table 14, meant to cover only safeguards related expenses such as capacity building programs, coordination and public consultation meetings, planning workshops, monitoring work, and environmental consultancy services.

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

Table 13: Indicative Budgetary requirements for implementing the ESMF for the Damal Caafimaad project

ESMF Requirements	Budget basis and assumptions	Total Cost (US$)
Trainings	Training of all staff on ESMF requirements – virtual and face to face	20,000
Meetings		20,000
Conferences **Workshops**: - Workshop to orient implementing partners and TPM and other contractors on ESF requirements before bidding - Workshops to input SRM into all project components - Workshops on SRM progress and strengthening		20,000 40,000
Fieldwork		10,000

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

ESMF Requirements	Budget basis and assumptions	Total Cost (US$)
Documentation work		10,000
Salaries	E&S Safeguards Specialists at PIU	200,000
Budget for implementation of SEP	All activities related to the implementation of the SEP by MoHD (contractors SEPs will be included in the contract amount	113,000
Budget for implementation of GBV action plan	All activities related to the implementation of the GBV action plan	300,000
Estimated budget for implementation of LMP	All activities related to the implementation of the LMP	200,000
Budget for contracting risk management firm to conduct a project and regional security risk assessment and management plans and support the security officer	An internationally certified security risk management firm will be contracted for the assignment based on key qualifications	300,000
Monitoring of implementation of ESMF in Project locations	Monthly visits of social specialist	20,000
		1,253,000
Contingencies (5%)		62,650
Total		**1,315,650**

7.6. Updating the ESMF

120. This ESMF will be used for screening of sub-projects and as a guide for the preparation, review and approval of environmental impact assessment instruments (EIAs and ESMP). It will also be a reference in the implementation of the sub-projects and their respective ESMPs. Since there may be new developments, guidelines or national legislations issued after its (ESMF) approval and posting on the World Bank website, the ESMF may need to undergo updating from time to time.

7.7. Disclosure of Environmental and Social Risk Management Instruments

121. This ESMF has been prepared in consultation with the relevant stakeholders in Somaliland (with meetings held between MoHD officials and counterparts in the health sector in Somaliland). Consultative meetings have been held for the purpose of preparing this ESMF. The stakeholder meetings were conducted virtually on diverse dates, including December 14, 2020, January 21, 2021, February 3, 2021, and finally on March 24, 2021. The meetings were attended by stakeholders in the health sector in Somaliland.

122. Copies of this ESMF and other safeguard instruments developed later (ESMPs), prepared for the subprojects to be financed under the project, should be disclosed in compliance with relevant country regulations and the World Bank Environment and Social Standards. The ESMF will be disseminated within Somaliland in all project sites. The executive summary will be translated into Somali language. It will also be disclosed in two daily newspapers for 21 days, or as required by country laws, while the World Bank will post the approved document at its Info Shop.

SECTION 8: MONITORING AND REPORTING

123. The social specialist will monitor and report on the implementation of the ESF instruments and the ESCP. The specialists will be responsible to monitor the implementation of the ESMPs by the contractors and report to the social specialist.

124. The PIU will submit quarterly progress reports or as otherwise requested by the World Bank on a case-by-case basis.

125. Internal Monitoring: The PIU will prepare data on activities and outputs in regular quarterly reports. The M&E process will be participatory, engaging community members of the districts benefiting from the project investments. Virtual GIS tagged monitoring tools may be used as in the RCRF project, e.g. Kobo toolbox and patient and community phone surveys. An end-line beneficiary survey will be carried out to measure who and to what extent people benefited from the project as well as how it affects their lives and the social impacts.

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

127. There will be an annual survey and balanced scorecard (including beneficiary feedback) including the following indicators:

a. GBV/FGM/C services;

b. Community satisfaction/community information;

c. Community satisfaction, perceptions of health service quality, perceptions of different types of services offered at facilities;

d. Community knowledge of and feedback on GM;

e. Health seeking behaviour of community members;

f. Assessment of health system effectiveness in terms of access to and utilization of health services and level of satisfaction by different wealth quintiles / socio-economic groups;

g. Fertility desires, beliefs (influences/barriers), and child spacing knowledge;

h. Utilization of health services by disadvantaged and vulnerable groups including minority groups, IDPs, the poor, and people from remote areas, etc.; and

i. Patient satisfaction, perceptions of quality, and experiences of different types of services offered at facilities.

128. Reporting back to stakeholders: Regular stakeholder workshops will be held to enable feedback on project progress and improvements to all stakeholders. In addition, component 4 of the new RCRF project supports the designing and use of tools to advance transparency and generate citizen feedback mechanisms up to the facility level (for selected locations). It also supports the learning and evaluation of the possible most impactful tools. A rigorous impact evaluation will be financed to assess the efficacy of citizen engagement on health access and quality with health teams.

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

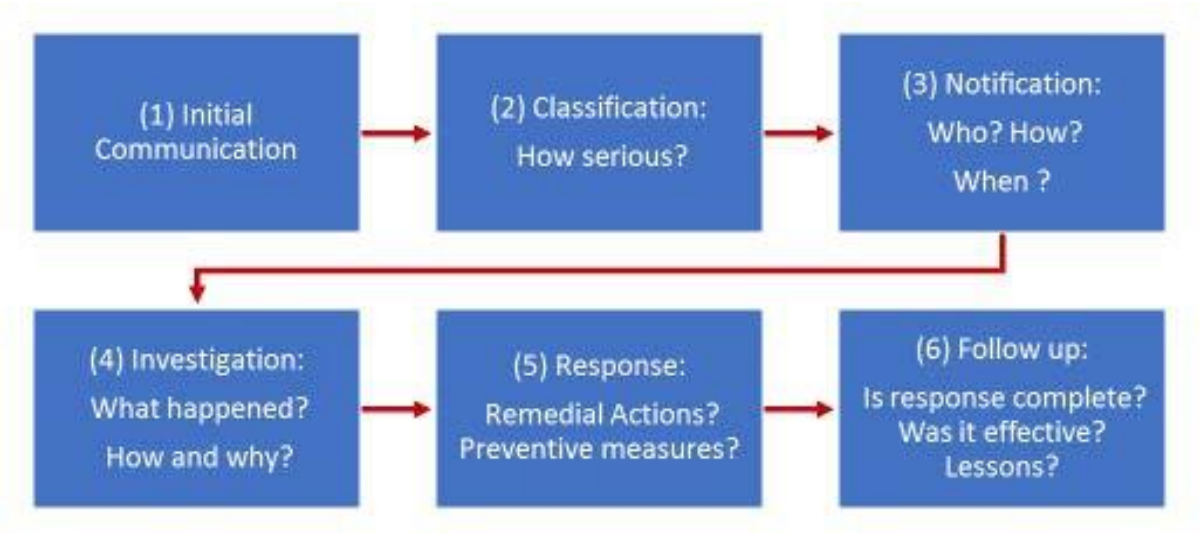

Figure 4: Incident reporting matrix

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

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

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

SECTION 9: GRIEVANCE MECHANISM

9.1. Introduction

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

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

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

9.2. Objective and Types of GM

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

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

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

- Fairness of contracting;
- Fraud or corruption issues;

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

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

9.3. Building Awareness on GM

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

140. The project will aim to address grievances through using the steps shown in Table 14 and indicative timelines.

Table 14: Grievance resolution timelines

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

No	Steps to address the grievance	Indicative timeline*	Responsibility
* If this timeline cannot be met, the complainant will be informed in writing that the GRC requires additional time.			SS specialist

9.4. Grievance Management Process

141. Grievance resolution requires localized mechanisms that take into account the specific issues, cultural context, local customs and tradition, and project conditions and scale. The following is the outline of the grievance process to be followed (the structure is illustrated in Figure 5):

- Receive, register and acknowledge complaint (see Annex 7) for a Grievance Registration Form Template;
- Screen and establish the basis of the grievance (e.g. nuisance complaint may be rejected but the reason for the rejection should be clearly explained to the complainant);
- GRC to hear and resolve the complaint;
- Implement the case resolution or the unsatisfied complainant can seek redress at a formal court of justice;
- Elevation of the case to a formal court if complainant is not satisfied with the GRC resolution; and
- Document the experience for future reference.

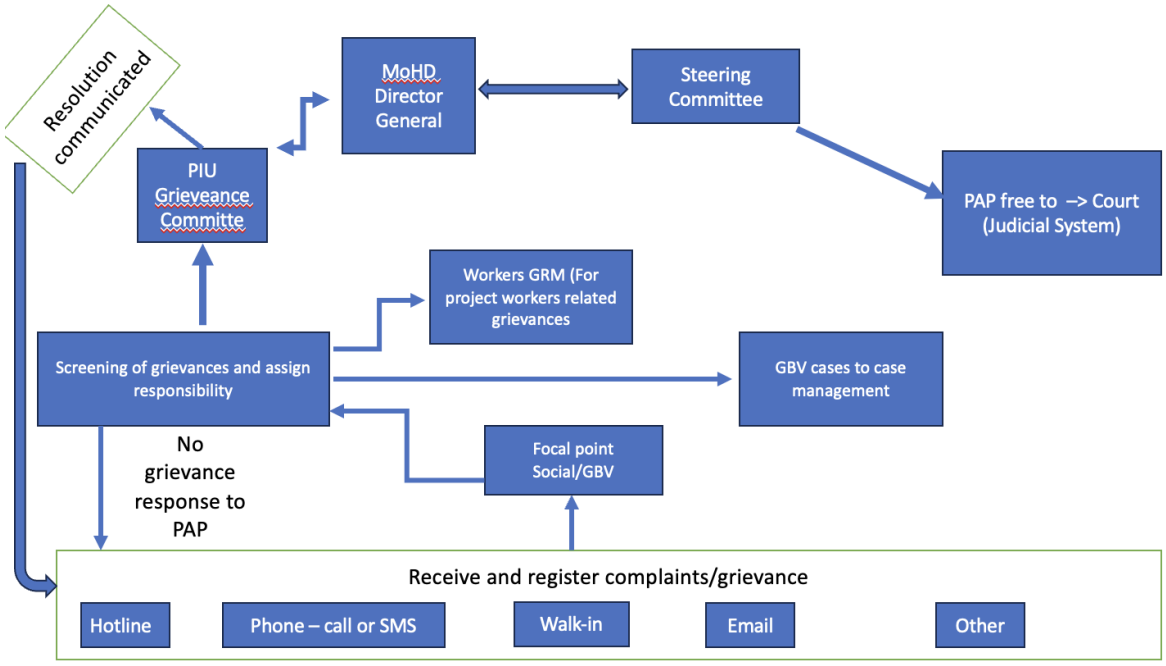

Figure 5: Structure of Grievance Mechanism

9.5. Grievances Related To GBV/SEAH

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

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

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

145. In consultation with the MoHD and relevant community stakeholders, separate channels and protocols for reporting and addressing allegations of GBV/SEAH will be identified and integrated into the GM. This will include information on disclosure and reporting guidelines/protocol for GBV/SEAH, processes for referral, and accountability and verification processes to manage cases should they arise. See GBV Action Plan in Annex 11, for more detail.

9.6. World Bank's Grievance Service

146. World Bank Somaliland Office: If no satisfactory resolution of complaints has been received from the PIU, complaints can be raised with the World Bank Kenya office on Somalilandalert@worldbank.org.

147. World Bank's Grievance Redress Service: Communities and individuals who believe that they are adversely affected by a World Bank supported project may submit complaints to existing project-level GMs or the WB's Grievance Redress Service (GRS).

For more information: http://www.worldbank.org/grs, email: grievances@worldbank.org or address letters to: The World Bank

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

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

ANNEXES

ANNEX 1: Individual Stakeholders Consulted During the Development of the Project

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

Table A1-1: Summary of the key risks and mitigation measures

Issue	Key Risks	Mitigation Measures
Perception about the project and its implementation	• The process of contracting NGOs may not be as transparent as required and this may lead to the delay of the project implementation. The contract may be awarded to an NGO with less capacity and the process may be flawed due to nepotism. Often the ministries officials have interest in the procurement processes. • Provision of health services to women and children may not be prioritized by the ministries and NGOs due to existence of high number of such facilities within the state (It is important for the ministry to know that these facilities do not have capacity to provide quality health services). • Elite capture - powerful individuals or groups may influence the project implementation process and end up benefiting their businesses and their process through employments and contracts. • Construction/rehabilitation of health facilities, can cause noise pollution and road blockages. • Environmental risks - disposal of syringes, injections and other equipment cause risks to the communities. There is no proper mechanism to dispose medical equipment. • Socio-cultural beliefs about medicines and vaccines within communities is however common in remote areas. For example, people may be discouraged to use conventional medicine, and instead encouraged to seek traditional medicines. • Community acceptance/ownership and participation: Acceptance of the project by the communities in the implementation areas. The communities have to understand the project components very well before implementation. • Recruitment of qualified people, especially the medical professionals – doctors, nurses, and midwives. Challenges: • Tension and fights between clans and village elders, and between the ministries and local administrations office over the management of the project. • The project may end up in the hands of the few people either through elite capture or contracts. • Lack of proper security assessment in the project locations may lead to selection of insecure areas. E.g. areas controlled by AS. • Duplication of activities i.e. health services already supported by other organizations. • Transparency in the procurement and contracting processes. • The project implementation process may be flawed because of tribalism.	• The procurement process should be conducted in a transparent manner and due diligence followed. • The ministries should remain focused to the activities set in the project. • The ministries and World Bank should have supervision role in the implementation of the project and monitor it closely. • Proper consultation with the key stakeholders, community members and local administration in order to avoid exclusion of certain groups. • Conduct proper security analysis and prior site visit before the target locations are chosen. • Conduct needs assessment in the target locations and coordinate the activities with agencies working in the sector • Contracting of employees from the local areas and improving their capacity because they understand the dynamics of the areas, we operate it. • Review security risks in the target areas. • Social risks can be minimized if all clans and communities are consulted about the project equally. • Proper plan should be in place during the construction of the health facilities. Construction material should be disposed properly. • Proper disposal mechanism for health equipment such as burning of the equipment. • Selection of proper sites for construction of health facilities (always avoid flood-prone areas). • Awareness raising conducted by experienced and respected women regarding misperceptions of vaccines • Support by the and MoH. • Adopt manageable approach.

Issue	Key Risks	Mitigation Measures
	• Exclusion of certain clans and groups within the communities especially minority clans and women in consultations and provision of health services. • Role of gate keepers in implementation they often play an intermediary role between the IDPs and the services providers.	• Community representation should be increased especially women. • Recruitment of medical professionals from local communities.
Exclusion during project implementation	• Yes. There could be exclusion of certain groups such as minority groups, IDPs and PWDs due to elite capture. • People from minority clans have little representation in the ministries and local administration, therefore they may also be excluded from receiving services provided at the health facilities and the contracts awarded. Similarly, IDPs may be excluded from receiving health services because they are regarded as external community. Issues such as child spacing and GBV services may be rejected by the communities and cause tension. • Exclusion of certain groups such as IDPs are expected especially in consultation and benefits. They are supposed to be treated as part of community but they are most often treated as an external group. IDPs are not in most cases considered to be part of the communities. • Similarly, PWDs are supposed to be part of the communities and should equally benefit from health services provided. • Dominant clans and elite groups may take over the implementation of the project. For example, the project workers may be selected from dominant clans and leave out minority clans. For example, the project workers may be recruited from dominant clans leaving out minority clans and NGOs owned and led by dominant clans may be contracted. • Yes, there will be rejection of child spacing services and GBV services by community elders, imams etc. • Dominant clans and elite group might take over the project but it depends on the NGO implementing the activities. The organization can put systems in place to avoid clan/elite capture. • Child spacing services might cause tension and rejection in some communities if proper awareness raising is not conducted.	• Proper consultation with these communities, and awareness to the communities regarding their rights to be part of the project. • Awareness raising. • Put policies in place. • Procurement of staff and services must be done in a balanced manner. • Be conscious of the IDPs and minority groups and include them in the implementation of the project. • Make the project as inclusive as possible. • Make the health facilities a disability-friendly premises. • Establish health centres in IDP populated areas/districts.
Labour-related risks	• Non-compliance of Somali labour laws are expected during the project implementation. For example, recruitment of workers may be flawed due to nepotism and elite capture.	• The WB should establish an advocacy group to counter this flawed process. • Safeguarding the Somali labour laws • Awareness raising

Issue	Key Risks	Mitigation Measures
	• Somali labour laws are not often followed in many organizations in the country and the rights of workers are abused. For example, fair recruitment may not be practiced during the implementation of the project. • Risks related to pay and working hours, GBV are expected from the project. Recruitment of project workers may be flawed - many people from dominant clans may be recruited and people from minority clans/groups excluded. • Non-Somalis in the top management of the project within the ministry of health. • Non-equal payment for project workers. Some employees are paid incentives while others are paid salaries.	• Equal payment for project workers depending on the qualifications and experience.
Security issues and conflict	• The project can be implemented in all the locations where there is presence of Somali government forces/AMISOM. • Presence of security forces may increase attention from AS, even though AS do not target health agencies. • Lesser security threats in Puntland.	• Project, regional and district Security risk assessments and management plans. • Specific security protocol for health workers may increase security threats against them. Medical workers should minimize unnecessary movements and limit their operations in AS-controlled areas.
Socio-cultural beliefs	• Some health facilities are associated to certain clans; therefore, some clans • (especially minority clans) may not feel comfortable seeking medical assistance from it. This is because these medical facilities are dominated by certain clans.	• Awareness raising. • Put policies in place to stop influence of clans in recruitment of health workers and initiate elimination of discriminatory behaviour in recruitment processes.
GM	• Grievance feedback mechanisms do exist but people are not confident of using it because they believe that their problem will not be solved. These mechanisms are not effective and transparent. • Somalis are oral society; people would prefer phone calls rather than suggestion boxes or email. It is important to provide a toll number where they would call and pass their concerns. • Due to security reasons, they do not trust anyone so it is difficult for them to complain about issues regarding a project. • In many projects, beneficiaries do use suggestion/feedback boxes provided to air their views and grievances about the project (Hirshabelle state). • People do not use suggestion boxes due to high illiteracy level. It is better for them to call and air their grievances (Puntland state).	• If a toll-free hotline number is established and the calls are managed by an external actor, the people may be comfortable conveying their grievances. Provide a toll-free phone number to the project beneficiaries. • Contract a third party to manage GM on behalf of the MoH. • Conduct forums/meetings at the community level regarding the implementation of the project.
Gender-based violence (GBV)	• Female health workers may be sexually exploited even though this is minimal. • Security may cause GBV to FHWs.	• Awareness raising about the consequences of the GBV in workplaces.

Issue	Key Risks	Mitigation Measures
	• Due to Somali culture which denounces GBV, such cases are expected to be minimal in the project locations, but it may happen in some places. • Due to the Somali culture and religious teachings, GBV is not expected.	
Occupational health and safety	• AS do not mostly target/attack health facilities. • If proper security analysis and security management planning is not conducted in target locations, the health workers may be attacked. • They can protect themselves from infectious diseases if they use PPEs.	• Security Assessments and management plans conducted for the project and target regions conducted by a certified risk management firm. Implementing partners develop district level SecMPs as part of their ESMPs.
	• Medical professionals are prone to infectious diseases and PPEs are not sufficient for them. They are at risk of contracting diseases. • Employees are likely to witness violence and injuries and death at work place. Most health workers do not have PPEs and are not able to protect themselves from infectious diseases.	• Security advisor oversees and monitors the implementation of the SMPs. • Emergency response. • Provide PPEs to the health workers including the FHWs. • Awareness raising on protection of health workers • Capacity building for health workers on protection of infectious diseases.
Stakeholder engagement	Stakeholder engagement can be conducted through meetings, community forum and bilateral meetings with elders.	• Engage various groups/segments within the community including women, community elders, religious leaders, youth, women groups and professionals through meetings and community forums. • Use media platforms such as TVs and radio especially during peak hours.
Recommendations	• Proper implementation of the project and engagement of wide range of stakeholders throughout the implementation process. • It is important to invest on the local ownership of the project and its sustainability after the funding ceases.	• Close monitoring by 3rd party and World Bank

ANNEX 2: Minutes of the Stakeholders Consultations on the E&S Instruments for the Project

Part A: Virtual consultations on February 03, 2021

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

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

Agenda

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

Participants

Name	Organization	Email
Non-state actors		
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Mohamed Hussein	NODO	
Dario	JOWHAR REGIONAL HOSPITAL Management	health.JRRH@terresolidali-som.org; Cc: nairobi@terresolidali.org;
Burhan Abdullahi Shiil	PMWDO	pmwd2000@gmail.com
Ibrahim Hassan Mohamed	MCAN	info@mcadvoc.org;
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Hassan Gedi	ARD-African	
Mandeq Abukar	Concern WW	mandeq.abukar@concern.net;
M. Salaad		

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Environmental and Social concerns raised and suggested mitigation measures

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

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

Part B: Virtual Consultations on August 22, 2023

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

Participants: representatives of disadvantaged and vulnerable groups and different NGOs working in the health sector in targeted regions of Maroodi Jeex region, Somaliland.

Agenda:

Time	Session	Lead
09:00 – 09:30	Opening Remarks/Introduction to Damal Caafimaad Project	Dr. Mohamed Herrgeye (MoHD DG)
0930 – 10:20	PPT: Environmental and Social risk stakeholders' consultation.	Dr. Mohamed Elmi
10:20 – 10:40	Tea Break	Participants
10:40 – 11:30	Discussion on social and environmental risks	Participants
11:30 – 12:00	Discussion on social and environmental mitigation measures.	Participants
12:00 – 12:20	Closing Remarks	MoHD Team

Participants: Stakeholder Engagement Session

S/N	Name	Organisation	Email
1	Dr Layla Hashi	UNFPA	lhashi@unfpa.Org
2	Mohamed Sahal Eidle	NDRA	planning.ndra@sldgov.org
3	Dr. Caroline Mwangi	FCDO	
4	Dr. Saed Abdi Ibrahim	Save the Children International	
5	Adan Qodax	PSI Somaliland,	
6	Mubarik Abdi Mohamoud	ALIGHT	mubarikm@wearealight.org
7	Abdifatah Ali Habbane		
8	Waliid Saryan	MoJ	Waliid.saryan571@gmail.com
9	Hamda Omar Yousuf	SOFHA	
10	Mohamed Abdi Hussien	MoHD	hsslead.mohd@sldgov.org
11	Ibrahim Saeed Abdi	Save the Children	
12	Wardere Hassan	ALIGHT	
14	Abdilaahi Hassan		
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16	Abdigani Abdilahi		
17	Abdulkadir Yousuf	PSI	
18	Abdilaahi A. Ahmed	NRD	
19	Adam Qodax	PSI	
20	Adan Adar		
21	Ahmed Abdi Wais		
22	Anowicka	Mercy USA	
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24	Deqa Abdi	ALIGHT	deqaa@wearealight.org,
25	Japheth ngureh	psi	
26	Kingsley chukumalu	Psi Somalia	
27	Anowicka	Health program USA	
28	Faaduma jama yuusuf	Psi Somaliland	
29	Bulaale	HPA somalia	
30	Tedeasa	Health program africa	
31	Beverly	HPA somaliland	
32	sohier	Program manager HPA	
33	Sahal cabdi naasir	Save the children Somaliland	

Minutes: Summary of the key risks raised and potential mitigation measures in the Somaliland Damal Caafimaad project.

	Key Risks	Mitigation Measures
Perception about the project and its implementation	- An issue of **conflict of interest** may arise during the hiring of the PIU team and selection of the NGO. For example, an unqualified consultant may be hired as a PIU team member or an NGO with limited experience and know-how might be selected. In turn, this causes delays to the project, which is already facing setbacks, and impacts the overall implementation. - **Duplication/overlapping** of the Damal Caafimaad with other projects. For instance, other organisations might be already supporting facilities targeted by the Damal Caafimaad project, causing duplication of health provisions/services. - **Project sustainability** and **exit strategy** must be clear; otherwise, a considerable gap will appear in the Somaliland health services. - **Poor conditions of health facilities** and the lack of instruments, such as wheelchairs, beds, and access for People with Disabilities and elderly persons, could slow down the implementation of the project. - **Lack of proper referral systems** within the health facilities. The service users need help accessing ambulances, especially in rural areas. Limited service usage may arise in the Damal Caafimaad Project, hindering the project's impact.	- MoHD should follow the WB procurement process and guidelines to ensure a fair and transparent process is followed. Also, the WB should monitor the process to ensure that due process takes place. - Coordinate with other supporting donors and health services providers to avoid overlapping with other projects. - Mapping and Strategies for Damal Caafimaad services to complement other projects. - Cost-sharing and government provision should be considered before the project exit. Additionally, The WB should consider the extension of the Damal Caafimaad. - Priorities within the Damal Caafimaad or consider other provisions to improve the condition of health facilities to enable vulnerable groups accessing to health services. - Establish well-coordinated referral system
Exclusion during project implementation	- IDPs account for 15% of the Somaliland population, and other vulnerable groups (women, children, PwDs, Mental Health and minorities, HIV, GBV, etc.) are already experiencing difficulties accessing health services. It is already perceived that	- Proper consultation with the key stakeholders should occur to avoid excluding vulnerable groups in the Damal Caafimaad.

	Key Risks	Mitigation Measures
	vulnerable groups are absent from the decision-making process (ministries and local administration), thus excluded from receiving services provided at the health facilities. Unless a thorough and well-strategised plan for inclusivity is implemented, vulnerable groups will be excluded from the Damal Caafimaad Project.	- Be mindful of the IDPs and vulnerable groups and include them in the implementation of the project. Make the project as inclusive as possible.
Labor-related risks	- **Immigration of health workers** from other regions to the project target region; thus, other regions might experience limited/shortages of health workers.	- Mobilize resources for underserved regions/communities to retain healthcare providers.
Security issues and conflict	- **Election related tensions**: The delayed Political Association and Presidential elections. Although the elections are scheduled for December 2023 (Political Association Election) and Nov 2024 (Presidential Election), there remains a political stalemate on the election sequence. - Generally, the planned elections might bring about additional insecurities relating to election frauds and results, further impacting the project region.	- Somaliland citizens are well known for resolving their differences through locally driven mediation. Currently, Somaliland elders are engaged in the mediation process. - Additionally, Somaliland Civil Society Organisations and other prominent members of society should play a part in the mediation role. - Local domestic election and international election observers, coverage should be planned and deployed to as many as possible to mitigate against elections.
Socio-cultural beliefs	- In Somaliland, the overall demand and uptake of family planning services are low due to cultural and religious misconceptions. Due to beliefs, the community may reject family planning services within the project.	- Mass media and community awareness by elders and religious leaders to limit the misconception around family planning. - Provision of integrated sexual and reproductive health services - Demand creation to increase the utilisation of family planning and including men as part of the solution.
Grievance Mechanism	- Grievance feedback mechanisms are ineffective due to the perception that the grievances raised are not resolved and needs to be more transparent.	- To improve the confidence of the end user, grievances should be dealt with in a quick turnaround.

	Key Risks	Mitigation Measures
Gender-based violence (GBV)	- The low risk of GBV is due to the cultural and religious teachings of Somaliland; nonetheless, there are risks related to GBV.	- Awareness raising on the consequences of the GBV in workplaces.
Occupational health and safety	- Medical professionals are exposed to infectious diseases. They are at risk of these contracting diseases. - Work-related risk can be caused by understaffed health facilities, which means medical staff are overworked, creating stress-related illnesses. - Lack of waste management systems and policies in the facilities.	- Protection - Training that ensures health workers have the prevention and skills to avoid such diseases. - Provide health workers with the right PPEs. - Counselling and training for health workers. - Establish proper waste management system at supported health facilities - Leverage existing waste management system
Stakeholder engagement	- Identify key stakeholders to provide continuous engagement that can be conducted through meetings, community forums, project steering committees, and ad-hoc meetings.	- Engage various groups/segments within the community, including women, community elders, religious leaders, youth, women groups and professionals through meetings and community forums.
Recommendations	- Proper implementation of the project and engagement of a wide range of stakeholders throughout the implementation process. - Investing in the local ownership of the project and its sustainability after the funding ceases is essential.	

ANNEX 3: World Bank Environmental and Social Standards

ESS1: Assessment and Management of Environmental and Social Risks and Impacts*[38]

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

ESS2: Labour and Working Conditions*

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

ESS3: Resource Efficiency and Pollution Prevention and Management*

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

ESS4: Community Health and Safety*

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

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

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

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

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

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

This Standard ensures that the development process fosters full respect for the human rights, dignity, aspirations, identity, culture, and natural resource-based livelihoods of Indigenous Peoples/SubSaharan African Historically Underserved Traditional Local Communities. ESS7 is also meant to avoid

adverse impacts of projects on Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, or when avoidance is not possible, to minimize, mitigate and/or compensate for such impacts.

ESS8: Cultural Heritage*

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

ESS9: Financial Intermediaries (FIs)

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

ESS10: Stakeholder Engagement and Information Disclosure*

[38] The asterisk sign (*) denotes that this Standard is applicable in the Somaliland health project

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

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

ANNEX 4: Indicative Environmental and Social Screening Checklist[39]

No	ITEM[40]	DETAILS				
INTRODUCTION						
1	Project Name	Improving Healthcare Services in Somaliland				
2	Project Location					
3	Sub-Project Description (brief)					
4	Does the Sub-Project require any:	*yes*	*No*	*If yes, extent in ha.*		
	Reclamation of land, wetlands					
	Clearing of grazing lands					
	Felling of trees					
5	Minimum land area required for the proposed development (ha)					
6	Available total land area within the identified location (ha)					
7	Contestation over land or ownership of the health facility					
8	Responsible contact person, contact Information					
9	Present land ownership	*State:*	*Private:*	*Other:*		
11	Total Cost of the Project					
12	Anticipated Date of Completion					
ENVIRONMENTAL IMPACT AND MITIGATION/ENHANCEMENT DURING CONSTRUCTION PERIOD (if any construction is undertaken)						
	Impacts	H[41]	M[42]	L[43]	N/A	Mitigation/Enhancement
13	Soil erosion					
14	Water pollution					
15	Indoor air pollution					
16	Hazardous waste generation					
17	Noise pollution					
18	Solid waste generation					
19	Loss of vegetation cover					
20	Habitat loss or fragmentation					
21	General disturbance to animal behavior					

[39] This form will be used in the event that major construction works are undertaken in the project

[40] This Annex (screening form) must be updated prior to use

[41] High impact (irreversible impacts)

[42] Medium impact (can be reversible with some effort)

[43] Low impact (meaning easily reversible)

22	Interference with normal movement of animals					
23	Irreversible/irreparable environmental change					
24	Presence of potential nearby receptors (inc. HCFs) + issues related to traffic during construction					
	EXISTING ENVIRONMENTAL LIABILITIES					
25	Wastewater pits					
26	Medical waste disposal					
27	Waste dumps (above or below ground)					
28	Contaminated soils					
29	Buildings with safety or access issues					
30	Buildings with potential for asbestos, lead based paint or other liabilities					
	ENVIRONMENTAL IMPACTS DURING OPERATION					
31	Increased safety and health risks, including exposure of medical personnel and waste handlers to dangerous and infectious healthcare waste					
32	Poor indoor air quality and risks of contracting communicable diseases in restricted spaces					
33	Healthcare wastes and general waste management					
34	Potable water management					
35	Increased surface runoff					
36	Community health and safety issues					

COMMUNITY ENGAGEMENT						
37	Number and nature of public consultation meetings conducted so far	Type of Meeting	Number of Meetings	Nature of Participants	Participants	
					Male	Female

CONTACT DETAILS OF OFFICIALS AND RECOMMENDATIONS		
38	Name of the person completing form	
39	Designation and contact information	

40	List of team members	
41	Signature and date	
42	Name of officer who checked and approved this form	
43	Designation and contact information	
44	Remarks	
45	Signature and Date	

ANNEX 5: Scope of an EHS Audit of Existing Healthcare Facility

1.0 INTRODUCTION

1.1 Scope of the EHS audit

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

1.2 Objectives of the audit

The objectives of the audit are to:

- review the functions of EHS systems in place in the audited healthcare facility (HCF) in Somaliland, and
- determine whether environmental health and safety measures and monitoring processes in place are in compliance with and World Bank policies and state regulations (if they are in existence). The audit will identify the potential environmental and social impacts at HCF operations levels associated with the project and then provide a determination of the efficacy of the measures that are in place to manage those impacts.

2.0 AUDIT DESCRIPTION

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

To achieve these objectives, the EHS audit will:

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

3.0 TASKS

The following tasks will be undertaken in the EHS audits:

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

ANNEX 6: Draft Terms of Reference for a Contractor ESMP for a Health Facility

Introduction and Project Description:[44]
Give a short description of the project

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

Tasks
The Contractors ESMP should cover:

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

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

Format

- Cover page
- Table of Contents
- List of Abbreviations, Acronyms and Units
- Introduction
- Project Site Description and Process
- Applicable standards: including World Banks Operational Performance Standards. Country Standards, Other funding partner standards, other international standards, if appropriate (ISO, WMO, WHO and so on) and other elements of good international practice. If there are specific international standards or practices that need to be met, these should be listed Assessment of environmental and social impacts and mitigation measures for project activities;
- Costed Plan within timing and responsibilities outlined, including:
- Regional specific Stakeholder engagement plan, inclusion plan, GBV action plan, and Labour management plan; area specific SecMPs;
- Monitoring indicators
- ESMP training requirements, if any **Timescale**

The contractor will produce the final ESMP one week after receiving consolidated comments from the World Bank, relevant Country institutions
Deliverables
Draft and Final ESMP (soft copy only)

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

ANNEX 7: Sample Grievance Registration Form45

Example of COMPLAINTS FORM (to be translated into Somali)

1. Complainant's Details

Full name or Reference number (if confidentiality requested):

_____

Male/Female

Mobile _____

Email _____

District_____

Relationship to the project

_____

Age (in years): _____

2. Which institution or officer/person are you complaining about?

Ministry/department/agency/company/group/person

_____

_____

_____

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

☐ Yes ☐ No

4. If yes, which one?

_____

_____

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

YES ☐ NO ☐

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

_____

_____

_____

7. What action would you want to be taken?

_____

_____

_____

_____

Signature _____

Date _____

_____

_____

[45] More details on registering grievances are elaborately indicated in the SEP for the Somali health project

ANNEX 8: Indicative Environmental Stewardship Framework for Contractors[46]

ENVIRONMENTAL STEWARDSHIP FOR ANY PHYSICAL INFRASTRUCTURE DEVELOPMENT FOR "IMPROVING HEALTHCARE SERVICES IN SOMALILAND" PROJECT[47]

SN	ENVIRONMENTAL ISSUE	POTENTIAL IMPACT	CODE OF CONDUCT REQUIREMENT
Pre-construction/Construction Phase			
1	Land Use	Passage of contractor's vehicles through grazing reserves or cultivated and forested land resulting in a permanent loss of the resources. The environmental effects can amplify if proper operation and maintenance schedules are not followed.	Plan and file Vehicular Traffic Movements (VTMs) so as to as much as possible avoid trekking through grazing reserves or cultivated, thus minimizing loss of resources
2	Material Use	Excess extraction of local resources, such as wood, sand, soil, boulders, etc. Degradation of forests, erosion and landslide at steep locales due to boulder, stone extraction. Change in river and stream ecosystem due to unchecked sand extraction	Extract materials only on need basis Avoid sensitive areas, such as steep slopes Follow engineer's directions at all times
3	Slope Stability	Extraction of forest products and cutting of trees in the steep slopes increases soil erosion and landslide due to loss of soil binding materials Wrong alignment can trigger slope failure Haphazard disposal of construction waste can disturb slopes Improper drainage facilities can result in erosion and landslides	Extract carefully and secure the topsoil within 25 cm from the surface Limit down grading of the infrastructure such as temporary road to 50 If down grading exceeds 70, construction of side drainage is necessary Keep optimum balance in extraction and filling of soil works, geo-hazardous assessment and mapping Use designated disposal site and avoid side-casting of spoil Provide proper drainage Use bio-engineering on exposed slopes
4	Wildlife	Wildlife habitats at forests, shrub-lands along water infrastructure corridor are	Avoid as much as possible areas with high biodiversity
		affected by the infrastructure construction activities Wildlife and human conflicts increase as wildlife might destroy the crops or attack the construction workers	Efficient movement of machinery and other traffic Control poaching activities and regulate movement of labor force and their dependents into the forest area

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

[47] This will be thoroughly reviewed and updated at project implementation.

SN	ENVIRONMENTAL ISSUE	POTENTIAL IMPACT	CODE OF CONDUCT REQUIREMENT
			District Forest or Range Office and its subsidiary body should be involved in monitoring the activities of the construction workers and officials to minimize wildlife harassing, trapping and poaching
5	Drainage	Higher flow rate of surface water and water logging induce landslides, erosion	It is strongly recommended that the crossdrainage outlets must be channeled to the confirmed natural drains If horizontal slope exceeds 5%, construction of flow control device necessary every 20 m
6	Protection of Vegetation	Protected areas and highly forested areas Degradation of forest areas Degradation of agricultural land	Use minimum and efficient use of wood products for construction Initiate plantation at damaged and damage prone areas Increase liability of local forest user groups Avoid protected areas or densely forested areas
7	Disposal of Construction Wastes	Dumping of wastes along the infrastructure such as roads or elsewhere	Selected spoil dumping sites should be used After disposal, the area should be levelled and compacted It is recommended to conserve the soil by planting indigenous plants including grasses Wastes could also be used as levelling materials along the infrastructure
8	Disposal of Sanitary Wastes	Unmanaged sanitary waste disposal creating health problems and public nuisance	Proper sanitation area needs to be demarcated Check for hygiene of work force
9	Impacts on amenities	Infrastructure such as road crossings at water supply, irrigation lines may be disturbed or damaged	Avoid as much as possible the crossing over such amenities
10	Pollution	Dust generation from construction activities, construction vehicular movement increases air pollution Noise pollution likely from construction machinery operation and vehicular movement Sanitary problems likely at the construction and workforce quarters.	Possibly construction period should be during any of the two rainy seasons when soil moisture content is highest in Somaliland (March-May or October-December) Enforce speed limit of vehicles and construct the infrastructure such as road according to volume and size of traffic movement
Operation Phase			
1	Encroachment	Unmanaged settlement, constructions near the new water points	Community zoning recommended, with enforcement
3	Pollution/Vehicle Emission	Dust generation from vehicular movement increases air pollution	Enforce speed limit of vehicles

SN	ENVIRONMENTAL ISSUE	POTENTIAL IMPACT	CODE OF CONDUCT REQUIREMENT
		Noise pollution likely from vehicular movement	Maintain traffic size movement Discourage use of horns
4	Aesthetics	Infrastructure such as water construction is likely to increase landscape scars In addition, if the construction spoils are disposed of improperly, the ground vegetation would be destroyed which will be visible from a distance	Such damage cannot be avoided but can be minimized through re-plantation of indigenous species and greenery development

ANNEX 9: Infection Control and Waste Management Plan

INTRODUCTION

1. This Infection Control and Waste Management Plan (ICWMP) has been prepared for the proposed "*Damal Caafimaad*" project.[48] It is meant to be implemented by the Somaliland in order to minimize biohazard wastes, collection, treatment, and disposal of laboratory generated wastes and control infection during the operation of the project in identified region/s.

DEFINITIONS AND SCOPE OF THE PLAN

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

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

TYPES OF WASTES FOR THE PROJECT

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

- **Infectious Waste**: Waste suspected to contain pathogens e.g. laboratory cultures, waste from isolation wards, tissues (swabs), materials, or equipment that have been in contact with tubing's, catheters, IGS toxins, live or attenuated vaccines, soiled plaster costs and other materials contaminated with blood infected patients, excreta.
- **Pathological Waste**: Human and animal tissues or fluids. e.g. body parts blood and other body fluids, foetuses, animal carcasses.
- **Sharps**: Sharp waste, e.g. needles, infusion sets, scalpels, knives, blades, broken glass that may cause puncture and cuts. This includes both used and unused sharps.
- **Pharmaceutical Waste**: Waste containing pharmaceutical e.g. pharmaceuticals that are expired or no longer needed; items contaminated by or containing pharmaceuticals (bottles, boxes).
- **Genotoxic Waste**: Waste containing substances with genotoxic properties. e.g. waste containing cytostatic drug (often used in cancer therapy), genotoxic chemicals.

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

- **Chemical Waste**: Waste containing chemical substances e.g. laboratory reagents; film developer, disinfectants, (disinfectants) that are expired or no longer needed solvents
- **Waste with High Content of Heavy Metals**: Batteries, broken thermometers, blood-pressures gauges, etc.
- **Pressurized Containers**: Gas cylinders, gas cartridges, aerosol cans.
- **Radioactive Waste**: Waste containing radioactive substances e.g. unused liquids from radiotherapy or laboratory research, contaminated glassware, packages, or absorbent paper, urine and excreta from patients treated or tested with unsealed radionuclides, sealed sources.
- **General Solid Waste**: Waste generated from offices, kitchens, packaging material from stores.
- **Microorganisms**: Any biological entity, cellular or non-cellular capable of replication or of transferring genetic material.

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

MANAGEMENT RULES FOR WASTES

Table A9-1: Bio-medical Waste Management Rules

Category	Waste Category	Treatment and disposal
1	Human Anatomical Waste (human tissues, organs, body parts)	Incineration / deep burial, placenta pits will consider local beliefs and customs
2	Animal Waste (animal tissues, organs, body parts carcasses, bleeding parts, fluid, blood and experimental animals used in research, waste generated by veterinary hospitals colleges, discharge from hospitals, animal houses)	Incineration / deep burial
3	Microbiology & Biotechnology Waste (wastes from laboratory cultures, stocks or specimens of micro-organisms live or attenuated vaccines, human and animal cell culture used in research and infectious agents from research and industrial laboratories, wastes from production of biological, toxins, dishes and devices used for transfer of cultures)	Local autoclaving / microwaving /incineration
4	Waste sharps (needles, syringes, scalpels, blades, glass, etc. that may cause puncture and cuts. This includes both used and unused sharps)	Disinfection (chemical treatment/autoclaving/microwaving and mutilation/shredding)
5	Discarded Medicines and Cytotoxic drugs (wastes comprising of outdated, contaminated and discarded medicines)	Incineration, destruction and drugs disposal in secured landfills
6	Solid Waste (Items contaminated with blood, and body fluids including cotton, dressings, soiled plaster casts, lines, beddings, other material contaminated with blood)	Incineration /autoclaving /microwaving
7	Solid Waste (wastes generated from disposable items other than the waste sharps such as tubing, catheters, intravenous sets etc.).	Disinfection by chemical treatment /autoclaving /microwaving and mutilation shredding

Category	Waste Category	Treatment and disposal
8	Liquid Waste (waste generated from laboratory and washing, cleaning, housekeeping and disinfecting activities)	Disinfection by chemical treatment and discharge into drains
9	Incineration Ash (ash from incineration of any bio-medical waste)	Disposal in municipal landfill
10	Chemical Waste (chemicals used in production of biological, chemicals used in disinfection, as insecticides, etc.)	Chemical treatment and discharge into drains for liquids and secured landfill for solids

MEDICAL WASTE MANAGEMENT PLAN

Table A9-2: Protocol for minimization, reuse, recycling, segregation, transport, and storage

<table>
<tr><th>Component</th><th>Actions recommended</th></tr>
<tr><td>Waste minimization, reuse, and recycling</td><td>Consider practices and procedures to minimize waste generation without sacrificing patient hygiene and safety considerations
Use of efficient stock management practices and monitoring, e.g.,
• For chemical and pharmaceutical stocks; Small/frequent orders for products that spoil quickly and strict monitoring of expiry dates
• Complete use of old product before new stock is used
• Maximization of safe equipment reuse practices, including: reuse of equipment following sterilization and disinfection (e.g., sharps containers)</td></tr>
<tr><td>Waste segregation</td><td>Waste should be identified and segregated at the point of generation.
• Non-hazardous waste, such as paper and cardboard, glass, aluminium and plastic, should be collected separately and recycled
• Food waste should be segregated for composting
• Infectious and/or hazardous wastes should be identified and segregated according to its category using a colour-coded system
• Colour code for Biomedical adopted from the WHO colour code (see below a nested table)
<table>
<tr><th>Color coding</th><th>Waste category</th><th>Treatment option</th></tr>
<tr><td>Yellow</td><td>Plastic bag Cat. 1, Cat. 2, and Cat. 3, Cat. 6.</td><td>Incineration/deep burial</td></tr>
<tr><td>Red</td><td>Disinfected container/plastic bag Cat. 3, Cat. 6, Cat.7</td><td>Autoclaving/Microwaving/Chemical Treatment</td></tr>
<tr><td>Blue / White Translucent</td><td>Plastic bag/puncture proof Cat. 4, Cat. 7. Container</td><td>Autoclaving/Microwaving/Chemical Treatment and Destruction/shredding</td></tr>
<tr><td>Black</td><td>Plastic bag Cat. 5 and Cat. 9 and Cat. 10. (solid)</td><td>Disposal in secured landfill</td></tr>
</table>
Other segregation considerations include the following:
• Avoid mixing general healthcare waste with hazardous healthcare waste to reduce disposal cost
• Segregate waste containing mercury for special disposal
• Aerosol cans and other gas containers should be segregated to avoid disposal via incineration and related explosion hazard
• Segregate healthcare products containing Polyvinyl chloride to avoid disposal via incineration and subsequent harmful air emissions</td></tr>
<tr><td>On-site handling, collection, transport and storage</td><td>• Seal and replace waste bags and containers when they are approximately three quarters full
• Full bags and containers should be replaced immediately
• Identify and label waste bags and containers properly prior to removal
• Transport waste to storage areas on designated trolleys / carts, which should be cleaned and disinfected regularly</td></tr>
</table>

Component	Actions recommended

	• Waste storage areas should be located within the facility and sized to the quantities of waste generated, with the following design considerations:
	  • Hard, impermeable floor with drainage, and designed for cleaning / disinfection with available water supply;
	  • Secured by locks with restricted access;
	  • Designed for access and regular cleaning by authorized cleaning staff and vehicles;
	  • Protected from sun, and inaccessible to animals / rodents;
	  • Equipped with appropriate lighting and ventilation;
	  • Segregated from food supplies and preparation areas;
	  • Equipped with supplies of protective clothing, and spare bags/containers
	• Store mercury separately in sealed and impermeable containers in a secure location
	• Store cytotoxic waste separately from other waste in a secure location
	• Store radioactive waste in containers to limit dispersion, and secure behind lead shields

Transport to external facilities for treatment	• Many of the health centres in Somaliland which will be supported by the project likely do not have onsite waste treatment facilities at the moment
	• Therefore, during operation, solid waste segregation, collection, and storage shall be the responsibility of the health facilities, whereas waste transportation to treatment facility and treatment shall be the work of a contracted biomedical waste handler
	• Therefore, the MoHD or its agent (such as the PIU) shall:
	  ○ Appoint a waste handler who is licensed by the local authorities and permitted by the local government to handle, transport and treat biomedical wastes at approved treatment sites using recommended treatment procedures given by the legal framework and respective government agencies
	  ○ The contractor shall transport waste destined for off-site treatment facilities according to the guidelines for transport of hazardous wastes biomedical wastes in international covenants to which Somaliland is a signatory
	  ○ Packaging for infectious waste should include an inner, watertight layer of metal or plastic with a leak-proof seal
	  ○ Outer packaging should be of adequate strength and capacity for the specific type and volume of waste
	  ○ Packaging containers for sharps should be puncture-proof
	  ○ Waste should be labelled appropriately, noting the substance class, packaging symbol (e.g., infectious waste, radioactive waste), waste category, mass/volume being carried, place of origin within health facility, and final destination
	  ○ Transport vehicles should be dedicated to waste and the vehicle compartments carrying waste sealed

INFECTION CONTROL

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

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

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

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

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

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

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

CAPACITY BUILDING AND AWARENESS

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

12. The following steps should be followed for implementing training:

- Conduct baseline assessment of training needs for HCS involved in the implementation of the project.
- Develop a Training Plan based upon existing capacity and training needs.
- At the outset, this plan should distinguish between trainers and non-trainers and elaborate the criteria for identifying trainers and their requirement for training.
- Training should be provided to all HCS, including doctors, nurses, ward boys, paramedics, laboratory technicians, and any housekeeping staff.

13. Training should be imparted through:

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

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

- Training on general aspects of infection control and waste management
- Training on OHS and environmental health and safety guidelines, as outlined in the World Bank's manual[49]
- Training on biosafety and biosecurity
- Training on emergency preparedness and response
- Training on handling pathogenic and potentially lethal agents
- Training on the use of MSDs[74], 'safe-work' practices, and appropriate PPE

15. The Train the Trainer program will have to be undertaken at government level. Training should be provided on an annual basis, with refresher courses annually or biannually. In addition to classroom type training, IEC material and awareness-creating activities also need to be employed for training the HCS. Training should preferably be provided on site.

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

REPORTING, MONITORING, EVALUATION AND WASTE TRACKING

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

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

19. The monthly report from contracted NGOs (or other appointed service providers) maintaining the health centres should directly be sent to the PIU.

20. **Periodic implementation review.** Periodic implementation review of the ICWMP should be undertaken, and as far as possible, this review should be inbuilt into the regular review process of the MoHD. This review should focus on consolidated information and reporting from individual health facility level. To

[49] Further information available at Environmental, Health, and Safety Guidelines' World Bank URL - http://documents1.worldbank.org/curated/zh/157871484635724258/pdf/112110-WP-Final-General-EHS-Guidelines.pdf [74] Material Safety Data Sheets

facilitate regular and sustained monitoring, each NGO running the health center should develop annual Action Plans specifically for IC and WM, which should be included into the MoHD plan of work performance assessment.

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

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

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

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

F9. IMPLEMENTATION OF ALL COMPONENTS OF THE IC-WM PLAN

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

EXTERNAL IMPLEMENTATION AUDITS

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

ANNEX 10: Inclusion Plan

INTRODUCTION

1. The project will give special consideration to disadvantaged groups, which include: minority castes and groups;[50] IDPs; people who live in remote rural areas or areas characterized by violence that are bereft of social services and amenities; nomadic pastoralist communities; PWDs; and female headed households including vulnerable orphans and unaccompanied minors.

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

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

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

ENGAGING DISADVANTAGED AND VULNERABLE GROUPS

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

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

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

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

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

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

a. Understand the operational structures in the respective communities;

b. Seek input/feedback to avoid or minimize the potential adverse impacts associated with the planned interventions; and

c. Identify culturally appropriate impact mitigation measures.

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

10. The implementing entity will:

a) Facilitate broad participation of disadvantaged and vulnerable individuals and groups with adequate gender and generational representation, community elders/leaders, religious leaders, and CBOs;

b) Provide the disadvantaged and vulnerable individuals and groups with all relevant information about the project including on potential adverse impacts;

c) Ensure communication methods are appropriate given the low level of literacy, local dialects and communication challenges for PWDs;

d) Organize and conduct the consultations in forms that ensure free expression of their views and preferences;

e) Document details of all consultation meetings with disadvantaged and vulnerable individuals and groups on their perceptions of project activities and the associated impacts, especially the adverse ones;

f) Share any input/feedback offered by the target populations; and

g) Provide an account of the conditions agreed with the people consulted.

11. Once the disadvantaged and vulnerable individuals and groups are identified in the project area, the provisions in this Inclusion Plan will ensure mitigation measures of any adverse impacts of the project are implemented in a timely manner. The project should ensure benefits to the disadvantaged and vulnerable by

ascertaining that they are consulted, have accessible and trusted GM to channel the complaints they might have on the project.

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

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

a) Provision of an effective mechanism for monitoring implementation of the Inclusion Plan by the PIU, the social safeguard and contracted NGOs;

b) Involve suitably experienced CBOs/NGOs to address the disadvantaged and vulnerable groups through developing and implementing targeted action plans that are issue focused (e.g. on access to health services for women in remote areas);

c) Ensuring appropriate budgetary allocation of resources for the contractors' Inclusion Plans as part of the contractors' ESMPs; and

d) Provision of technical assistance for sustaining the activities addressing the needs of the disadvantaged and vulnerable individuals and groups.

ANNEX 11: GBV Action Plan

INTRODUCTION

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

2. The MoHD will implement the proposed project. The MoHD will provide overall health sector stewardship, including regulatory oversight and monitoring of service delivery implementation. Besides, the MoHD will manage service delivery contracts for Maroodi Jeex region. Additionally MoHD will monitor and supervise contract implementation, managing relevant safeguard instruments with oversight from the MoHD.

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

DEFINITION OF TERMS

4. 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.

5. 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.

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

WHY SHOULD THE HEALTH SECTOR ADDRESS GBV?

7. Gender-based violence has adverse consequences on women's sexual and reproductive health. The experience of gender-based violence has also been linked to increased risk of gynaecological disorders[51],

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

unsafe abortion, pregnancy complications,[52] miscarriage, low birth weight,[53] and pelvic inflammatory disease. Abuse, primarily physical and sexual violence, can limit a woman's ability to negotiate on the use of contraception, putting them at a higher risk for unintended pregnancies and sexually transmitted infections (STIs), including HIV. Childhood sexual abuse has been associated with risky behaviours such as drug and alcohol use, more sexual partners and lower contraceptive use.[54]

8. Gender-based violence has been identified as a significant cause of disability and death among women. Epidemiological evidence indicates that among women of reproductive age, intimate partner violence alone is a major cause of disability and mortality throughout the world.[55] Gender-based violence has profound, negative consequences for women's physical and emotional health, ranging from emotional distress, bodily injury, and chronic pain to deadly outcomes such as suicide and homicide. It is a risk factor for many physical, mental, and sexual health problems.

9. Healthcare workers and in particular female health workers may face GBV risks, especially those working in more remote areas with little supervision. At the same time, healthcare workers may put women at risk if they are uninformed or unprepared. Health professionals who breach patient confidentiality, respond poorly to the disclosure of violence, blame victims, or fail to offer support where needed can put women's safety, well-being, and their lives at risk.[56] For instance, providers can cause further harm by:

a. Expressing negative attitudes to women who are survivors of physical or sexual abuse, such as rape;

b. Discussing woman's injuries in a consultation room which can be overheard by a potentially violent spouse standing outside;

c. Breach confidentially by sharing information about pregnancy, abortion, STIs, HIV, or sexual abuse with another family member without the woman's consent; and

d. Providing inappropriate medical support by missing out on the reasons behind a repetitive, sexually transmitted infection.

COUNTRY CONTEXTUAL RISKS

10. Gender-based violence (GBV) affects 1 in 3 women in their lifetime. Most recent global estimates suggest that 35% of women worldwide have experienced physical and sexual intimate partner violence (IPV) or non-partner violence. Over 200 million girls and women are estimated to have undergone Female Genital Mutilation[57].

11. Available evidence indicates GBV is common in the lives of women and girls across the life course in Somaliland, with some forms of GBV endemic. FGM/C has in the past been near universally practiced. Intimate partner violence and sexual violence, the most prevalent types of GBV globally, are commonplace in Somali women and girls' lives. Some forms of GBV are normative in Somaliland, including FGM/C, child marriage and some intimate partner violence behaviours. Other normative forms of GBV in Somaliland include cultural

[52] Heise L, Ellsberg M, Gottemoeller M. "Ending Violence Against Women." Population Reports, Volume XXVII, Number 4, Series L, Number 11, 1999.
[53] Murphy C et al. "Abuse: a risk factor for low birth weight? A systemic review and meta-analysis." Canadian Medical Association Journal, 164(11):1567-1572, 2001.
[54] Walker et al. "Adult health status of women HMO members with histories of childhood abuse and neglect." American Journal of Medicine, 107.4: 332-339, 1999.
[55] Krug E et al, eds. World Report on Violence and Health. Geneva: World Health Organization, 2002.
[56] Bott S et al. "Improving the health sector responses to Gender Based Violence." Resource manual for healthcare professionals in developing countries.
[57] International Alert/CISP (2015) The Complexity of Sexual and Gender-Based Violence: Insights from Mogadishu and South Central Somaliland, International Alert, Nairobi.

practices of abduction and forced marriage and widow inheritance[58]. The extent to which each type of GBV is practiced and normative varies across regions of the country, and there are indications of apparent shifts in beliefs and attitudes that support FGM/C, child marriage and intimate partner violence within Somaliland.

12. Sexual violence, along with other violence, is said to have become normalized in Somaliland. This apparent normalization appears to be the result of sustained exposure to elevated levels of sexual violence over past decades compounded by the lack of national and community-level communication, discussion and dialogue about sexual violence and other forms of GBV[59]. This combination of high levels of exposure ad low levels of public and private discourse have created an environment which not only enables violence against women and girls to continue, but also curbs national and community-level awareness, commitment and action to do something about it.

13. A growing body of epidemiological evidence demonstrates that gender-based violence can cause or contribute to a host of health problems among women. These range from the immediate health effects of physical and sexual violence, including injury and infection, to long-term health impacts of substance use, depression or anxiety, poor pregnancy outcomes such as low birth weight) and increased rates of abortion among survivors of violence[60].

14. Evidence indicates that health service delivery for sexual assault survivors is inadequate in Somaliland. There is a lack of a trained medical workforce, inadequate infrastructure and supply of essential post-rape care equipment and drugs. For example, a study of 779 health centres across Somaliland revealed that only 25 percent had the necessary drugs to treat sexually transmitted infections and fewer than 18 percent had the capacity to provide counselling and testing for HIV[61].

15. 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.[70] 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.[71] Anecdotal evidence from humanitarian and development agencies indicate that sexual exploitation and abuse is a largely unreported and significant problem in the country.

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

IDENTIFIED PROJECT-RELATED GBV RISKS

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

a. Potential abuse of power and sexual exploitation in labour practices: The recruitment process can distort power relations and lead to opportunities for abuse. Hiring and employment practices that seek to increase the number of women can also expose them to incidents of sexual exploitation, harassment, or violence. Additionally, unequal gender norms and harmful beliefs run the risk of creating hostile environments for female workers. In cases where

[58] Norwegian Country of Origin Information Centre (2018) Somaliland: Marriage and divorce, Landinfo, Oslo.

[59] International Alert/CISP (2015).

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

[61] GBV Sub-Cluster Strategy 2018-2020.

female workers have less time for traditional gender-related work such as childcare, this can also lead to a potential increase in IPV.

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

c. Limited or incomplete training of personnel, as well as a lack of competent survivor-centred primary, secondary and tertiary services can increase risk of harm. Other risks include violence or death for survivors of GBV, women, girls and other groups (such as people with disabilities and people of minority ethnic/tribal groups). Survivors of GBV who choose to seek services and disclosure their experience be it in a primary healthcare setting, to FHWs or at designated clinical management of rape services may experience more violence and harm by providers or health personnel who do not observe survivor-centred principles – namely safety, confidentiality, non-discrimination, and informed consent – or who do not abide by safe and ethical operating procedures for referrals to specialized services.

d. **Lack of appropriate rooms for private consultation and examination to ensure the privacy and safety of survivors seeking care can break confidentiality or breaks in considerations for a survivor's safety and choices** could lead to a slew of consequences including retaliation by perpetrator(s), intimate partners or family members, social isolation, targeted physical attack and death.

e. **The inability to recognize or respond appropriately to the signs of trauma from survivors** can lead first responders such as FHWs to inadvertently exacerbate stigma, trauma, and/or survivors' ability to access safe appropriate services.

f. Limited or lack of essential supplies and drugs of treatment of infections and management of rape could put the survivors at further risks. Survivors of violence who seek services at the health facilities where there are no drugs and limited referral services could further harm their health and physical safety.

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

EXISTING RISK MANAGEMENT SYSTEMS/GAPS

18. *Regulations and Policies:* The health workforce deployment and procedures developed in 2019 to help the Ministry of Health Development 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 Somaliland.

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

20. The code of conduct for the Government of Somaliland sets the values, standards of behaviour and rights and responsibilities of all staff. The Code of Ethics has been developed to set out the framework within which all civil servants will work and the core values and standards of `behaviour they are expected to uphold.

It is clear that the CoC developed emphasizes on supporting a positive working environment by observing the civil service policy on harassment, sexual harassment and bullying. There is a need for staff capacity development to include regular orientation to understand better the ethical requirements related to their work and operations. The development of simplified information, education, and communication materials translated in different Somali dialects can be facilitated to enhance the uptake of the COC content in all the project locations.

THE CLINICAL MANAGEMENT OF RAPE PROTOCOL

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

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

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

h. GBV requirements and expectations included in the procurement process, including essential supplies and drugs for health and nutrition and the signing of the Code of Conduct by all the project staff to cultivate an environment free from GBV and SEAH.

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

j. Utilizing the GM developed and being implemented under the RCRF project with a separate channel to manage GBV-related complaints integrated into the GM to enable reporting in a safe, confidential survivor-centric manner.

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

Table A11-1: GBV ACTION PLAN

#	Objective:	To reduce the risks of GBV/SEAH and enhance health response services for GBV survivors					
	Activity to Address GBV/ SEAH risk	**Steps to be taken**	**Timelines**	**Institutional Focal Point**	**Collaborating actors/relevant ministries**	**Output indicators**	**Estimated Budgets (USD) 2021-2025**
1.	Define and reinforce GBV/SEAH requirements in procurement processes and contracts						
a)	Incorporate GBV/SEAH/Requirements and expectations in the any standard bidding documents, as well as contractor and consultants' contracts (see annex 12 for sample contract for contractors).	Ensure that GBV/SEAH issues are incorporated in all bidding documents and contracts signed by contractors and consultants	Before project activities begin.	MOHD	MOHD	GBV/SEAH standards in procurement/contract document	N/A
b)	Codes of Conduct signed and understood by project management team, consultants, CSOs/NGOs service providers and private sector network	Define the requirements to be included in the CoC which addresses GBV/SEAH Review CoC for provisions/clauses that guard against GBV/SEAH Have CoCs signed by all staffs Train all project-related staff on the behavior obligations under the CoCs. Display CoC in project sites and translated into the local language(s)	Before project activities begin	MOHD	MOHD	Percentage of workers that have signed a CoC (target 100 percent)	The training of the staff on CoC will be conducted by the GBV specialist with support from WB
2.	Review the IA's capacity to prevent and respond to GBV/SEAH;						

#	Objective:	To reduce the risks of GBV/SEAH and enhance health response services for GBV survivors					
	Activity to Address GBV/ SEAH risk	**Steps to be taken**	**Timelines**	**Institutional Focal Point**	**Collaborating actors/relevant ministries**	**Output indicators**	**Estimated Budgets (USD) 2021-2025**
a)	Recruit GBV specialist to support the project and supervise the implementation of the GBV action plan	Recruitment of GBV specialist	Within the first 3 months of project effectiveness	MOHD	MOHD	Qualified and competent GBV staffs recruited	120,000
b)	Develop and train frontline health workers & other non-clinical staff including security guards, receptionist on GBV basic concepts including on referral pathway, Psychological first aid etc.	Develop a training plan Develop training materials/ content using global/national standards, human rights and survivor centred approaches Conduct training for project staff	Within the first 3 months of project effectiveness Retraining during project implementation.	MOHD	MOHD,PIU (Project Implementation Unit)	Number of trainings conducted for project staff Number of health staff and frontline workers who have received orientation on the GBV referral pathway and are able to refer survivors to appropriate care.	319,500
c)	Develop M&E programme	Develop a comprehensive M&E plan to monitor GBV action plan implementation Promotion of high-level commitment on monitoring the implementation of GBV Action Plan in order to support efforts to provide multi-sectoral support to GBV survivors. Monitor GBV action plan	Maintained throughout Project implementation.	GBV/SEAH Specialist-MOHD	MOHD	M&E framework in place .	N/A
3.	Inform project stakeholders about GBV/SEAH risks						
a)	Establish partnerships with key stakeholders	Identify and officially inform the stakeholders on the components of	Within the first 3 months of project effectiveness	MOHD	MOHD	Number and types of stakeholders engaged	N/A

#	Objective:	To reduce the risks of GBV/SEAH and enhance health response services for GBV survivors					
	Activity to Address GBV/ SEAH risk	**Steps to be taken**	**Timelines**	**Institutional Focal Point**	**Collaborating actors/relevant ministries**	**Output indicators**	**Estimated Budgets (USD) 2021-2025**
		the projects and project-related risks of GBV/SEAH Develop interview/ facilitation guides Conduct stakeholder meetings/ Conduct regular SEAH safety audits Prepare field visit reports	Maintained throughout Project implementation.				
b)	Identify, train and establish GBV Focal points in each health facility and community (Female health workers)	Establish trained, dedicated and committed GBV focal points in each health facility with clear responsibilities related to the care of survivors (e.g., clinical care (CMR), mental health and psychosocial support and referral etc.) Identify and train-where feasible-female doctors and nurses to provide support for survivors of GBV since most survivors are women and have female health practitioners may facilitate disclosure and access to appropriate care.	Within the first 3 months of project effectiveness Maintained throughout Project implementation.	MOHD	MOHD	Number of GBV focal points identified and trained	Cost covered under the training of health personnel)

#	Objective:	To reduce the risks of GBV/SEAH and enhance health response services for GBV survivors					
	Activity to Address GBV/ SEAH risk	**Steps to be taken**	**Timelines**	**Institutional Focal Point**	**Collaborating actors/relevant ministries**	**Output indicators**	**Estimated Budgets (USD) 2021-2025**
c)	Develop relevant IEC materials for community engagements within the community and in the health facilities and nutrition centres	Develop relevant GBV IEC materials that targets everyone without discrimination and are easy to comprehend. IEC materials to include information on GBV response services (such as hotline and where to get help). Print out medical charts with pictogram and information on how to better access services Integrate GBV issues into IYCF and mobilization sessions Develop GBV /SEAH information guide integrated into the health materials for female health workers outreach teams	Within the first 6 months of project effectiveness Maintained throughout Project implementation.	MOHD	MOHD	Number and type of GBV/SEAH IEC material developed	30,000
4.	Mapping of service delivery for GBV/SEAH prevention and response						
a)	Develop and or/update a multisectoral GBV/SEAH referral pathway(s)	On the basis of mapped GBV/SEAH prevention and response service providers, develop/update a GBV/SEAH referral list of preferred service providers. Identify key gaps where remedial measures may be required (e.g.,	Within the first 3 months of project effectiveness Maintained throughout Project implementation.	MOHD	MOHD	Referral pathway developed/updated Number/type of GBV/SEAH preventive and response services available.	N/A

#	Objective:	To reduce the risks of GBV/SEAH and enhance health response services for GBV survivors					
	Activity to Address GBV/ SEAH risk	**Steps to be taken**	**Timelines**	**Institutional Focal Point**	**Collaborating actors/relevant ministries**	**Output indicators**	**Estimated Budgets (USD) 2021-2025**
		training staff on psychosocial first aid) Disseminate the referral pathway/list to stakeholders including other service providers such as legal, psychosocial etc.					
b)	Conduct CMR capacity assessment in key health facilities	Using the existing CMR protocol conduct regular audits through CMR checklist to identify gaps Identify gaps and remedial action on the provision of post rape treatment kits-this will facilitate effective response for the GBV survivors who come to these health centers. Ensure steady supplies of CMR in all key health facilities with CMR capacity	Within the first 3 months of project effectiveness Maintained throughout Project implementation.	MOHD	MOHD, GBV specialist/Consultant CSOs/NGOs service providers and private sector network	Number of sites with health facilities that can provide CMR services Number of health facility with the post rape treatment kits	60,000
5.	GBV/SEAH sensitive channels for reporting in GM						
a)	Review GM for specific GBV/SEAH procedures	Building from the RCRF project, regular update reporting pathways that include support systems and accountability mechanisms including how to handle SEAH allegations properly Evaluate the effectiveness of the anonymous and confidential	Within the first 3 months of project effectiveness	MOHD	MOHD	GM with GBV/SEAH procedure integrated In the GM	N/A

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

ANNEX 12: TOR for SOCIAL/GBV SPECIALISTS

Background

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

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

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

Scope of Work

Reporting to the Project Manager at the PMT at the state Ministry of Health, the Social and GBV

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

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

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

Duration of assignment

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

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

Reporting

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

Qualifications and Experience

The Social and GBV Specialist will possess the following qualifications:

- A degree in sociology, anthropology or community development, or gender;

- 5 years' community development experience in Somaliland, preferably in different regions of including promoting gender and vulnerable and marginalised groups inclusion, conflict mitigation, labour management, participatory approaches and feedback mechanisms;
- Excellent English and Somali written and verbal skills;
- Excellent understanding and commitment to social inclusion, conflict mitigation, labour management, gender and GBV, stakeholder engagement and participatory development;
- Familiarity with the World Bank's Environmental and social framework and commitment and passion to develop skills in social risk management;
- Strong interpersonal skills and the capacity to apply a survivor-centered approach to support, guide, listen, assess, plan and follow up on services and survivor support;
- Operational experience at country/regional level in the implementation of programming related to violence against women and children, sexual exploitation and abuse, GBV, gender, and child protection; and
- Experience in delivering gender-sensitization trainings to a wide range of audience including in challenging environments.

ANNEX 13: TOR for GBV Specialist

Background

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

A GBV action plan has been prepared and a GBV advisor is needed to ensure its implementation.

Scope of Work

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

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

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

- Support implementation of community awareness raising activities that include the risk of SEA related to the project, the code of conduct for workers, the GM and the ways in which the community members can safely report concerns; and
- Other key tasks related to GBV risk identification and management that may arise during the assignment.

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

Duration of assignment

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

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

Reporting

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

Qualification and Experience

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

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

ANNEX 14: TOR of Senior Social Specialist

Background

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

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

Scope of Work

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

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

The senior social safeguards specialist will be responsible for ensuring inclusive and genuine stakeholder engagement and a project wide GM that is accessible to all communities, workers and stakeholders and ensure synergy with the component on citizen engagement and feedback. They will provide leadership on

social risk management and identify synergies and promote coordination across government partners and other agencies.

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

Deliverables

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

Reporting

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

Qualifications and Experience

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

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

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

ANNEX 15: Terms of Reference for a Contractor's Environmental and Social Assessment and Management Plan (ESMP)

Introduction and Project Description:[62]
Give a short description of the project

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

Tasks
The Contractors ESMP should cover:

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

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

Format

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

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

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

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

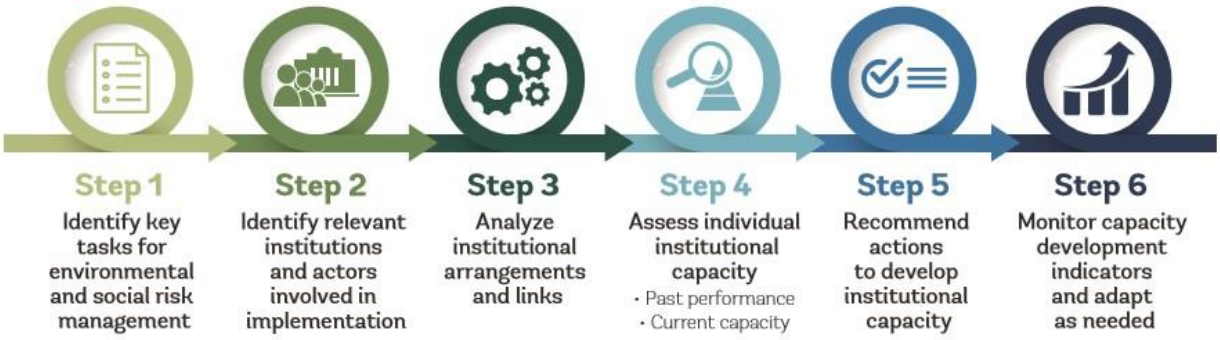
Deliverables

Draft and Final ESMP (soft copy only)

ANNEX 16: Draft TOR for E&S Capacity Assessment

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

Figure A16-1. Six steps for project-level capacity assessment



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

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

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

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

Table A16-1. Example of a matrix for analyzing the roles of institutions and actors for project-level tasks

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

X indicates a role in implementation of the task

Step 3 assesses the overall governance structure for a project—the institutions involved and the nature of the operational links among them. The analysis at this stage identifies potential issues that could undermine project implementation and provides recommendations for improving the project's institutional governance structure. This step of the assessment focuses on: (i) clarifying the respective mandated roles and accountabilities of the institutions identified in Step 2; (ii) identifying any gaps, areas of overlap, excessive fragmentation of responsibilities, potential redundancies or conflicts, etc., as indicated in Box 3; and (iii) evaluating the effectiveness of necessary lines of communication and coordination mechanisms among the institutions.[86]

Box 3. Key questions to assess institutional roles and responsibilities *Is there a clear governance structure for this task?*

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

Step 4 divides the assessment of individual institutions' capacity to carry out their specific E&S risk management tasks into two parts: (1) assessment of past performance and (2) assessment of current capacity considering future responsibilities. Some aspects of an institution's capacity—such as level of commitment to implement its policies, effectiveness of institutional and individual incentives, and ability to adapt to changing circumstances—can only be meaningfully evaluated based on its track record in similar situations. Newer institutions will not have a track record by which to demonstrate this capacity, so the assessment must rely on evaluating the current established systems and available resources.

Step 4.1: Assess past performance of contractors

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

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

Box 4. Questions to assess whether an institution is able and committed to implement its E&S risk management tasks *Can you provide documentation and other evidence that this institution …?*

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

Step 4.2: Assess current capacity of institution

The assessment considers four elements of institutional capacity that are relevant for E&S risk management: external enabling environment; organizational arrangements; human resources; and budget, equipment, and means. The list in Table 4 recognizes that some factors affecting institutional performance may be external to the institution itself (enabling environment), and that the systems for managing human, financial, and material resources can be as important as the scale and availability of the resources themselves.

Table A16-2. Elements and sub-elements of individual institutional capacity

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

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

Step 5 uses the previous analytical steps to identify specific needs and actions for capacity development that may be required to enable individual institutions (and the project's institutional structure as a whole) to fulfil their roles. Formulate recommendations as concrete operational actions. Include the actions in the ESMP with specific capacity development measures and related responsibilities, outcomes, budgets, timelines, and indicators that are necessary for successful implementation. These measures should be referenced where relevant in the ESCP, with indicators for monitoring progress and adaptive management.

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

Typical tasks for project-level E&S risk management [63]

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

ESS 1 Environmental and Social Assessments

Task	Specific responsibilities
Assess, manage and monitor the environmental and social risks and impacts of the project throughout the project life cycle	Conducts environmental and social assessments considering elements of international good practice, including: - In-line with mitigation hierarchy - proportionality, - comprehensive approach (social and environment); - alternatives assessment; - consider direct, indirect, and cumulative impacts; - consultations and disclosure of information - monitoring and reporting
	Assess the environmental and social risks and impacts of the project throughout the project life cycle
	Understands and can apply EHSGs of the WBG
Environmental and social assessment	Considers social risks in a comprehensive manner and in accordance with elements of ESS 1
	Proposes and implements differentiated measures so that adverse impacts do not fall disproportionately on the disadvantaged or vulnerable, and they are not disadvantaged in sharing any development benefits and opportunities resulting from the project
	Can identify and assess the potential environmental and social risks and impacts of Associated Facilities
	As appropriate, recruit and hire independent experts for high risk projects
	Considers risk and impacts associated with the primary suppliers
	Consider potentially significant project-related transboundary and global risks and impacts
Environmental and Social Commitment Plan (ESCP)	Implements the measures and actions identified in the ESCP in accordance with the timeframes specified, and can review the status of implementation of the ESCP as part of its monitoring and reporting
	Can carry out, as appropriate, additional assessments and stakeholder engagement in accordance with the ESSs, and propose changes, for approval by the Bank, to the ESCP where project context or activities change
Project monitoring and reporting	Monitors the environmental and social performance of the project in accordance with the legal agreement (including the ESCP)
	Engages stakeholders and third parties, such as independent experts, local communities or NGOs, to complement or verify its own monitoring activities
	Provide regular reports as set out in the ESCP to the Bank of the results of the monitoring
	Identify any necessary corrective and preventive actions, and will incorporate these in an amended ESCP or the relevant management tool
Stakeholder engagement and information disclosure	Engage with, and provide sufficient information to stakeholders throughout the life cycle of the project, in a manner appropriate to the nature of their interests and the potential environmental and social risks and impacts of the project
	Provide information on risks and impacts associated with project changes and consult with projectaffected parties as to how these risks and impacts will be mitigated

Management of contractors	Assesses the environmental and social risks and impacts associated with project contractors
	Ascertain that contractors engaged under the project are legitimate and reliable enterprises, and have knowledge and skills to perform their project tasks in accordance with their contractual commitments
	Incorporate all relevant aspects of the ESCP into tender documents
	Ensure contractors apply the relevant aspects of the ESCP and the relevant management tools, and including appropriate and effective non-compliance remedies
	Monitor contractor compliance with their contractual commitments
	Require contractors to have equivalent arrangements with their sub-contractors

ESS 2 Labour and Working Conditions

Task	Specific responsibilities
Labour management	Develop written labor management codes, adopt facility or industry labor standards and practices and disseminate to project workers
	Implementation of terms and conditions of labor for eligible workers in line with ESS 2 requirements
	Ensure decisions on hiring and promotion are non-discriminatory
	Monitor, supervise and assess compliance with labor codes
Protecting the workforce	Establish and enforce provision on child labor and minimum work age
	Establish practices and procedures to ensure not use of forced labor
	Provide adequate training and safety measures for project workers including community workers
	Monitor and enforce regulations and practices
Grievance Mechanism	Develop and implement grievance measures for all project workers
	Inform and disseminate information on worker rights and obligations
Protections for community workers	Assess whether project labor is or will be provided on a voluntary basis as an outcome of individual or community agreement
	Prepare labor management procedures for community workers used in project
	Assess risk of child or forced labor where community labor is contributed to project activities
	Provide training on workplace safety
Occupational Health and Safety measures	Assess existing OHS measures against criteria listed in ESS
	Prepare OHS plan or similar policy for project workers
	Implement OHS plans and measures
	Establish mechanisms for workers to raise complaints, concerns, recommendations for improved safety practices
	Establish and implement measures for monitoring, supervising and enforcing agreed plans and measures
Primary Supply Workers	Identify labor risks associated with project primary suppliers
	Set out rules and responsibilities of primary suppliers to ensure compliance with policy principles
	Require primary supplier to comply with safety and labor requirements
	Monitor, supervise and enforce agreements reached with primary suppliers

Community Exposure to Health Issues	Identify and implement measures to avoid or minimize transmission of communicable diseases that may be associated with the influx of temporary or permanent project labor
	Establish project management plans to avoid or minimize community exposure to water-borne, water- based, water-related, and vector-borne diseases, and communicable and non-communicable diseases
Emergency Preparedness Planning	Identify and implement measures to prevent or minimize adverse impacts from emergency situations
	Establish emergency preparedness plans including institutional responsibilities, evacuation plans, communications strategies, housing and other logistical support
	Prepare and implement Risk Hazard Assessments (RHA) and Emergency Response Plans (ERP)
	Establish coordination and communication mechanisms for implementing emergency response plans
Management and Safety of Hazardous Materials	Develop operational management plans for hazardous materials in-line with policy objectives, national requirements and/or GIIP
	Assess direct project risks from use, transport, storage, disposal of hazardous materials
	Supervise and enforce entities responsible for executing management plans
Management of Security Personnel	Assess overall security risks from contracted security personnel inside and outside of project facilities or surrounding development sites
	Establish project security operations policies in line with ESS 4, national legal requirements and/or GIIP
	Conduct thorough verification screening and evaluation of personnel and/or security firms retained for security services. Including investigations of any past abuses by personnel or firms

ESS 10 Stakeholder Engagement

Task	Specific responsibilities
Engagement during project preparation	Identify and analyze project stakeholders including disadvantaged groups and how to engage them
	Prepare stakeholder engagement plan
	Disclose project information
	Conduct meaningful consultations
Engagement during project implementation and external reporting	Engage with, and provide information to, project-affected parties and other interested parties throughout the life cycle of the project
	Conduct stakeholder engagement in accordance with the SEP, and build upon the channels of communication and engagement already established with stakeholders
	If there are significant changes to the project that result in additional risks and impacts provide information on such risks and impacts and consult with project-affected parties as to how these risks and impacts will be mitigated
Grievance mechanism	Establish effective grievance mechanisms
	Respond to concerns and grievances of project-affected parties related to the environmental and social performance of the project in a timely manner
	Handle grievance in a culturally appropriate manner: be discreet, objective, sensitive and responsive to the needs and concerns of the project-affected parties

Organizational capacity and commitment	Define clear roles, responsibilities and authority as well as designate specific personnel to be responsible for the implementation and monitoring of stakeholder engagement activities and compliance