Evaluation of the UNICEF Response to the Humanitarian Crisis in South Sudan

Part 1: Child survival – WASH, health, nutrition and related issues
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EVALUATION OF THE UNICEF RESPONSE TO
THE HUMANITARIAN CRISIS IN SOUTH SUDAN

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United Nations Children’s Fund
Three United Nations Plaza
New York, New York 10017

January 2019

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<table>
<thead>
<tr>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
</tr>
<tr>
<td>Abbreviations</td>
</tr>
<tr>
<td>Executive summary</td>
</tr>
<tr>
<td><strong>1. Introduction</strong></td>
</tr>
<tr>
<td>1.1 Purpose and scope of the evaluation</td>
</tr>
<tr>
<td>1.2 Context: The South Sudan crisis and its impact</td>
</tr>
<tr>
<td>1.3 Evaluation approach and methodology</td>
</tr>
<tr>
<td><strong>2. UNICEF’s Level 3 programme response: 2016–2018</strong></td>
</tr>
<tr>
<td>2.1 Overview of UNICEF’s Level 3 response to the crisis in South Sudan</td>
</tr>
<tr>
<td>2.2 UNICEF’s overall strategy and country programme</td>
</tr>
<tr>
<td>2.3 Delivery against targets and the CCCs</td>
</tr>
<tr>
<td><strong>3. The nutrition response</strong></td>
</tr>
<tr>
<td>3.1 The food security and nutrition context</td>
</tr>
<tr>
<td>3.2 Needs assessment and data quality</td>
</tr>
<tr>
<td>3.3 UNICEF’s nutrition strategy</td>
</tr>
<tr>
<td>3.4 Implementing the strategy: Results and effectiveness</td>
</tr>
<tr>
<td>3.5 Programme quality</td>
</tr>
<tr>
<td>3.6 Programme efficiency</td>
</tr>
<tr>
<td>3.7 UNICEF and the Nutrition Cluster</td>
</tr>
<tr>
<td>3.8 Resilience and risk-informed programming</td>
</tr>
<tr>
<td>3.9 Conclusions and lessons learned</td>
</tr>
<tr>
<td><strong>4. The WASH response</strong></td>
</tr>
<tr>
<td>4.1 The WASH context</td>
</tr>
<tr>
<td>4.2 Needs assessment and data quality</td>
</tr>
<tr>
<td>4.3 UNICEF’s WASH strategy</td>
</tr>
<tr>
<td>4.4 Implementing the strategy: Results and effectiveness</td>
</tr>
<tr>
<td>4.5 Programme quality</td>
</tr>
<tr>
<td>4.6 Programme efficiency</td>
</tr>
<tr>
<td>4.7 UNICEF and the WASH Cluster</td>
</tr>
<tr>
<td>4.8 Resilience and risk-informed programming</td>
</tr>
<tr>
<td>4.9 Conclusions and lessons learned</td>
</tr>
</tbody>
</table>
## 5. The health response

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 The health context: Threats, vulnerabilities and needs</td>
<td>91</td>
</tr>
<tr>
<td>5.2 Needs assessment, monitoring and data quality</td>
<td>93</td>
</tr>
<tr>
<td>5.3 UNICEF’s health strategy</td>
<td>94</td>
</tr>
<tr>
<td>5.4 Implementing the strategy: Results and effectiveness</td>
<td>95</td>
</tr>
<tr>
<td>5.5 Programme quality</td>
<td>101</td>
</tr>
<tr>
<td>5.6 Programme efficiency</td>
<td>103</td>
</tr>
<tr>
<td>5.7 UNICEF and the Health Cluster</td>
<td>104</td>
</tr>
<tr>
<td>5.8 Resilience and risk-informed programming</td>
<td>104</td>
</tr>
<tr>
<td>5.9 Conclusions and lessons learned</td>
<td>105</td>
</tr>
</tbody>
</table>

## 6. Programme support and operational modalities

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Resource mobilization</td>
<td>108</td>
</tr>
<tr>
<td>6.2 Communications and advocacy</td>
<td>109</td>
</tr>
<tr>
<td>6.3 Communication for Development, community engagement and social mobilization</td>
<td>111</td>
</tr>
<tr>
<td>6.4 Implementing partnerships</td>
<td>113</td>
</tr>
<tr>
<td>6.5 Direct implementation: The Integrated Rapid Response Mechanism</td>
<td>116</td>
</tr>
<tr>
<td>6.6 Supply and logistics</td>
<td>123</td>
</tr>
<tr>
<td>6.7 Monitoring and information management</td>
<td>126</td>
</tr>
</tbody>
</table>

## 7. Conclusions and recommendations

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 Overall conclusions</td>
<td>129</td>
</tr>
<tr>
<td>7.2 Topic-specific conclusions and recommendations</td>
<td>131</td>
</tr>
</tbody>
</table>

### Annexes

Available online as a separate report
In December 2013, a political power struggle broke out in South Sudan between the President and his former deputy. This was followed by the onset of a civil war, which has continued to the present. Despite the signing of a peace agreement in August 2015, the violence that erupted in Juba in July 2016 led to a marked escalation in the pace and scale of displacement. As of December 2018, the number of people uprooted since the start of the conflict had reached more than 4 million, including 1.9 million people who are internally displaced and 2.27 million people who have taken refuge in neighbouring countries.

UNICEF activated the Level 3 corporate emergency procedure in South Sudan in May 2014 and over the years has continued to provide humanitarian assistance to children, women and communities in different parts of the country. Despite the re-classification of the situation as a Level 2 emergency in 2018, the emergency in South Sudan remains one of the most serious humanitarian crises in the world and continues to pose major challenges for UNICEF and its partners.

In line with the UNICEF Evaluation Policy, the Evaluation Office undertook this independent evaluation of UNICEF’s response to the South Sudan humanitarian crisis. This part of the evaluation focuses on the child survival sectors – nutrition, health and water, sanitation and hygiene (WASH) – for the period January 2016 to May 2018.

Overall, the evaluation found that UNICEF and its partners performed well during the evaluation period, in an often hostile and challenging operating environment. Some areas of programming – notably nutrition – were stronger than others. Despite the best efforts of UNICEF and its partners, the concern remains that child survival and basic development indicators have continued to worsen, and the related caseloads have continued to grow. Mass displacement, insecurity and access constraints continue to challenge the organization’s ability to assist children and their families; and UNICEF and its partners will need to adapt their approaches to address these challenges. UNICEF is already testing or proposing several new initiatives and course corrections; and this evaluation has attempted to identify additional opportunities and necessary improvements. The recent peace agreement may offer a greater prospect of progress, not just on the humanitarian agenda but on chronically neglected development priorities, including education – without which the life chances of children in South Sudan will remain seriously compromised for the foreseeable future.
The evaluation team was led by James Darcy, an independent consultant and experienced evaluator. He was joined on the team by Hisham Khogali, Volker Huls, Ramlat Musa Ali Wani and Alimure Awuda Amena.

This evaluation was supported by UNICEF staff across the organization. I would like to thank the Regional Director for Eastern and Southern Africa Leila Pakkala and her colleagues for their strong support of the evaluation; UNICEF South Sudan Representative Mahimbo Mdoe; UNICEF South Sudan Deputy Representative Andrea Suley; and Chief of Social Policy, Monitoring and Evaluation Hyun Hee Ban and her team, for generously hosting and supporting the evaluation.

The evaluation also benefited from the guidance of a reference group, which included staff from the Eastern and Southern Africa Regional Office, UNICEF South Sudan, the Office of Emergency Programmes, the Programme Division, the Field Results Group and the Supply Division. I have very much appreciated their technical support throughout the evaluation process. I would also like to thank my colleagues in the Evaluation Office who managed this work, namely Koorosh Raffii and Jane Mwangi. Finally, I would like to thank Celeste Lebowitz, Geeta Dey and Dalma Rivero for their administrative support throughout the process.

George Laryea-Adjei
Director of Evaluation
UNICEF
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAP</td>
<td>Accountability to affected populations</td>
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<tr>
<td>C4D</td>
<td>Communication for Development</td>
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<td>CCC</td>
<td>Core Commitments for Children in Humanitarian Action</td>
</tr>
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<td>CPD</td>
<td>Country Programme Document</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<td>DTP</td>
<td>Diphtheria, tetanus, pertussis</td>
</tr>
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<td>ECHO</td>
<td>Directorate-General for European Civil Protection and Humanitarian Aid</td>
</tr>
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<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>EWARS</td>
<td>Early Warning and Alert Response System</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>FAO</td>
<td>Food and Agriculture Organization</td>
</tr>
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<td>GAM</td>
<td>Global acute malnutrition</td>
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<td>HCT</td>
<td>Humanitarian Country Team</td>
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<td>HRP</td>
<td>Humanitarian Response Plan</td>
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<td>iCCM</td>
<td>Integrated community case management</td>
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<td>IOM</td>
<td>International Organization for Migration</td>
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<td>IPC</td>
<td>Integrated Food Security Phase Classification</td>
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<td>IRRM</td>
<td>Integrated Rapid Response Mechanism</td>
</tr>
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<td>IYCF</td>
<td>Infant and young child feeding</td>
</tr>
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<td>MAM</td>
<td>Moderate acute malnutrition</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<td>OCHA</td>
<td>Office for the Coordination of Humanitarian Affairs</td>
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<td>OTP</td>
<td>Outpatient therapeutic programme</td>
</tr>
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<td>PCA</td>
<td>Programme cooperation agreement</td>
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<td>PoC</td>
<td>Protection of Civilians</td>
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<td>RRM</td>
<td>Rapid Response Mechanism</td>
</tr>
<tr>
<td>SAM</td>
<td>Severe acute malnutrition</td>
</tr>
<tr>
<td>SMART</td>
<td>Standardized Monitoring and Assessment of Relief and Transitions</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>UNMISS</td>
<td>United Nations Mission in South Sudan</td>
</tr>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WASH</td>
<td>Water, sanitation and hygiene</td>
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<td>WFP</td>
<td>World Food Programme</td>
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<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

This evaluation, commissioned by the UNICEF Evaluation Office in New York, covers UNICEF’s response to the humanitarian crisis in South Sudan between January 2016 and May 2018. It was designed to fulfil two functions: 1) an accountability function designed to account (internally and externally) for one of UNICEF’s largest and most life-critical country programmes, and an emergency designated a corporate Level 3 priority and now in its fifth year; and 2) a learning function, reflecting the need to capture lessons from a programme of this duration and significance to inform the country programme and UNICEF’s global programming and practice.

This constitutes the first part of a two-part evaluation. The scope of this first part is largely restricted to the child survival components of the programme – specifically WASH, health and nutrition – as well as cross-cutting themes that emerged during the evaluation.1 These include attempts to reduce risk and foster resilience in the medium term, and the synergy between humanitarian and development approaches. Some of the related process issues, including partnerships and other operational modalities, including the Integrated Rapid Response Mechanism (IRRM), are considered in terms of programme coverage, quality, effectiveness, efficiency and accountability.

This report is based primarily on evidence gathered by the evaluation team during a three-week visit to South Sudan in May 2018, as well as a review of relevant documentation. Interviews with informants internal and external to UNICEF were held in Juba and in several locations around the country, alongside programme observation and consultation with affected communities served by UNICEF and its partners. The team also accompanied one IRRM mission. This in-country fact finding was supplemented by interviews with staff from the UNICEF Eastern and Southern Africa Regional Office and UNICEF Headquarters in New York, and with the results of an Internet survey of staff and partners. The provisional findings were presented and discussed at a validation workshop in Juba in August 2018.

THE SOUTH SUDAN CONTEXT

Despite the recent internal re-classification of the situation in South Sudan as a Level 2 emergency, this remains one of the most serious humanitarian crises in the world and one that continues to pose major challenges for UNICEF and its partners. Key children’s health and nutrition indicators have been in steady decline since the onset of the civil war in December 2013. These indicators were already alarming before that date, following decades of conflict and under-development; and many of the related challenges are essentially developmental in nature. Since the conflict began, the typical annual cycles of acute malnutrition have shown a continuous downward spiral, to the extent that localized famine occurred in 2017 and should be expected to recur, possibly on a wider scale. Likewise, the 2016–2017 cholera outbreak – serious enough in its own right – may be a warning of worse epidemics to come, particularly if population movements to urban centres continue.

1 The second part of the evaluation, which will be completed in 2019, will cover the education and child protection components of the emergency response, as well as the application of the ‘centrality of protection’ principle. It will also deepen the analysis of the cross-cutting themes mentioned here.
Perhaps above all, the situation in South Sudan during the evaluation period has constituted a protection crisis in which children have been extremely vulnerable to both generalized insecurity and targeted violence and coercion. While part two of the evaluation will consider UNICEF’s response to protection issues in detail, part one sets the context for much of UNICEF’s wider programme. More generally, a range of factors – including mass displacement, the collapsing economy, loss of livelihoods and a lack of government services – have combined to form a context of extreme vulnerability for millions of children and their families. The aid agenda has become predominantly humanitarian and reactive, constrained by limited access, limited funding and high levels of aid worker insecurity. Meanwhile, the development agenda has essentially been stalled since 2013, at least at the national level.

The peace agreement of September 2018 does not change the immediate humanitarian outlook; though if the ceasefire holds, it may provide a window of opportunity for needs assessment, service delivery and local capacity building. Past experiences of failed peace processes should make the humanitarian community wary of higher expectations. Even if peace holds, South Sudan has been so damaged by the crisis, and so chronically under-invested in, that it will take many years for the country to recover politically, socially and economically. Establishing good governance is itself a long-term project; and establishing social and ethnic harmony is an even longer one. At the same time, there is little short-term prospect of the mass return of displaced people and refugees, and the humanitarian situation remains critical.

**UNICEF’S ROLE AND STRATEGY**

Weak or absent government capacity has meant that much of UNICEF’s role during the evaluation period has been concerned with filling critical gaps in core state services. In other words, UNICEF and other aid actors are playing an essentially substitutional rather than auxiliary role in much of what they currently do in South Sudan, and this is likely to continue in the short to medium term. Yet ultimate responsibility for people’s welfare, development and protection lies with the Government, and it is important to maintain this line of political accountability. This raises an important question for UNICEF: How does the organization help to strengthen the sense of political responsibility and accountability for services and outcomes, given its largely substitutional delivery role? The answer must lie partly in continuing collaboration with national and local government authorities on both policy and service delivery, with the aim of transitioning roles over time as circumstances permit.

While meeting basic needs has been the priority, UNICEF and others have been rightly concerned with helping to build resilience – the ability of people and systems to withstand and recover from shocks – which bridges the humanitarian and development agendas. The evaluation team found that UNICEF, in collaboration with others – including the Food and Agriculture Organization (FAO), the United Nations Development Programme (UNDP) and the World Food Programme (WFP) – had made considerable progress in defining the resilience agenda, but that much remained to be done to make this actionable and measurable. It noted that resilience in one domain (e.g., WASH) should result in greater resilience in other domains (e.g., nutrition and health), and that a cross-sectoral approach was therefore essential. It also noted that household economic resilience was linked to resilience in these child survival sectors. Crucially, household resilience also depended on families being equipped with the knowledge and understanding needed to help keep children safe, well-nourished and healthy. The creation of a community mobilization network holds considerable promise in this regard.
At the World Humanitarian Summit, UNICEF affirmed its commitment “to risk-informed programming that promotes resilient development and is making risk analysis a core element of its planning processes.” South Sudan represents an important test case for UNICEF in its ability to deliver on this commitment, in a particularly high-risk environment. In this regard, the preventive and responsive agendas need to be prioritized equally. This is true both of short-term prevention, such as ensuring moderately malnourished children do not become severely malnourished; and longer-term prevention, such as averting developmental problems due to chronic malnutrition.

A related agenda concerns the localization of the response. With little short-term prospect of full government ownership of basic services, and access windows that can close as quickly as they open, it is imperative that UNICEF and other international agencies do as much as possible to build local ownership for each component of its response, to ensure both the reach and continuity of services. UNICEF is rightly attempting to localize its response by increasing its work with local civil society organizations. Yet the potential trade-offs on the quality of the response and accountability have yet to be fully recognized and managed, and the evaluation suggests that the partnership model itself needs to be revisited. This includes addressing issues related to monitoring, oversight and capacity building, as well as the need for a less instrumental approach to partnerships and more genuine collaboration.

As recognized by the new Country Programme Document (CPD) 2019–2021, all of this demands better data and evidence, including about the baseline situation of existing infrastructure, capacities, behaviours and attitudes; about priority needs and vulnerabilities; and about the impact of UNICEF and partners’ interventions. UNICEF is currently operating blind in too many areas of its work. Data on water and sanitation coverage in South Sudan are outdated and generally seen as unreliable. Nutrition information is better, but its reliability is often questionable and there are significant gaps. Health information (e.g., on immunization coverage) is patchy and often based on out-of-date child population estimates. Both to inform its own programming and to inform the wider response, UNICEF needs to devote more attention to this aspect of its role, in close partnership with other agencies and the relevant clusters.

The need for better data and contextual understanding extends beyond individual sectors. A range of factors interact to threaten the health of children, and this varies across different parts of the country. A more in-depth, geographically differentiated causal analysis is therefore needed to identify specific causal factors and thereby enable the design of more targeted prevention and control measures.

**UNICEF’S PROGRAMME AND RESULTS**

During the evaluation period, UNICEF largely met its output targets in the child survival sectors, though some significant deficits occurred. In 2016, UNICEF and others struggled to meet the needs of children and their mothers, largely due to the period of political instability, insecurity and constrained access that followed the resumption of armed hostilities in July of that year. In 2017 and 2018, UNICEF’s performance was much stronger, particularly in nutrition, in part because it found more flexible means of service delivery. Yet despite concerted efforts in the food security and nutrition sectors, given the threats facing the South Sudanese people

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and the challenges facing the humanitarian system in South Sudan, levels of acute malnutrition remain critically high; young children remain extremely vulnerable to disease; and the underlying issues related to water access and sanitation (in particular) have changed little.

**Nutrition**

While coverage remains a challenge, UNICEF and its partners have focused on the right interventions and achieved impressive output results in a very difficult operating environment. Where targets were not achieved (e.g., in the treatment of severe acute malnutrition (SAM) in 2016), this can largely be explained by the outbreak of conflict and the reduced access. The evaluation suggests that the life-cycle approach to nutrition highlights some critical points of intervention that are currently underserved. The evaluation identified some areas for improvement, including the need for:

- More ambitious target setting in infant and young child feeding (IYCF) programmes;
- An increased effort to prevent cases of moderate acute malnutrition (MAM) from becoming severe;
- The inclusion of adolescent and school-aged children (particularly girls) in nutrition programmes; and
- The development of approaches to address chronic malnutrition.

Many of these agendas require concerted effort across agencies, particularly between WFP and UNICEF. To date, collaboration with WFP and FAO has been strong, and appears to have worked well. This collaboration should continue to be built and leveraged for nutrition and resilience programming more broadly.

**Health**

South Sudan’s health indicators are among the worst in the world. High levels of vulnerability are compounded by multiple factors, including conflict and displacement, multiple causes of morbidity, weak or absent health services, poor nutrition, inadequate water supply and sanitation and the more general effects of poverty. Children under 5 years, particularly infants, are especially vulnerable to the effects of malaria, diarrhoea and pneumonia, which are the main causes of under-five mortality. Given the low immunization coverage, the measles threat is high. Maternal mortality rates are among the highest in the world. While UNICEF’s role in the health sector is relatively modest, the organization plays a central role in immunization and cold chain provision, as well as supporting the core pipeline for supplies.

The evaluation conclusions on health include the following:

- Coverage of routine immunization is low, and increasing coverage is a clear priority. A more regular mobile outreach solution – such as that proposed in the integrated outreach initiative – is required.
- Only a small proportion of adolescent girls are currently accessing antenatal care. UNICEF should explore ways to increase this proportion.
- The delivery of health promotion at the community level needs to be expanded. The potential expansion of coverage through the proposed consolidation of community nutrition, health and WASH volunteers would address this to some extent.
- The prevention and treatment of malaria should be a priority for UNICEF. In particular, UNICEF should explore all available means for increasing the distribution of treated bed nets.
EXECUTIVE SUMMARY

WASH

During the evaluation period, UNICEF’s strategy and approach to WASH was somewhat at odds with the demands of the situation. The CPD 2016–2018 reads more like a recovery plan than a humanitarian plan, and includes some approaches (e.g., to community-led sanitation) that have proven to be unrealistic. Perhaps more importantly, given the circumstances, the separation between development and humanitarian WASH appears artificial and counter-productive since the same basic principles apply to both. In its 2019–2021 strategy, UNICEF is moving in the right direction, towards better integration of development and humanitarian WASH approaches.

The evaluation conclusions on WASH include the following:

- During the evaluation period, UNICEF achieved its targets on access to water but fell short on its targets on access to sanitation, which were perhaps over-ambitious given the structural and developmental deficits involved. New approaches to community engagement appear to be needed here.

- Based on observations made by the evaluation team, the quality of work delivered by UNICEF WASH partners is of some concern. UNICEF needs to invest more in technical oversight and quality assurance.

- Engagement with REACH on WASH baseline assessments is essential and should be prioritized.

CROSS-CUTTING ISSUES

Coordination and the clusters: UNICEF has generally coordinated well with its peers in the United Nations Country Team and the Humanitarian Country Team (HCT), establishing a particularly strong working relationship with WFP – both on the IRRM and more generally. Cluster lead functions are also present in all key field hubs. Cluster partners interviewed for the evaluation were generally positive about UNICEF leadership of the Nutrition Cluster and its role in the Health Cluster. The WASH Cluster has been more problematic, though reports indicate that UNICEF leadership of the WASH Cluster is currently working well. Across each of these sectors, UNICEF’s role in managing the core pipeline for supplies was particularly appreciated.

Supply and logistics: It appears that the UNICEF South Sudan supply and logistics team works as efficiently as possible in a highly challenging environment. At the same time, evidence points to some challenges, including a time-consuming focus on following up on permits at the cost of more productive tasks. Internal studies suggest that the unit is relatively short staffed. Given the central importance of UNICEF’s role in managing the core pipeline, this should be reviewed and additional capacity should be established as needed.

Communication for Development (C4D): The C4D element of UNICEF’s response was strengthened significantly in 2017 and 2018, notably through the creation of a large network of community mobilizers. C4D is playing both a mobilizing and a ‘pulse check’ function, giving UNICEF and its partners a window into the evolving attitudes, behaviours and priorities of communities and households. That said, the degree to which sustained behaviour change has been achieved is difficult to assess, and doubts were expressed by informants, particularly regarding the impact of C4D hygiene messaging. More precise approaches may be needed to gauge the effectiveness of behaviour change approaches.
**Programme balance:** Although limited data on programme balance was available to the evaluation team, it appears that roughly equal effort goes into the Protection of Civilians (PoC)/displacement camps, static programmes and outreach programmes, including the IRRM. UNICEF should review the balance of its programming for PoC/camp populations and more remote (and generally underserved) populations, with a view to shifting more resources to the latter through outreach programmes, and thereby increasing overall coverage and equity. More generally, UNICEF and other international agencies working in South Sudan should be wary of the tendency to become ‘bunkered’ in Juba and urban centres and privilege the relatively easier programme targets over the more challenging ones. The evaluation team found some evidence of this, for example regarding the limited field monitoring conducted by UNICEF staff.

**The IRRM:** The IRRM modality is essential for UNICEF and delivers multiple benefits, including the ability to reach otherwise unserved populations. However, UNICEF needs to be clearer with itself and others about the specific value and inherent limitations of direct service delivery through the IRRM. Its value needs to be more carefully articulated and the claims made for it should be more nuanced, particularly regarding its effectiveness and coverage. UNICEF should aim to monitor the actual, rather than presumed, effects of its interventions, as a basis for planning follow-up missions and adapting the IRRM approach and planning framework as necessary over time.

**Monitoring and reporting:** Field observations made by the evaluation team suggest that UNICEF monitoring is not as strong as it should be. Several clear quality control issues were observed, notably in relation to WASH construction (e.g., poorly built latrines). Staff suggested that more direct field observation was needed, in conjunction with other methods of supervision (including third-party technical monitoring, where appropriate). Greater use of peer-to-peer monitoring may be appropriate, and could encourage greater cross-sector learning.

**Efficiency:** While the evaluation was unable to make valid cost comparisons regarding the delivery of different programme components, it was able to draw broader conclusions on efficiency. Some of these were already clear to UNICEF and its partners: for example, the urgent need to replace expensive water trucking with more sustainable alternatives, including piped water supply to camps and urban centres. Others have emerged from opportunities for streamlining processes, such as the agreement between the World Health Organization (WHO) and WFP to use general food distributions as a basis for simultaneously distributing treated bed nets. The evaluation team suggests that there may be many such opportunities for streamlining both within UNICEF’s own programme (e.g., multi-sector programme cooperation agreements (PCAs)) and in collaboration with other actors.

**Accountability:** Regarding accountability to affected populations (AAP), UNICEF has been slow to adopt a formal policy framework, though its practice in South Sudan appears to have been reasonably consistent with accepted principles. This is an aspect of the programme that needs strengthening. Rather than being treated in isolation, AAP should be part of a wider concerted effort to enhance community engagement and community mobilization that includes standard two-wayAAP communication approaches. While responsibility for AAP lies with C4D, wider responsibility for community engagement needs to be shared across the entire programme, with community mobilization treated as a shared modality.
While accountability to donors through reporting is relatively strong, UNICEF’s own monitoring processes are not yet robust enough to warrant full confidence in the results reported. Claims about UNICEF beneficiary outcomes need to be based on stronger evidence. As noted above, it is important that UNICEF does not lose sight of the overarching political accountabilities for people's safety and welfare, and that its advocacy and work with government authorities help to maintain and build a sense of state responsibility for the provision of related services.

GENERAL CONCLUSION

Overall, the evaluation found that UNICEF and its partners performed well during the evaluation period, in an often hostile and challenging operating environment. Some areas of programming – notably nutrition – were stronger than others, and UNICEF needs to do more to test the effectiveness of its interventions across the board. Despite the best efforts of UNICEF and its partners, the concern remains that child survival and basic development indicators have continued to worsen and the related caseloads have continued to grow. Mass displacement, insecurity and access constraints continue to challenge the organization’s ability to assist children and their families; and UNICEF and its partners will need to continue to adapt their approaches to address these challenges. The country team is already testing or proposing several new initiatives and course corrections; and this evaluation has attempted to identify additional opportunities and necessary improvements. The recent peace agreement may offer a greater prospect of progress, not just on the humanitarian agenda but on chronically neglected development priorities, including education – without which children’s life chances in South Sudan will remain seriously compromised for the foreseeable future.

RECOMMENDATIONS

The recommendations presented below follow from the evaluation’s findings and conclusions. They outline the main priorities for improving UNICEF’s response to this humanitarian crisis and, where relevant, UNICEF’s response to emergencies more generally.

1. **Nutrition:** Extend and enhance the nutrition programme, including:
   a. Ensure that target setting is more ambitious without compromising quality; advocate with partners, particularly WFP, to increase supplementary feeding coverage; and include school-aged children and adolescents, particularly girls, in the nutrition programme.
   b. Improve the quality of sanitation facilities at feeding centres; consolidate the various cadres of community volunteers that work multi-sectorally; and integrate nutrition into mobile health outreach.
   c. Advocate for addressing chronic malnutrition (with partners, particularly WFP and FAO), across sectors; and explore more strategic partnerships to address training and capacity building, among other areas.

2. **Health:** Extend and enhance the coverage of UNICEF’s health programme, including:
   a. Increase immunization coverage through mobile outreach; and explore other distribution mechanisms to increase the reach of insecticide-treated bed nets.
   b. Work with other sectors to incorporate nutrition into mobile outreach and to consolidate the cadres of community volunteers that work multi-sectorally.
   c. Increase the targeting of adolescent girls and better address their specific vulnerabilities.
3. **WASH**: Ensure the quality and sustainability of UNICEF’s WASH programme, including:
   a. Integrate humanitarian and development approaches, ensuring minimum standards of implementation; and where possible, ensure the sustainability of WASH facilities, in terms of the quality of construction, operation and maintenance, including the full implementation of planned engineering supervision.
   b. Transition from hygiene campaigns to behaviour change work where possible; and work with other sectors to consolidate the cadres of community volunteers that work multi-sectorally.
   c. Strengthen water source data collection and sharing through contractual obligations and advocacy.
   d. Strengthen operation and maintenance through contractual obligations by more systematic teaching water committees about the value of water source data and management plans.

4. **Supply and logistics**: Review and supplement UNICEF’s human resources capacity in supply and logistics as necessary.

5. **Programme balance**: Review and progressively address the balance between camp, static and outreach programmes.

6. **IRRMM**: Review IRRM targeting, effectiveness, follow-up and reporting, including:
   a. Review missions more consistently and schedule follow-up missions of partner visits to ensure continuity.
   b. Systematically collate and share situational data from IRRMs.
   c. Review how the results of IRRM missions are reported to ensure more coverage information can be substantiated; and undertake a comprehensive stock take that analyses and learns from the specific model pursued in South Sudan.

7. **Sector evidence base**: Strengthen the sector evidence base, specifically in WASH and nutrition, including by investing in a WASH baseline (also as part of the REACH initiative) and strengthening nutrition information and analysis.

8. **Monitoring and reporting**: Strengthen the programmatic evidence base, including through stronger monitoring and oversight processes, by further increasing the regularity and coverage of field monitoring visits by UNICEF staff and considering alternatives for triangulation that go beyond third-party systems.

9. **Efficiency**: Take additional steps to increase efficiency through combined processes, both internal and shared, including through joint PCAs and a common cadre of community volunteers.

10. **Accountability to affected populations**: Take additional steps to strengthen accountability to beneficiaries and support claims of programme effectiveness.

11. **Partnership model**: Review the current partnership model and strengthen related business processes, including pursuing multi-year agreements where rules permit and accelerating internal review processes to reduce delays in contracting.

12. **Resilience in practice**: Take steps to make the resilience agenda actionable and measurable within and across sectors, starting with clearly defined criteria for what constitutes resilient households, communities and systems in each area of intervention.
1.1 PURPOSE AND SCOPE OF THE EVALUATION

This evaluation of UNICEF’s response to the humanitarian emergency in South Sudan was commissioned by the UNICEF Evaluation Office in New York. It considers the UNICEF response to the South Sudan crisis between January 2016 and May 2018 and was designed to fulfil two functions:3

1. A summative accountability function, reflecting the need to account internally and externally for one of UNICEF’s largest and most life-critical country programmes, and an emergency designated a corporate Level 3 priority and now entering its sixth year;4 and

2. A formative learning function, reflecting the need to capture lessons from a programme of this duration and significance, to inform the country programme and UNICEF’s global programming and practice.

Though the focus of the evaluation is on the humanitarian components of the UNICEF programme, it also considers resilience and the reduction of vulnerability in the medium term. The overall guiding question for the evaluation is therefore: How well did UNICEF respond to the short- to medium-term threats to children’s well-being and development in South Sudan between January 2016 and May 2018? How well placed is the organization now to respond to future threats?

Adequately fulfilling both the accountability and learning functions proposed in the terms of reference posed a challenge for this evaluation – particularly as each seemed to require a different approach. The accountability function suggested a relatively broad review of UNICEF’s response as a whole during the evaluation period, judged against certain basic criteria. Learning required a narrower focus on specific sectors and topics of interest or concern, allowing greater depth of analysis. Given the time and resource constraints associated with the rapid and timely evaluation approach (see section 1.3), it was decided to focus the learning component on the sectors most directly related to child survival. Much of the focus of the evaluation is therefore on the nutrition, health and WASH components of UNICEF’s response to the Level 3 crisis.5

In addition to this child survival agenda, the evaluation explores a number of cross-cutting issues, including the balance of UNICEF’s emergency programmes between different groups and areas; efforts to promote the resilience of families, communities and systems; related attempts to localize the programme, working closely with communities and civil society organizations; the relationship between emergency and development agendas and approaches; and the current partnership model that UNICEF is using to deliver the bulk of its programming. Related process issues are also explored, including UNICEF’s vital supply and communications roles, partnership processes and its coordination role within the cluster system.

Although the evaluation considers the UNICEF emergency response between January 2016 and May 2018, emphasis is placed on the recent and current response, including the question of whether lessons learned over the past two

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3 See Annex 1 for the terms of reference; and the Inception Report (9 July 2018) for an interpretation of the terms of reference.

4 As of June 2018, the situation has been re-designated as a Level 2 priority. This reflects a judgment about the increased capacity of UNICEF South Sudan rather than any amelioration of the humanitarian situation.

5 The scope of the evaluation was originally intended to include education and child protection, but it proved impossible to find specialist evaluators in the necessary timeframe. Part two of the evaluation will cover these topics.
years are currently being applied. The recommend-
mations made are based on the team’s under-
standing of the future challenges likely to face UNICEF and the wider humanitarian
system in South Sudan.

The primary intended users of the evaluation
are the managers and staff of UNICEF South
Sudan as they plan and implement UNICEF’s
response to the prevailing humanitarian crisis
within the framework of the CPD 2019–2021. At
the country level, the evaluation should be of
use to those responsible for coordinating clus-
ter and sub-cluster responses within the wider
HCT-led humanitarian response in South Sudan.
At the international level, the evaluation is
intended for use by staff of the UNICEF Eastern
and Southern Regional Office and Headquarters
divisions concerned with the conduct of and
support to the South Sudan Level 3 response.

Beyond UNICEF, the evaluation should also be
of interest to a wider range of stakeholders
in the Level 3 response. At the country level,
these include the Government of South Sudan
and related state authorities; United Nations
Country Team and HCT partners; international
and national non-governmental organization
(NGO) implementing partners; and donor rep-
resentatives. From an accountability perspective,
the evaluation will be of interest to UNICEF
Executive Board members and donor govern-
ments; and from a learning perspective, to other
organizations concerned with the crisis in South
Sudan and the response to it. Finally, the eval-
uation will hopefully be useful to those South
Sudanese people affected by the crisis and the
response to it, including intended beneficiary
communities and their local representatives,
and South Sudan’s children, adolescents and
women and their representatives.

Following the presentation of the provisional
findings and conclusions of the evaluation at
UNICEF South Sudan in Juba in August 2018, it
was agreed that a second part of the evaluation
would be commissioned to extend the eval-
uation scope to cover the education and child
protection components of the emergency
response. This second part of the evaluation
is also intended to broaden and deepen the
analysis of cross-cutting issues contained in
part one. Part two will be primarily conducted
in early 2019 and a synthesis report will be
produced (covering parts one and two) once
the second part of the evaluation is substan-
tially completed.

1.2 CONTEXT: THE SOUTH SUDAN
CRISIS AND ITS IMPACT

UNICEF has worked in South Sudan since the
country gained its independence in 2011, and for
many years prior to that in what was then the
southern part of the Sudan. UNICEF played a
leading role in Operation Lifeline Sudan during
the second Sudanese Civil War (1983–2005)
and in the negotiation with the Government of
the Sudan and the Sudan People’s Liberation
Movement on the ground rules for the delivery
of humanitarian assistance to all communities
in need.

Following the signing of the Comprehensive
Peace Agreement in 2005, the need for human-
itarian assistance gradually declined, due
to greater security and the return of many of
those displaced during the war. When the South
Sudanese people voted overwhelming for inde-
pendence in 2011, the new country of South
Sudan was created in a mood of great optimism,
which was matched by a large investment of
international funds and political backing.

That optimism did not last. In December 2013,
a political power struggle broke out between
the President and his former deputy. This
was followed by the onset of a civil war that
has continued to the present. While the war
is principally a conflict between the Sudan
People’s Liberation Movement in Government
and the Sudan People’s Liberation Movement in Opposition, fighting between several factions on multiple fronts across the country has made the course of the conflict difficult to read. The conflict has a strong ethnic dimension, fuelled, in particular, by the long-standing tensions between the Dinka and Nuer tribal groups, which politicians have been quick to exploit. Growing insecurity and violence across the country has affected all communities, however, with both government and opposition parties engaging in ethnically-targeted killing, rape, torture and forced displacement. As a 2018 report from the United Nations Commission on Human Rights in South Sudan makes clear, some of these acts constitute war crimes and crimes against humanity. In addition to armed hostilities, criminal activity and banditry present other sources of insecurity that long pre-date the present conflict and can be difficult to distinguish from it.

Mass displacement is a defining feature of the conflict. Despite the signing of a peace agreement in August 2015,7 violence that erupted in July 2016 in Juba and that spread across the Equatorias and into Unity state led to a marked escalation in the pace and scale of displacement. In total, over 4 million people are now displaced from their homes, or about one third of the entire population of 12.5 million. 2.27 million of the displaced have fled to neighbouring countries as refugees.8 For both displaced and non-displaced people, the threat of violence is very real: fear tactics have been central to how the conflict has been waged and there have been strong age and gender aspects to the violence. According to the 2018 human rights report, “conflict-related sexual violence is endemic.”9 Girls are increasingly at risk of sexual violence, child marriage and exploitation. Recruitment of child soldiers continues despite assurances from parties to the conflict, though there have also been some recent (limited) releases of children.10

The protection agenda is clearly of central concern, but it is also the most challenging aspect of the humanitarian agenda. Children and their families are largely at the mercy of the warring parties, who have so far shown no inclination to modify their behaviour in the face of international condemnation. The United Nations Mission in South Sudan (UNMISS), the United Nations Chapter VII-mandated protection force, has “authority to use all necessary means 1) to protect United Nations personnel, installations and equipment; 2) to deter violence especially through proactive deployment and active patrolling; 3) to protect civilians from threats, regardless of source; 4) to create conditions conducive to delivery of humanitarian assistance by international and national actors...”11 [numbers added]. In reality, in part due to lack of resources, UNMISS’ role is largely confined to securing the various Protection of Civilian (PoC) sites across South Sudan. The United Nations Security Council notes “with concern that the extensive resources needed to protect civilians at the United Nations Protection of Civilians sites has limited UNMISS’ presence outside [those sites]...”12

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7 The Agreement on the Resolution of the Conflict in the Republic of South Sudan.
12 Ibid.
This lack of protection extends to residents of the PoC camps who venture outside of the camp – notably women in search of firewood – often at great risk to their personal safety. Events in Malakal in 2016 demonstrated that the PoC sites themselves are not always secure from attack. Meanwhile, the civilian population beyond the camps is left highly vulnerable and often with few safe options. As one commentator noted, “the Mission’s inability to project force outside the PoC sites has increased the need for civilians to seek refuge within. Humanitarian assistance has, in turn, often concentrated disproportionally on these sites, even though the vast majority of displaced people, including the most vulnerable, are elsewhere.”

Displaced populations outside of the camps and the communities that host them present a significant challenge for the humanitarian response, both in terms of assistance and protection.

Just as UNMISS has struggled to protect civilians outside of PoC camps, its ability to provide a safe environment for humanitarian assistance beyond the camps has been limited. Ultimate responsibility for this lies with the warring parties. This role has notably included the provision of armed escorts for aid convoys into insecure areas. Still, South Sudan is one of the most dangerous environments in the world for aid workers, particularly for civil society organizations. According to the 2018 Humanitarian Response Plan (HRP), between January and October 2017, 19 aid workers – most of whom were South Sudanese – were killed (24 were killed in 2016). There were also 451 reported attacks on aid workers and aid assets and 503 aid staff had to be relocated. Aid worker abductions, including of UNICEF staff, appear to have increased in 2018. Even in Juba, UNMISS has been unable to protect aid workers when they were targeted in their own living quarters in July 2016. The looting of aid supplies has also become endemic.

In addition to the impact of insecurity on aid programming, the denial of access to humanitarian assistance is also a major protection concern. At different points during the evaluation period, secure access to conflict-affected areas of South Sudan was very difficult to achieve. The 2017 HRP noted, “In 2016, humanitarian space was compromised by active conflict, denials of access, attacks against humanitarian staff and assets, bureaucratic impediments, and targeting of civilians receiving assistance. The number of humanitarian access incidents spiked significantly in the second half of 2016... The complexity of humanitarian access negotiations also increased due to the proliferation of armed actors operating in areas where humanitarian needs exist.” The 2018 HRP noted 100 “bureaucratic access impediments” (including denials of access permission) between January and October 2017.

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14 In June 2017, the HCT established some suggested thresholds and consequences for local violations against aid workers and assets. See South Sudan Humanitarian Country Team, ‘Consequences for Violations Against Humanitarian Workers & Assets’, position paper, endorsed 8 June 2017.
17 A 2017 study by the Office for the Coordination of Humanitarian Affairs (OCHA) documented a range of bureaucratic access impediments to humanitarian interventions in South Sudan. Restrictions on or denials of movement were perceived to have the greatest impact on response, despite being encountered less frequently than other impediments.
18 These constraints are compounded by the logistical challenges of delivering aid in South Sudan, particularly during the rainy season when roads may become impassable for months on end. This also adds to the cost of delivery, including the cost of using transportation alternatives such as planes and helicopters.
The constraints on access to humanitarian assistance appear, at least in part, to be a deliberate strategy, which is in itself a major protection concern. These constraints cannot be characterized as simply a set of technical, operational or bureaucratic hurdles for humanitarian agencies. As the United Nations Human Rights Commission said in its 2018 report: “Humanitarian aid has been deliberately blocked from reaching civilians perceived to be from the ‘other side’ or on the basis of ethnicity... People are fleeing as a result, leaving behind ghost towns and unattended crops, further exacerbating the food crisis. Hunger, lack of access to health care and schools are used to break down the other side in this conflict. The rights to life, physical integrity, to adequate food, water, health care, adequate accommodation and education are constantly violated.”

Acute food insecurity brought large parts of the country to the brink of famine during the evaluation period; and indeed pockets of famine were seen in 2017. In southern Unity, some 100,000 people were reportedly living in famine conditions. More than half of the population was suffering from acute food insecurity by December 2017 – an unprecedented situation. Levels of acute malnutrition are correspondingly high: in 2018, an estimated 250,000 children were suffering from SAM. Coupled with poor sanitation, lack of access to health services and exposure to disease – particularly malaria and diarrhoeal diseases such as cholera – the nutrition situation is particularly dangerous for young children.

In February 2017, famine was declared in some counties in Greater Unity, and other counties were declared at high likelihood/risk of famine

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21 Integrated Food Security Phase Classification for South Sudan, November 2017.
By May 2017, the end of famine had been declared. However, the situation remained worrying in 2018. The number of people in Integrated Food Security Phase Classification (IPC) 3 (crisis) and 4 (emergency) continued to rise in 2018, and the previously stable region of Greater Equatoria became increasingly food insecure. Across the country, large numbers of people became highly vulnerable and were on the brink of acute food insecurity.

The threats to children and their families in South Sudan derive from both the direct and indirect effects of conflict. South Sudan has been at war for most of the past 60 years, with no history of stable governance and little investment in infrastructure or systems. The effects of the current conflict have to be seen against this backdrop. As service providers, the Government and its ministries have limited reach and capacity. Donors are not willing to provide development assistance in a context of weak and unstable governance, characterized by high levels of corruption and widespread human rights abuses. Opportunities for development are correspondingly few, despite the potential for agricultural expansion, and the country’s economy has largely collapsed. Vital revenues from oil production have fallen, agricultural production – particularly in the fertile southern states – has been severely disrupted and inflation is rapidly eroding the value of the South Sudanese pound. Traditional livelihoods are being lost as a result of insecurity and displacement of farmers. The result is that millions of South Sudanese are now destitute and acutely food insecure.

At the beginning of 2018, four years into the conflict, more than half of the nation’s children were affected by the crisis.22 As reported in UNICEF’s 2018 Humanitarian Action for Children funding appeal for South Sudan: “These children are facing famine, disease, forced recruitment and lack of access to schooling – vulnerabilities that are compounded by the worsening economic conditions and limited access to food and fuel….Women and children are particularly vulnerable to food insecurity, and their circumstances are expected to deteriorate.”23 In addition, 2018 began with more than 5 million people in urgent need of safe water for drinking and hygiene24; 2.2 million children out of school; and girls making up only 40 per cent of those accessing education.25

Underlying this is a history that includes the consistent failure of the rule of law, chronic under-investment in development and lack of state service provision. Since independence, the Government has been unable to fulfil many of the basic functions of the State. According to the CPD 2016–2018, “…since the creation of South Sudan in July 2011, the new State has not been able to deliver on much-needed security, rule of law and basic social services, despite its high potential wealth from natural and agricultural resources. The country’s development is constrained by conflict, weak governance, inadequate access to basic services, lack of physical infrastructure, frequent disasters, including floods and epidemics, and widespread animal and crop disease.”26 All of this remains true today, and the result is a low development base coupled with high levels of risk to children and their families.

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23 Ibid.
This combination of limited development and extreme vulnerability makes it difficult – and even unhelpful – to draw a distinction between development programming and emergency response. Much of what constitutes the current humanitarian agenda could be framed in terms of basic development deficits. However, the severity, extent and immediacy of the related threats to well-being demand an emergency approach. The 2017 cholera outbreak highlighted this in regard to health. In the context of such a protracted crisis, however, questions about sustainability and resilience inevitably arise; and many of the criteria for what constitutes appropriate humanitarian response also reflect good development practice.

The distinction between humanitarian and development approaches is often characterized by differences in the relationship between the international aid efforts, the Government and national policy agendas. Prior to 2016, UNICEF and other United Nations actors had closely aligned their strategies with the United Nations Development Assistance Framework (UNDAF) agreed to in 2011, which proved unworkable in the context of South Sudan’s civil war. As noted in the CPD 2016–2018, “Government expenditure on the social sectors is minimal, with only 3 per cent of the national budget for 2015-2016 allocated to health and 4.3 per cent to education. Even this modest allocation has been undermined by the reduction in government oil revenues and the de-prioritization of funding to the social sectors, leaving the salaries of critical workers unpaid... The very limited State capacity means that international aid agencies and civil society deliver most social services countrywide, both in emergency and non-emergency situations.”

Furthermore, the budget allocation to the social sectors has continued to decline. According to the UNICEF National Budget Brief for 2017, “… allocations to the social sectors (education, health and social and humanitarian affairs) consumed only 5 per cent of the budget in the current fiscal year [2017/18], which marked a decrease from 2016/17 when these sectors accounted for 6.7 per cent of total budget allocations. This means that the Government is investing 13 times more in security and public administration than in social services.”

27 Ibid.
CHAPTER 1: INTRODUCTION

BOX 1 Selected development indicators for South Sudan

Much of the available human development data for South Sudan is uncertain, based on old estimates and uncertain population data. The following is a selection of some of the most life-critical indicators for children and their mothers based on the best available information. Full source references are provided in the related sections of this report.

Health
- Routine Expanded Programme on Immunization (EPI) coverage is low in South Sudan. As of the end of December 2017, the Health Cluster reported that over the course of the year, only 38 per cent of children received measles vaccination; 45 per cent received polio vaccination; and 29 per cent received pentavalent 3 before age 1. This low coverage will affect herd immunity against vaccine-preventable diseases.
- In 2016, infant and child mortality rates were 59.2 and 90.7 per 1,000 live births, respectively.
- Maternal mortality was 789 deaths per 100,000 live births.
- Malaria, diarrhoea and pneumonia constituted 77 per cent of the total outpatient diagnoses for children under 5 years. Measles and meningitis are a growing threat.
- An estimated 50 per cent of health facilities are not functioning.

Nutrition
- During 2016–2018, many states registered global acute malnutrition (GAM) rates above the 15 per cent WHO emergency threshold. Seven out of eight Standardized Monitoring and Assessment of Relief and Transitions (SMART) surveys conducted in May 2018 (lean season) in Jonglei and Unity showed GAM rates above the 15 per cent emergency threshold.
- GAM prevalence among pregnant and lactating women was reported to be 17.3 per cent, with some States, such as Jonglei, having a prevalence as high as 28.8 per cent.

WASH
The 2017 report of the WHO/UNICEF Joint Monitoring Programme (JMP) estimated that 50 per cent of the South Sudan population had limited or unimproved water sources or no direct access to water, and more than 60 per cent did not have access to adequate sanitation facilities. Also, only 45 per cent of South Sudan’s 3,349 primary schools have access to safe water; and only 17 per cent have adequate sanitary latrines for both girls and boys.

Education
According to the Education Management Information System, the gross enrolment rates in 2016 were 76 per cent at the primary level and 10 per cent at the secondary level; and the gender parity index was 0.75 at the primary level and 0.57 at the secondary level. In mid-2017, an estimated 2 million primary-school-aged children were out of school, and nearly 1.3 million were at risk of dropping out. Approximately one third of primary schools are damaged, occupied or closed due to the conflict and failure to pay teacher salaries. Quality is also a concern: most primary school children do not achieve foundational literacy, numeracy or life skills instruction. Two thirds of teachers are untrained and there are major shortages in teaching and learning materials.

29 The last Population and Housing Census in South Sudan took place in 2008, and all population data since then have been based on projections. The last national South Sudan Household Survey was undertaken in 2010, and plans for subsequent surveys in recent years have been shelved due to the conflict.
The Interim Cooperation Framework that replaced the UNDAF in January 2016 set a more tentative development agenda, emphasising resilience and social services for the most vulnerable. This was intended to consolidate and build on the 2015 peace agreement, in anticipation of a full-scale development framework based on the Sustainable Development Goals. But with the resumption of conflict, that has proven largely unworkable. Following the 2015 peace agreement, there was some cautious optimism that if the agreement held “it may be possible to return to addressing the causes of conflict and the country’s development priorities.\textsuperscript{30} In the two years following the resumption of hostilities in July 2016, no such progress was made and the humanitarian situation became progressively worse. While some agencies such as UNICEF have maintained strong links with the relevant ministries and local authorities, most of the humanitarian effort has bypassed government authorities altogether.

While another peace deal was signed three years later, in August 2018, the prospects for lasting peace remain highly uncertain. The 2018 peace agreement does not change the immediate humanitarian outlook; though if the ceasefire holds, it may at least provide a window of opportunity in terms of increased access for needs assessment, service delivery and local capacity building. It may also provide an important advocacy opportunity, and allow for the demobilization of increased numbers of child soldiers. If the peace lasts, there is the opportunity for a sustained cessation of conflict and violence against civilians, particularly gender-based violence against women and girls; the return of those millions displaced within South Sudan and beyond its borders; and a period of some economic recovery. There might also be some re-orientation of the budget from military spending to development priorities, including desperately needed investments in education and health.

Given past experiences, however, these projections are ambitious: The potential for conflict is partly structural in South Sudan, past agreements have failed to last and there are armed elements that are not party to the agreement. Even if the peace holds, South Sudan is so damaged and chronically under-invested in that it will take years to recover – politically, socially and economically. Establishing good governance and rule of law is itself a long-term project, and establishing social and ethnic harmony is an even longer one. Regarding displaced people and refugees, the perception of security is key: People will look for tangible evidence of stability and the prospect of a viable livelihood before committing themselves to returning home. It must be anticipated that many or most of those currently displaced or in exile may remain so for the foreseeable future. Those living in PoC sites may face challenges in returning home given the political and security issues involved.

Among the trends noted in the South Sudan 2017 Country Office Annual Report, one of the most striking is the process of urbanization related to forced displacement. As the report notes: “Although South Sudan is traditionally a rural society, it is rapidly urbanizing, even if mostly involuntarily and in an unplanned manner. Since the last quarter of 2016, a large part of the population in the Greater Equatorias have either fled to seek refuge in Uganda or moved to the relative safety of urban areas within the region. In other parts of the country, people have continued to look for safety in the PoC sites located in urban centres. Returnees have come back to towns and cities where they

have better access to security, food markets and basic services.”

While this trend sets the context for much of the current humanitarian agenda, it also highlights the challenges faced by those who remain in the countryside where such services are much harder to access and where little if anything exists in terms of protection.

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**BOX 2 South Sudan timeline: December 2013 to September 2018**

**December 2013**
Fighting erupts in Juba and quickly spreads to Jonglei, Unity and Upper Nile. Thousands flee their homes.

**January–April 2014**
- Cessation of hostilities agreement signed by parties to the conflict (January).
- Fighting breaks out in Leer town, Unity and Malakal town, Upper Nile. Fighting breaks out again in Bentiu, with hundreds massacred. UNMISS compound in Bor is attacked.

**May 2014**
- Parties to conflict sign Recommitment on Humanitarian Matters of the Cessation of Hostilities Agreement; and subsequently the Agreement to Resolve the Crisis in South Sudan.

**August–October 2014**
- Aid workers killed in Maban County, Upper Nile. Bentiu town attacked.

**January–July 2015**
- Fighting intensifies around Renk and Kaka. Fighting in the Greater Upper Nile region intensifies. Aid workers are forced to relocate from several counties in Unity. Heavy fighting in Malakal town with multiple changes of control. Restricted aid movements in Upper Nile.

**August 2015**
- Agreement on the Resolution of the Conflict in the Republic of South Sudan signed by conflict parties.

**October 2015**
- Fighting resumes in Unity. Humanitarian partners suspend operations and withdraw staff from Leer. Fighting in Western Equatoria displaces thousands and threatens key supply routes.

**February–June 2016**
- Fighting breaks out in Malakal PoC, Pibor, Wau, Yambio and Mundri West causing destruction and displacement. Renewed conflict in Western Bahr el Ghazal displaces tens of thousands of people.
- Formation (in April) of the Transition Government of National Unity of the Republic of South Sudan.

**July–November 2016**
- Fighting breaks out in Juba and spreads to multiple locations in the Equatorias, as well as Unity. Tens of thousands are displaced. Tens of thousands of refugees flee to the Democratic Republic of the Congo and Uganda as fighting escalates in the Equatorias. Clashes in Unity; thousands to flee to remote swamps/bushes.

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February–March 2017
• Localized famine is declared in Leer and Mayendit counties. Insecurity forces relocation of aid workers from Mayendit. Six aid workers killed in attack travelling from Juba to Pibor.

April–July 2017

September–November 2017
• The number of South Sudanese refugees passes 2 million. One million are in Uganda alone, as insecurity continues in the Equatorias. An equivalent number (1.9 million) are internally displaced. Fighting in the Equatorias displaces tens of thousands.

February–May 2018
• IPC analysis estimates 6.3 million people, or 57 per cent of the population of South Sudan, will be severely food insecure from February to April 2018. Thousands are displaced due to clashes in Unity.

August–September 2018
• Signing of cessation of hostilities and power-sharing agreement (August) followed by a new peace agreement (September) – the Revitalized Agreement on the Resolution of the Conflict in the Republic of South Sudan – which brings some hope of sustained cessation of hostilities. But many uncertainties remain, including the question of mass return of those displaced by conflict.

1.3 EVALUATION APPROACH AND METHODOLOGY
The terms of reference for this evaluation (see Annex 1) were drafted following a country visit by the evaluation team. The results of that visit are recorded in a separate paper. This also constituted Phase I of the evaluation process, including initial fact finding and scoping. The inception report for the present evaluation set out the evaluation team’s interpretation of the terms of reference and the proposed approach for the evaluation, including its scope, guiding questions and areas of focus. This followed in-country consultation at the outset of the field mission on the evaluation scope and approach with the UNICEF South Sudan deputy director and the chief of planning, monitoring and evaluation. This interpretation was agreed on with the Evaluation Office. Overall, the team’s approach was determined by what it took to answer the guiding questions with a reasonable degree of confidence. The length of the report reflects the ambitious scope of the assignment.

The approach agreed diverges from the options set out in the terms of reference, which, upon further consultation, did not appear to provide an appropriate basis for conducting the evaluation. Given the somewhat conflicting demands of the accountability and learning purposes noted above, the evaluation adopted a two-strand approach:

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33 ‘UNICEF South Sudan L3 Evaluation – Inception Report’, 9 July 2018. This was drafted following consultations in Juba in May 2018 and a preliminary review of data and documentation.
1. The first strand (accountability) consists of a limited review of the entire UNICEF Level 3 programme during the period of January 2016 through May 2018. This includes an analysis of the programme as a whole and its component parts against a limited set of quality and performance criteria, including overall relevance, scale, coverage, balance, coherence, resourcing, target achievement, compliance with the Core Commitments for Children in Humanitarian Action (CCCs), equity and gender; and application of humanitarian principles.

2. The second strand (learning) involves a more focused review of lessons emerging from those sectors related most directly to child survival within UNICEF’s overall response (nutrition, health and WASH). This includes both areas of apparent under-performance or challenge, and areas of good or innovative practice that could benefit UNICEF globally. Our starting point for this component was a review of existing learning and questions arising from earlier evaluations and reviews.

The evaluation was conducted in line with the Evaluation Office’s new rapid and timely approach to humanitarian evaluations, under which the standard evaluation process is accelerated to produce real-time results that can feed directly into programme decision-making. Under this approach, the intention is that the period from commencement to completion of the full evaluation report should be approximately four months. In order to achieve results in this timeframe, some of the standard phases of evaluation need to be merged, shortened or undertaken simultaneously. A workshop was held in Juba on 30 August 2018, with staff from the regional and country office, to discuss the provisional results of evaluation, and further develop the recommendations and encourage the uptake and use of the findings.

The evaluation approach has been primarily qualitative, using key informant consultations to identify lessons and ways forward in collaboration with the staff involved in the response. Wherever possible, this qualitative approach was supplemented with quantitative analysis, though relevant data for such analysis was sometimes lacking (see later sections of the report for additional detail). While the overall approach was consultative and participatory, the evaluation team took care to maintain independence of judgement and a willingness to challenge accepted wisdom. The accountability dimension of the evaluation demanded such independence. The evaluation was conducted in accordance with the United Nations Evaluation Group ethical guidelines for evaluation.\textsuperscript{34} As a rule, views expressed by informants are not attributed to the individuals or organizations concerned, other than to distinguish views expressed by UNICEF sources from those expressed by other sources.

Limitations of the evaluation

The evaluation’s two main limiting factors were the lack of relevant outcome data, which made effectiveness hard to evaluate; and the time constraints posed by the evaluation format.

itself. The lack of reliable data is considered in the following sections, both in relation to specific sectors and to the limits of programme monitoring. The relatively short timeframe for the field-level fact finding component of the evaluation allowed for only a limited degree of programme observation and consultation with communities, local partners and field staff.

The nature of the evaluation and its object (three years of a complex, country-wide programme), and the requirement that accountability and learning be given equal attention, demanded a more extended process than allowed by the standard rapid and timely approach. The decision to conduct a second part of the evaluation (together with a synthesis report) reflects this and should help to remedy at least some of the limitations of part one.

Methodology

Following the approach outlined above, the primary methods used in the evaluation have been key informant interviews, both with UNICEF staff and with staff of other organizations; and document review, using mainly UNICEF materials. These methods were supplemented by field observations and limited consultations with affected communities and local partners. Altogether, six field locations were visited beyond Juba: Iholong (Eastern Equatoria) as part of an IRRM mission, Pibor town (Jonglei), Kapoeta, Koch and Bentiu. Annex 3 provides additional information on these visits.

Short online surveys were conducted with UNICEF South Sudan staff and in-country partners, and the results helped inform the evaluation's conclusions. A validation workshop was held at the UNICEF South Sudan office in Juba to discuss the findings and provisional recommendations of the evaluation, based on the first draft report.

Some 70 interviews were conducted with individuals internal and external to UNICEF who were judged as best placed to answer the evaluation’s guiding questions. The majority of key informants were UNICEF staff involved in the South Sudan response directly or indirectly from the UNICEF South Sudan Juba office and field offices, the Eastern and Southern Africa Regional Office and UNICEF Headquarters. Implementing partner organizations, both national and international (i.e., those with which UNICEF has concluded PCAs) were interviewed, as were staff from other United Nations bodies, including WFP, FAO, WHO, OCHA, the United Nations High Commissioner for Refugees (UNHCR), the International Organization for Migration (IOM) and the deputy special representative of the secretary-general/resident coordinator/humanitarian coordinator. Relevant government ministries and departments were also consulted. The team leader also met with major donors based in Juba.

The evaluation team devised a framework of guiding evaluation questions, building on the questions laid out in the terms of reference and reflecting the accountability and learning topics described above. Together with sub-questions, criteria and potential evidence sources, these formed the basis of the evaluation matrix included in Annex 2. As noted, the overall guiding question for the evaluation was: How well did UNICEF respond to the short- to medium-term threats to children’s well-being and development in South Sudan during the period

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35 See Annex 4 for a summary report of the results of the online surveys.
36 See Annex 3 for a list of those consulted.
of January 2016 through May 2018? How well placed is the organization now to respond to future threats?

The specific guiding questions derived from this overarching question are included in Annex 2. The questions were grouped as follows:

**Accountability**
- A1: Context and needs
- A2: UNICEF response: Scale, coverage and setting targets
- A3: Achievement vs. targets
- A4: Compliance with the CCCs and other principles
- A5: Key cross-sectoral functions: C4D and supply/logistics

**Learning**
- L1: Programme strategy and design (health, nutrition and WASH)
- L2: Programme performance (health, nutrition and WASH)
- L3: UNICEF’s use of evidence (health, nutrition and WASH)
- L4: Operational modalities and working with others
- L5: Coordination and strategic harmonization with other actors
- L6: Efficiency

The report is largely structured around the learning topics noted above, reflecting the desire of UNICEF sections to consolidate the analysis of UNICEF’s programme areas and programme support. The report begins with a review of UNICEF’s evolving programme strategy in the context of the unfolding crisis in South Sudan; and goes on to review the programme’s performance, focusing on the child survival sectors, with data and evidence as a sub-topic in each case. It then looks at some of the related programme support and operational issues, considering the effectiveness and efficiency of the various processes through which the response has been delivered, supported and coordinated.

During the field visits, a limited number of group discussions were held with local communities and partners, the results of which helped inform the conclusions of the evaluation. These consultations were held in the field locations listed above. The protocol and guiding questions for these group discussions are provided in Annex 7.

Two short web-based surveys were also undertaken in July 2018. These were directed at two main stakeholder groups: UNICEF staff – including relevant staff in field offices, only some of whom could be interviewed – and UNICEF implementing partners. These surveys aimed to complement the field phase by seeking responses to questions about the strengths and weaknesses of UNICEF’s response, the quality of working relationships and alternative ways of working. A summary report of the survey results is provided in Annex 4.

Analysis of key documents and the data they contain formed a core part of the evaluation. These documents were used both as sources of information and as a basis for triangulating the information gathered through key informant interviews. A reference library of documents was compiled during the inception phase. These included the following types of materials:

- Overview and general analysis documents from UNICEF and external sources;
- UNICEF country programme documents and related files;
Documents related to the Level 3 emergency designation, including the respective justifications for extension and the Level 3 simplified standard operating procedures;

Needs assessments, both joint and UNICEF-specific;

Response plans (HRPs, but also cluster plans and UNICEF-specific plans);

UNICEF Humanitarian Action for Children appeals and situation reports;

UNICEF programming documents, including work plans, sector strategies and related documents;

Implementation data from the UNICEF results assessment module;

Documents related to the operations function, including the country programme management plan and human resources materials;

Documents related to resource mobilization, including consolidated emergency reports;

Supply and logistics data and relevant documents, including specific studies undertaken in South Sudan;

Monitoring tools, including the Kobo platform, and data as required; and

Relevant studies and evaluations, including updated situation analyses.

A more comprehensive list of the documents consulted is included in Annex 5.

Ethical Considerations

As part of the recruitment process, the Evaluation Office ensured that the evaluation team was familiar with the United Nations Evaluation Group (UNEG) Code of Conduct for Evaluation in the United Nations System, and UNICEF’s procedures, guidelines and tools to ensure the human dignity of children is honoured and that their rights and well-being are respected in all research, irrespective of context. These include the International Charter for Ethical Research Involving Children, the Ethical Research Involving Children (ERIC) compendium, UNICEF’s Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis, and the working paper on ethical research involving children in humanitarian settings.

The evaluation team members also signed the United Nations Evaluation Group Code of Conduct for Evaluation in the United Nations System, which commits signees to independence, impartiality, proper disclosure of conflicts of interest, honesty and integrity, among other principles. Because this evaluation included data collection from vulnerable groups, the inception report and the data collection tools were reviewed and approved by an external review board. This ensured proper protocols were in place for informed consent, data protection, safeguards to protect the rights of vulnerable subjects, etc. See Annex 8 for the official evaluation ethics approval.


This section reviews the overall strategy, content and performance of UNICEF’s emergency response in South Sudan since January 2016. The results of phase one of the evaluation are used as a starting point for this analysis. Many of the issues raised are reviewed in more detail in subsequent sections of the report. In the case of education and child protection, which are covered in this section, a detailed analysis will be provided in part two of the evaluation.\(^\text{39}\)

2.1 OVERVIEW OF UNICEF’S LEVEL 3 RESPONSE TO THE CRISIS IN SOUTH SUDAN

In response to the acute threats to children and their families, UNICEF’s response has been large-scale, multi-sectoral and delivered through various modalities. The South Sudan 2017 Country Office Annual Report gives a sense of the recent balance of the programme: “A large part of UNICEF South Sudan’s humanitarian response has been directed at the displaced children and their families in the PoC sites, internally displaced families on the move and host communities. The response has covered all basic services, with a particular focus in 2017 on the integrated management of acute malnutrition, combining interventions in nutrition, health, WASH and child protection, while working closely with WFP and FAO to ensure complementarity with food security interventions.”\(^\text{40}\)

Work with both displaced and settled communities has been increasingly conducted through civil society organizations, with local organizations constituting a growing part of the partner portfolio – a reflection of the challenges that international NGOs have faced in maintaining access to populations in need. In 2017, UNICEF South Sudan transferred US$55 million to 149 civil society implementing partners. Sixty-six per cent of these partnerships (40 per cent of total funds transferred) were with national partners.\(^\text{41}\)

UNICEF has also made extensive use of the IRRM, principally in partnership with WFP. This has involved flying in mixed teams with essential supplies on short missions to hard-to-reach communities in areas where partners on the ground have been unable to operate or forced to withdraw. UNICEF’s use of the IRRM mechanism is assessed in section 6.

The analytical review\(^\text{42}\) written as part of phase one of this evaluation summarizes UNICEF’s overall response to the crisis in 2016–2018. In doing so, it gives rise to several questions that phase two of the evaluation has attempted to address. Some of the main issues are highlighted here.

Coverage and reach

During the evaluation period, UNICEF and its partners provided assistance to varying degrees to more than one third of South Sudan’s

\(^{39}\) This is planned for late 2018/early 2019.


\(^{41}\) Ibid, p.3

\(^{42}\) ‘Focused Ambition? UNICEF’s Country Programme in South Sudan 2016-2018’.
population in need – a large majority of them children. While this is an important achievement given the circumstances, questions remain about the extent and location of unmet needs, the quality and extent of UNICEF’s reach through mechanisms such as the IRRM and the different levels of vulnerability of beneficiary populations (i.e., given the lack of sex- and age-disaggregated data). These issues are analysed further in relation to the child survival sectors later in the report.

**Funding and resources**

While the overall resourcing of the UNICEF programme has been relatively healthy, with adequate funding for nutrition and education in particular, some major funding deficits have persisted, notably in WASH and health (apart from the EPI component). Funding for child protection has been hard to mobilize, resulting in the programme being cut by 30 per cent in 2017. In addition to donor fatigue, this may also be due to limited partner capacity in the child protection sector.

**Results**

UNICEF’s overall performance against targets (mainly output-based) was relatively strong during the review period, with 80 per cent of Humanitarian Action for Children targets met in 2016 and 2017. In some cases, these results have been achieved despite major operational hurdles; for example when UNICEF effectively scaled up to assist more than 500,000 people in response to famine conditions in Unity State in February 2017. Nonetheless, challenges remain in key areas, including sanitation coverage and measles vaccination. Policy-related work and system building is severely constrained by lack of governmental capacity, nationally and locally. The effectiveness of resilience-building approaches has yet to be proven.

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43 See ‘Focused Ambition? UNICEF’s Country Programme in South Sudan 2016-2018’, paragraph 11. The question of measuring coverage is not straightforward, and this is explored further later in the evaluation.

44 Key informant interview, May 2018.

Respondents to the analytical review raised questions about the longer-term sustainability of UNICEF programming across all sectors and asked: what happens next for children treated for SAM or people reached by the RRM? “We are sustaining lives, not progressing lives” was a common theme. The extreme volatility of the context and related uncertainties in the political, economic and social/demographic spheres may make this inevitable, but UNICEF is perceived to have an important role in helping to build stability where possible.

Programme modalities and service integration

The analytical review highlights both its management flexibility and the mixed modalities approach as strengths in UNICEF’s response. Only a small proportion of the country programme is implemented through government bodies; the bulk of the programme is delivered in partnership with international NGOs and (increasingly) national and local NGOs. The other main modality is the IRRM, which is run in partnership with WFP. More akin to a campaign approach than a regular programme, this allows for reaching hard-to-reach populations for a short duration with a mix of health, WASH, nutrition, education and child protection services. While this is an essential humanitarian approach in the current context and extends UNICEF’s reach considerably in otherwise inaccessible areas, the approach raises questions about the quality and durability of results achieved through this modality.

Decentralized structure

The analytical review notes that “UNICEF’s decentralized field-based structure is considered a significant strength” but implementation of the structure still poses challenges, notably ensuring that capacities to deliver match the level of responsibility and accountability at the field office level. Decentralization is perhaps better described as a system of delegated responsibility, particularly regarding sub-budgets and partner/project management. Overall responsibility for delivery of outputs remains with the UNICEF South Sudan Juba office.

The monitoring function

The analytical review found that the monitoring and evaluation function has faced significant challenges. Questions have been raised about “the credibility of targets set, and a risk of excessive focus on achieving output numbers”. UNICEF’s system for collecting data on outputs is also noted as a “concern” related to the “limited capacity of partners and a multiplicity of planning and results reporting processes [that] may require streamlining and rationalization”. Section 6 provides additional analysis of these issues.

Human resources

UNICEF recruited a number of staff to implement the country programme, including 124 people in 2016 and 129 in 2017. The speed of recruitment also increased from an average of 75 days in 2016 to 49 in 2017. This recruitment push was considered effective and human resources management appeared to be working well. Important human resources challenges persist, however, particularly in hiring staff with adequate skill levels (especially soft or managerial skills) and the underperformance of some staff due to lack of capacity and burnout, especially in field locations.
The Level 3 corporate emergency designation

UNICEF’s Level 3 Corporate Emergency Activation Procedure was activated for South Sudan on 8 February 2014. As recorded in the phase one report: “The L3 was declared for an initial three-month period, and has since been extended 10 times, bringing its total duration to 4 years and 5 months, as the current expiry date is 30 June 2018.”48 During phase one, a set of operational benchmarks was identified, based on the defining Level 3 criteria of scale, urgency, complexity, capacity and reputational risk. The resulting analysis describes the varying degrees of progress made in these areas.49

As of June 2018, the Level 3 Corporate Emergency Activation Procedure in South Sudan was deactivated and the emergency was transitioned to Level 2 status. The explanatory memo from the Executive Director, dated 25 June 2018, states that although the humanitarian situation continues to deteriorate, “UNICEF’s capacity to respond has been significantly strengthened over the past years and the Country Office has the requisite capacity to sustain the response. However, given the volatility of the situation and with the high level of humanitarian funding needs, our support to South Sudan remains an organizational priority. Therefore, I have approved the recommendation... to de-activate the South Sudan Level 3 response on 30 June 2018 and transition to an L2 designation until 31 December 2018.”50

Given that UNICEF has multiple such organizational priorities, the decision to transition to Level 2 is understandable. Some fears were expressed to the evaluation team that the transition might make it more difficult to maintain the necessary international capacity for the response. Given the continuing severity and volatility of the situation, UNICEF should be prepared to temporarily re-instate the Level 3 status, for example in the event of a major cholera epidemic or widespread famine conditions, particularly to expedite the secondment of specialist support staff.

2.2 UNICEF’S OVERALL STRATEGY AND COUNTRY PROGRAMME

Although the period covered by this evaluation is 2016–2018, it is important to understand both the context and UNICEF’s programme within a slightly broader timeframe. It is worth recalling the ambitions for the programme at the time of independence, as reflected in the CPD 2012–2013. At that time, the emphasis was on poverty reduction – the legacy of decades of conflict and under-investment – and the development opportunities that existed in what was a relatively stable country context. The programme would involve close cooperation with the Government and others, in line with the UNDAF, on the agreed national development priorities, for which ambitious targets were set.51 The UNICEF programme was to contribute to all four UNDAF outcomes: 1) core governance and civil service functions are established and operational; 2) chronic food insecurity is reduced and household incomes increase; 3) key service delivery systems are in place, laying the groundwork for increased demand; and 4) violence is reduced and community security improves.

48 Ibid.
49 Ibid.
50 Memo from the UNICEF Executive Director, 25 June 2018.
Even before the outbreak of civil war in 2013, the Government and the aid community were struggling to make progress against these objectives. With the outbreak of hostilities, the UNDAF outcomes proved unrealistic. The focus of activities was increasingly on preventing and mitigating the effects of more acute threats to children and their families while attempting to build the resilience of communities and social service systems. The conflict and its effects massively compounded the humanitarian situation, particularly food insecurity, which was already serious before December 2013. The humanitarian agenda became the dominant priority, and in February 2014, UNICEF declared the situation a Level 3 corporate emergency priority.

The signing of the peace agreement in August 2015 saw another short period of optimism, though more cautious than before. The CPD 2016–2018 reflected this mood and the need to bolster the possibility of a lasting peace. But it also recognized that the operating environment had dramatically changed for the worse. It states: “The ability to implement programming relies on key assumptions, including that the Peace Agreement will hold and that the dividends from peace can be quickly demonstrated; [and] that government priorities can shift from security to development...”

UNICEF managers were not blind to the deteriorating environment. As the Country Programme Management Plan noted, “the 2016–2018 CPD was already designed to operate in a volatile operating environment.” The related programme budget review included three elements that reflected this: 1) a decentralization of UNICEF’s capacities outside of Juba; 2) the development of cross-sectoral interventions linking humanitarian relief, recovery and stabilization; and 3) the strengthening of a country team with versatile capacities to switch from humanitarian response to development work as needed. The July 2016 crisis further highlighted the importance of decentralization so that UNICEF would remain able to operate across the country through its 10 field offices. The revised programme budget review and Country Programme Management Plan emphasized UNICEF South Sudan’s shift toward a more decentralized structure with “realistic and affordable prioritizations” of the interventions agreed to in the CPD.

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54 The Interim Cooperation Framework five strategic outcomes were: 1) more resilient communities; 2) strengthened social services for the most vulnerable; 3) strengthened peace and governance; 4) invigorated local economy; and 5) improved status of women and youth.
56 Ibid.
**BOX 3  UNICEF priorities and approach 2016–2018**

Excerpt from the Country Programme Management Plan 2016–2018 (as revised in September 2016):

“UNICEF’s 2016–2018 priorities in South Sudan are (i) to protect the basic welfare of children and mothers in the sectors of health, nutrition, education, protection, water, sanitation and hygiene, (ii) to promote their rights, and (iii) to give them a voice in decision-making and peace-building… The overall goal of the country programme is that, by June 2018, 2.4 million children in South Sudan will have improved access to integrated basic social services and increased fulfilment of their rights. The emphasis will be on empowering girls, supporting the return and reintegration of displaced populations, and building the resilience of the most disadvantaged communities. An important strategy will be to ensure a continuum of UNICEF development and humanitarian programming in an environment in which the humanitarian response is expected to remain at a very high level over the next two years.”

“In order to achieve this, the new CP [country programme] emphasized ‘risk-informed and flexible programming’. The most marked change from the previous strategy was the refocus on humanitarian and resilience agenda, and on attempts to strengthen systems at sub-national and community levels. ‘While UNICEF will continue to engage in system strengthening at the local and national levels, lessons from past crises have shown it is unlikely that long-term national level policy development work be possible under the volatile political and security environment. The country programme will therefore focus on its humanitarian, recovery and resilience components, adapting them to the changing and fragile context. It will not drop development activities, but will use a nuanced approach to maintain development interventions when feasible, depending on the context of field locations. It will hence focus on:

• Implementing life-saving interventions and early recovery when feasible, that should be expanded towards stabilization and resilience work as situation and access improve.

• Reaching more vulnerable populations outside of Protection of Civilian camps.

• Using national partners for implementation as much as possible, understanding the need to build their capacity given that international NGOs have limited access and implementation capacity, and that many left the country.

• Strengthening political-economy analysis and field monitoring in the context of strengthening HACT [harmonized approach to cash transfer] implementation.

• Delaying and adjusting activities linked to upstream policies given the ongoing changes at the national level. When feasible, working with subnational levels and prioritizing community-based systems, as opposed to statutory national systems.”

Despite the greater realism of the CPD 2016–2018 and the Interim Cooperation Framework, there remained a significant gap between aspiration and reality in terms of the stated strategic aims and UNICEF’s ability to achieve them. To some extent, the approach was founded on a distinction between ‘green’ (relatively stable) states that offered some prospect of system building and developmental progress; and ‘red’ (stable) states, for which humanitarian response was the only viable option and the clear priority. Given the more generalized insecurity that followed the events of July 2016, particularly in the Equatorial states, this distinction became increasingly difficult to draw. Even working on subnational and local system strengthening proved too difficult in many cases.

57 Ibid.
The national developmental agenda stalled in 2013 and never recovered. The overall evolution of UNICEF’s approach during the initial months of the conflict shows the organization continuing to try to combine its developmental aspirations for children with its humanitarian commitments, while finding it ever more difficult to make progress on the former and finding itself stretched to capacity with the latter. While the ongoing commitment to keeping the development agenda alive – at least at the local level – is understandable, it meant that synergy and alignment between policy and practice were lacking. The CPD 2019–2021 attempts to resolve this and is based on a tougher assessment of prospects than the previous CPDs. The challenge for UNICEF is that it must be ready to support prospects for peace and development as they arise and decide to what extent to base its planning and engagement with the Government on the assumption of greater stability, stronger governance and delivery against stated commitments on social services. As the uncertainties surrounding the recent peace deal demonstrate (August 2018), the balance between realism and constructive engagement can be challenging for an organization such as UNICEF.

The humanitarian-development issue also plays out in UNICEF’s approaches to service delivery. As noted in section 1.2, the evaluation team found that the distinction was often artificial and unhelpful in the current context, where the development base is so low, and vulnerabilities are so high. It also found that at times, UNICEF made an artificial separation between the two agendas, which hindered the synergies between them. In the current context, good humanitarian practice – such as to help build a degree of community resilience and meet immediate needs – overlaps strongly with good local development practice. This issue is explored further in the following sections of the report.

Conclusions on strategy

- Weak or absent government capacity have meant that UNICEF’s role during the evaluation period was appropriately focused on helping to meet basic needs and mitigate the worst effects of the conflict through a mix of partnership-based programmes and direct service delivery. Given the limited service provision by the Government, the South Sudan people are increasingly dependent on international assistance and civil society support to meet their basic needs.

- UNICEF and other aid actors are currently playing a more substitutional than auxiliary role in South Sudan; this is likely to remain the case in the short to medium term. Yet ultimate responsibility for the South Sudanese people’s welfare, development and protection lies with the Government, and it is important to maintain this line of political accountability. This raises an important question: How does UNICEF help strengthen the sense of national and local political responsibility and accountability for services and outcomes, given its substitutional delivery role?

- Humanitarian-development distinctions start to break down in a context such as South Sudan, where the development base is so weak and access to basic services is so limited. While tackling the most immediate threats to children and their families clearly remains a priority, UNICEF and others are rightly concerned with helping to build resilience – the ability of people and systems to withstand and recover from shocks. This bridges the humanitarian and development agendas but is too abstract a concept to be operationally useful. Work remains to be done to better define this more broadly, as well as for each individual sector. This is appropriately high on the United Nations Country Team agenda.
• Since there is no short-term prospect of government ownership of the basic service provision agenda, and access windows can close as quickly as they open, it is imperative that UNICEF and other international agencies do as much as possible to build local ownership for each component of the response to ensure both the reach and continuity of services. UNICEF’s efforts to localize its response – increasingly working with local civil society organizations, community groups and authorities – is appropriate. Yet there are severe capacity constraints in this approach, and potential trade-offs in terms of accountability, speed and the quality of response need to be recognized and addressed.

2.3 DELIVERY AGAINST TARGETS AND THE CCCS

Phase one of the evaluation reviewed the overall results of the programme during the evaluation period, in terms of output targets and indicators, based on UNICEF’s own reporting. Figure 1 illustrates the relative success of the different sectors in achieving their output targets.

Social policy was always likely to be a challenging area, given how much it depended on working with the relevant government ministries, which were themselves hugely constrained. For the other sectors, the constraints were related to resources and access, among other factors. As the phase one report noted, UNICEF’s ability to achieve results remains challenged in key areas. Indications are persistent about low sanitation coverage, which according to respondents is related to generally poor infrastructure in the country. The difference between routine (2016 – below target) and campaign (2017 – above target) measles vaccination coverage also points to deficiencies in health infrastructure and the health system overall.

FIGURE 1 Self-reported output status at the end of 2017

![Figure 1 Diagram](image-url)

Source: Analysis by the evaluation team using data from the results assessment module.

59 Ibid.
This section reviews UNICEF’s performance in South Sudan against its global commitments and specifically the CCCs. The essential backdrop to this (in accountability terms) is how well UNICEF delivered – or ensured delivery by others – against identified needs in its areas of responsibility. For the core child survival sectors (nutrition, health and WASH), which are the focus of this evaluation, UNICEF’s performance is considered in depth later in the report. This section focuses on the top-line commitments across the programme and the extent to which UNICEF delivered against them.

Nutrition

Though the nutritional situation of children in South Sudan varies over the course of the annual season, children’s nutritional health steadily deteriorated during the review period – and indeed has been deteriorating since the crisis began in 2013. In collaboration with WFP, UNICEF has played a central role in preventing and treating acute malnutrition. According to a 2017 UNICEF report:

Despite the deployment of a massive humanitarian effort, people in South Sudan still face the very real risk of another famine as a result of armed conflict and high food prices. Extremely poor diets, very limited access to health services, disease outbreaks and low coverage of sanitation facilities have led to high levels of acute malnutrition. In early 2017, South Sudan experienced the world’s first famine in six years. An increase in international aid helped end the famine in June, but the nutrition situation remains critical.

Almost 5 million people out of a population of 10 million are severely food insecure. A total of 1.3 million people are considered to be on the brink of famine. An estimated 1.1 million children are acutely malnourished, including close to 280,000 who suffer from severe acute malnutrition, a potentially life-threatening condition. Malnutrition rates are even increasing in Equatoria, a region of South Sudan traditionally considered the breadbasket of the country, but now the scene of bitter fighting and desolation.

UNICEF’s record in this sector is strong: all nutrition CCCs have been substantially addressed in South Sudan. Effective leadership has been provided through the cluster mechanism and UNICEF has played a critical role in providing the core pipeline of commodities required for treatment of SAM. Community-based management of acute malnutrition and IYCF activities are undertaken wherever access is possible, as are vitamin A supplementation and deworming. Screening and referral activities conducted by community nutrition volunteers have provided a regular opportunity for children and women to access the information and nutrition programmes that UNICEF supports.

UNICEF has contributed to timely nutrition assessment and surveillance through support to the IPC, the Food Security and Nutrition Monitoring System and SMART surveys undertaken throughout South Sudan. Improvements in nutrition information have also been achieved through the nutrition information system, which has standardized partner reporting. That said, significant concerns remain concerning data availability and reliability.

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60 United Nations Children’s Fund, ‘Core Commitments for Children in Humanitarian Action’, UNICEF, New York, May 2010. The CCCs provide a central element of its global framework of accountability in humanitarian contexts. They are intended to provide a “framework for collective action for children affected by humanitarian crisis, which UNICEF invites partners to support. Regardless of the availability of UNICEF resources or the country programme profile, the CCCs are relevant to all countries. However, the role of UNICEF and that of its partners will vary depending on the local conditions and respective capabilities.” The document goes on to note that “the fulfilment of the CCCs... depends on many factors, including the contributions of other partners and the availability of resources” (p. 2). In a context such as South Sudan, the operating environment, including major restrictions on access and security concerns, has a significant bearing on UNICEF’s ability to fulfil its stated commitments.

Despite its relatively strong performance in this sector, the nutritional situation of children and their mothers remains critical and has continued to deteriorate over time. This highlights the crucial importance of continued nutritional support, as well as integrated support across the sectors that most affect nutritional outcomes, including food security, health and WASH. Close coordination with WFP, FAO and others – and between the related sectors/clusters – is essential in this regard.

UNICEF’s performance against the specific targets and commitments made in relation to South Sudan are reviewed in detail in section 3.

**Health**

Children and women in South Sudan face threats related to both endemic and epidemic disease patterns, as well as high levels of vulnerability related to armed conflict, poverty and malnutrition. The health system has broken down, with only limited health services available in most parts of South Sudan, particularly in rural areas.

The cholera epidemic of 2016–2017 demonstrated how vulnerable people are to disease outbreaks in South Sudan. According to a 2017 UNICEF report:

South Sudan’s health system, already fragile before the conflict, is at breaking point. Health facilities have been looted or destroyed and many health workers have not been paid. Disease outbreaks have become more widespread, and more deadly. The conflict has severely restricted access to safe water and basic sanitation facilities…

The lack of adequate health, water and sanitation services provide fertile ground for the spread of diseases at a time when fighting, displacement and malnutrition have weakened communities, leaving children particularly vulnerable. Malaria, pneumonia and diarrhoea are major killers of children in a country where 1 in every 10 children dies before reaching the age of 5, and almost 1 in 100 births results in the death of the mother. More than 1.3 million people fell ill with malaria in the first nine months of 2017. Every week, the mosquito-borne disease kills nearly 220 people, most of them children under 5.62

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62 Ibid.
**Health strategic result:** Excess mortality among girls, boys and women in humanitarian crisis is prevented.

The specific health commitments can be summarized as follows:

1. **UNICEF support for inter-agency coordination**, strategy and planning
2. **Life-saving interventions** for children and women (measles vaccines, bed nets, etc.)
3. Access of children, adolescents and women to **essential health services** (EPI, etc.)
4. Women and children in all affected populations get key **health education** messages
5. Women and children (more than 90 per cent) have access to **essential household items**

UNICEF’s efforts in South Sudan have substantially addressed the health CCCs, though apart from immunization, its contributions have been relatively modest in scale. UNICEF has coordinated its own work with that of the Health Cluster – including the work of NGOs funded from the Health Pooled Fund – and the South Sudan Ministry of Health. UNICEF has also made substantial contributions to life-saving interventions, including measles vaccination, micronutrient supplementation and the provision of treated bed nets.

UNICEF has also supported essential health services, targeting the three main morbidities in South Sudan: malaria, pneumonia and diarrhoea. Access to maternal health services has been facilitated through support for antenatal care, safe delivery and prevention of mother-to-child transmission of HIV. Key health education and promotion messages have been delivered both at facilities and at the community level through mother-to-mother support groups and integrated community case management (iCCM) activities. The evaluation team was unable to find evidence of any activities undertaken by UNICEF to address Commitment 5 during the evaluation period, however.

Particularly in the health sector, given the extent of the needs and vulnerabilities, it is difficult and even unhelpful to distinguish humanitarian and development programming. Much of UNICEF’s work in this area could be classified under either heading. The urgency of this work is due in part to the specific risks of vaccine-preventable diseases affecting children, which are heightened in the context of significant population movement. The dangerously low levels of vaccination in some areas make routine EPI a critical priority.

UNICEF’s specific commitments on health in South Sudan are set out in the CPD and related health strategy, as well as the related appeal and programme funding documents. These are reviewed in detail in section 5.

**WASH**

In South Sudan, access to WASH facilities is severely constrained due to lack of investment, damage to infrastructure and behavioural/cultural factors. As WASH Cluster lead and through its own programming with implementing partners, UNICEF plays a major role in the area of WASH, which presents a unique set of challenges. According to the CPD 2019–2021:

The World Health Organization/UNICEF Joint Monitoring Programme estimated that in 2015 only half the population had at least basic access to improved water, while a further 30 per cent had limited access (at least a 30-minute walk), with minimal urban/rural differences. Just 10 per cent of the population had at least basic sanitation facilities

As stated in the 2018 HRP: “In urban areas, increasing fuel prices or unavailability of fuel has put an additional strain on existing water systems and substantially increased the cost of water, forcing people to resort to using unsafe drinking water.”\footnote{‘South Sudan: 2018 Humanitarian Response Plan’.}

Overall, during the evaluation period, UNICEF showed substantial delivery against all five WASH CCCs, though for reasons largely beyond its control, it has fallen short of full achievement. Commitment 1 on leadership now appears to be well achieved, with cluster leadership back on track after a period of deficits, and appreciated by WASH Cluster partners. Commitment 2 has only been partially achieved as gaps remain in the coverage of the overall WASH response. Furthermore, the WASH Cluster targeted only a proportion of those identified in need in the 2017 HRP,\footnote{The HRPs for both 2016 and 2017 set targets for the WASH Cluster that are lower than the estimated population in need. Additional details can be found in section 4.} explicitly referring to resource constraints as a factor. Not all people in need of WASH assistance were reached by the sector response. The same is true for Commitment 3 on sanitation, with an even larger gap between estimated needs, targets and delivery. While Commitment 4 is worded without clear reference to the depth of the messaging, there have been concerns from WASH partners about the effectiveness of UNICEF’s hygiene promotion activities. Finally, while there is evidence of UNICEF’s delivery on Commitment 5 on WASH in schools and child-friendly spaces, the extent of the coverage and gaps could not be established with the available data.

UNICEF’s specific WASH commitments in South Sudan are set out in the CPD and related South Sudan WASH strategy note, along with the related appeal and programme funding documents. These are reviewed in section 4.

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**BOX 6**  UNICEF’s global WASH commitments under the CCCs

**WASH strategic result:** Girls, boys and women have protected and reliable access to sufficient, safe water and sanitation and hygiene facilities.

The specific WASH commitments can be summarized as follows:

1. Effective **cluster leadership**, including identification of needs and gaps
2. Children and women have **adequate clean water** for drinking, cooking and hygiene
3. Children and women access adequate **sanitation facilities** (toilet and washing)
4. Children and women receive sufficient **hygiene information** to prevent illness
5. Children access safe **WASH facilities in schools** and child-friendly spaces
Education

Though it is less visible than some other aspects of the crisis, the effects of the emergency on children’s education may be among the most serious and long lasting. The education deficit long pre-dates the conflict, and conflict has exacerbated the challenges, as illustrated by the following excerpts from a 2017 UNICEF report and the CPD 2016–2018:

The crisis is depriving millions of children of the education they need, in a country that already had poor education indicators before the conflict started. Some 2 million school-age children in South Sudan are estimated to be out of school – at 72 per cent it is the highest proportion in the world. Insecurity, attacks on schools and their use by the armed forces or armed groups, as well as hunger and displacement have severely affected the education system. A systematic failure to invest in quality education has further aggravated the situation. Teachers’ salaries are low and paid irregularly and, as a result, 31 per cent of teachers have stopped going to school due to non-payment of salaries [and] insecurity and are looking for another job. Schools are getting only limited support from the Government, and facilities are often inadequate – as many as 36 per cent of primary school students do not have access to latrines, according to a 2016 census. If the current situation persists, only 1 in 13 children is likely to complete the full cycle of primary education.66

Since 2010, primary school attendance has fallen from 1.4 million to 1.1 million. At 30 per cent, the net enrolment rate for girls in primary school remains more than 10 points lower than that of boys, and less than half the average for Eastern and Southern Africa. While primary enrolment increased since 2013 in the seven states not affected by the conflict —with strong gains in schooling among girls in the older years—the impact of the conflict accounts for much of the overall decline. Inequalities in access remain high: Children living in poverty, children from pastoralist communities and children with disabilities are less likely to attend school. The number of children attending pre-primary education is growing, albeit from a very low base.67

Despite the hugely challenging environment, UNICEF has done well to help maintain and extend access to education in the more accessible areas of the country through education-in-emergencies interventions. With regard to the Education Cluster, one of UNICEF’s most important roles has been to manage an education supply pipeline for partners.68

Through the Back to Learning initiative, children who were out of school were able to return to the education system. Though there is limited evidence on the sustainability of the interventions, in 2017, UNICEF reported that 200,000 children were retained from the 2016 campaign, and another 300,000 children were newly enrolled. These results speak to Commitment 2. In line with Commitment 3, UNICEF supported the construction or rehabilitation of safe and secure learning centres, including early childhood development centres. Temporary learning spaces were established for areas of high population mobility.69

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66 ‘Childhood Under Attack: The staggering impact of South Sudan’s crisis on children’.
68 Data from the UNICEF results assessment module (internal), as of the end of 2017.
69 Ibid.
Geographical coverage appears to have increased in 2017: Education-in-emergencies interventions expanded in 2017 to additional counties in Western Equatoria, Lakes and Jonglei states. In PoC sites, the capacities of schools increased to accommodate more children. Some counties in Greater Upper Nile and conflict-affected parts of Central and Western Equatoria remained inaccessible during the evaluation period, indicating gaps in UNICEF’s ability to fulfil the CCCs.70

There is evidence that newly built schools and classrooms gained access to WASH facilities and kitchens, in line with Commitment 4. UNICEF also reported that a proportion of children was reached with psychosocial support activities through schools. It is not clear from UNICEF situation reports to what extent health is integrated into education responses, however. This will be considered further in part two of the evaluation.71

Child protection

As described in section 1, children in South Sudan face extraordinary threats to their safety and well-being. Violent conflict has added new layers to this, as illustrated in the following excerpt from a 2017 UNICEF report:

The violent conflict has taken a staggering toll on the new nation’s youngest, whose lives and rights are constantly under threat. In total, 3,739 incidents of grave violations against children were reported to the United Nations Monitoring and Reporting Mechanism between December 2013 and October 2017. These reported incidents have affected 117,386 children. But those are only the figures that could be documented and the actual numbers are feared to be far higher. Lack of access to some areas, and major reporting challenges make it impossible to document the full scale of the violations.
The reported cases include:

- The recruitment of more than 19,000 children.
- Over 3,200 children abducted.
- More than 1,200 children affected by sexual violence.
- Some 293 incidents of military use and attacks on schools, affecting over 90,000 children.
- Children are targeted and killed for their ethnic background or for the political affiliation of their relatives or community members.

Children also have been affected by the break up of families, in large part because of fighting and displacement. Since the beginning of the crisis, over 16,000 unaccompanied, separated and missing children have been registered for family tracing services. Many children have lost loved ones and witnessed brutal attacks that have left them with deep psychological scars. An estimated 900,000 children suffer from psychosocial distress.72

In child protection, perhaps more than in any other sector, the gap between vulnerabilities and the ability of humanitarian agencies to reduce them is clear. This is not a matter of under-performance but a characteristic of the protection agenda as a whole, as both the ability and responsibility to protect lies directly with the warring parties themselves. UNICEF has been consistent in its efforts to create a safer environment for children and provide remedial services for those exposed to violence or separated from their families. Yet insecurity and lack of access has severely disrupted these efforts.73

In its humanitarian response, UNICEF has consistently reported incidents of grave rights violations against children to the United Nations Monitoring and Reporting Mechanism,74 corresponding directly to Commitment 2. There is also evidence of related advocacy in UNICEF situation reports. Commitments 3, 4, 5 and 6 have been largely fulfilled through child protection interventions, including community-based programmes to establish case management services and psychosocial care through strengthening the protective skills of caregivers, social groups and child protection networks.75 Gender-based violence prevention is a dedicated aspect of this work. Specific psychosocial support services are also provided through learning facilities. UNICEF registers and supports the return of unaccompanied and separated children to their families or safe environments, and supports the registration of missing children.76

Regarding Commitment 7, UNICEF has actively supported the release and re-integration of children associated with armed forces and armed groups, as well as related advocacy; and has had significant success in this area.77 In line with Commitment 8, UNICEF has provided mine risk education to children and adolescents, focusing on prevention.

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72 ‘Childhood Under Attack: The staggering impact of South Sudan’s crisis on children’.
74 ‘Childhood Under Attack: The staggering impact of South Sudan’s crisis on children’.
75 Data from the UNICEF results assessment module (internal), as of the end of 2017.
76 UNICEF situation reports for the evaluation period (2016-2018).
77 UNICEF situation reports; and data from the UNICEF results assessment module (internal), as of the end of 2017.
Some of UNICEF’s activities have had an indirect but important role to play in keeping children safe, helping them recover from trauma and securing their rights. Education services are the most obvious example. UNICEF’s successful sponsoring of legislation on birth notification also reflects this. More broadly, the ways in which UNICEF and its partners provide assistance has the potential to make children and their families either more or less safe. This is a question related to the centrality of protection in the humanitarian response, and a matter of mainstreaming protection concerns throughout the programme. As staff admit, UNICEF and its partners have a way to go in terms of fully embedding this approach into the response, which is linked to the question of programme quality. This will be considered in more detail in part two of the evaluation. There are also specific areas of concern, including child protection for refugee and displaced children, for which greater collaboration with UNHCR may be needed.

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**BOX 8** UNICEF’s global child protection commitments under the CCCs

**Child protection strategic result:** Girls’ and boys’ rights to protection from violence, abuse and exploitation are sustained and promoted.

The specific child protection commitments can be summarized as follows:

1. Effective **coordination and leadership for child protection and gender-based violence** areas of responsibility; support for coordination of mental health and psychosocial work
2. **Monitoring and reporting of grave violations** plus related advocacy
3. Key **child protection mechanisms** are strengthened in emergency-affected areas
4. **Separated and unaccompanied children** are identified and appropriate care is provided
5. **Violence, exploitation and abuse** of children and women is prevented and addressed
6. **Psychosocial support** is provided to children and their caregivers
7. **Child recruitment** is addressed and prevented for conflict-affected children
8. Use of **landmines and indiscriminate weapons** is prevented and their impact is addressed
3 THE NUTRITION RESPONSE
Despite massive humanitarian efforts, nearly half of the population of South Sudan is food insecure, and 1.3 million people are on the brink of famine, due to the armed conflict and high food prices. An estimated 1.1 million children are acutely malnourished, including nearly 280,000 children who are suffering from SAM. These findings highlight the crucial importance of continued nutritional support, as well as integrated support across the sectors that most affect nutritional outcomes. The section identifies key areas and ways in which UNICEF can further strengthen its nutrition and resilience programming.

3.1 THE FOOD SECURITY AND NUTRITION CONTEXT

Up to 95 per cent of people in South Sudan are dependent on climate-sensitive activities for their livelihoods, including agriculture, forestry resources and fisheries. More than 95 per cent of the country’s total area is considered suitable for agriculture, and 50 per cent is considered prime agricultural land. Yet that potential is not being realized: Currently only 4 per cent of the country’s land is actively cultivated, and levels of crop and vegetable production in South Sudan remain low. Farmers rely heavily on rain-fed crop production so that erratic or delayed rains result in poor or no harvests, while heavy rains and flooding can waterlog fields and destroy stocks. At the same time, conflict and mass displacement have forced farmers from their fields during key times in the planting season; and the limited availability of and access to quality seeds and planting materials has constrained yields.

Livestock – particularly cattle, goats and sheep – is an important social and economic asset in South Sudan. Endemic diseases are undermining livestock production, however, and threatening the livelihoods of nearly two thirds of South Sudan’s population. Local and national capacity to monitor, control and respond to these diseases is severely limited. In addition, the conflict has caused abnormal migration, heightening tensions between herders and settled farmers and increasing instances of disease outbreaks among livestock.

These factors, coupled with the country’s economic crisis, low purchasing power and high prices, have heightened food insecurity.

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Figure 2 details the number of people identified as acutely food insecure by the IPC and classified in IPC phases 3 (crisis), 4 (emergency) and 5 (catastrophe) during the evaluation period.

Figure 2 shows a deteriorating food security situation during the evaluation period, with 5.3 million people classified in IPC phases 3, 4 and 5 in January 2018, compared with 2.8 million people classified in one of these phases in January 2016. During this period, geographical variations in food security existed throughout the country. In 2016, the bulk of the acutely food insecure population (57 per cent) was located in the Greater Upper Nile states of Unity, Jonglei and Upper Nile. Unity State was the most affected by continued fighting and looting that displaced large populations and disrupted livelihoods due to loss of livestock. The sustained fighting also limited access to humanitarian assistance, further exacerbating the food security situation.

In January 2017, famine was declared in some counties in Greater Unity, while other counties were declared at high likelihood/risk of famine. Though the end of famine was declared in May 2017, the prospects for improvement in 2018 and beyond remained worrying. The number of people in IPC phases 3 and 4 has continued to rise, with the previously relatively stable region of Greater Equatoria becoming more insecure, and large numbers of people becoming highly vulnerable.
Nutrition threats and vulnerabilities

Nutrition data correlate with the IPC data, with many of the states registering GAM rates above the 15 per cent emergency threshold during 2016–2018. Figures 3 and 4 illustrate GAM and SAM prevalence by state. These high GAM rates at the state level mask even higher GAM rates at the county level.

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FIGURE 2
Number of people in IPC phases 3, 4 and 5, 2016–2018 (millions of people)

Source: Integrated Food Security Phase Classification.

FIGURE 3
GAM prevalence by state, 2015–2018 (weight for height Z-Score greater than -2)


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85 Nutrition data provided by the Food Security and Nutrition Monitoring System.
86 Gaps in Figures 3 and 4 reflect gaps in the reported data for the relevant states.
As noted, in addition to conflict, displacement and fragile livelihoods, poor maternal and child feeding practices, morbidity, lack of access to clean water and constrained access to health and nutrition services have also led to high levels of acute malnutrition.\textsuperscript{87} A 2016 analysis found that children who suffered from malaria, pneumonia or diarrhoea were much more likely to be acutely malnourished than children not suffering from one of those illnesses.\textsuperscript{88} An additional factor heightening vulnerability to acute malnutrition is gender inequality, including child marriage and violence against women.\textsuperscript{89} The nutrition crisis is particularly severe for children and mothers. GAM prevalence among pregnant and lactating women, measured as mid-upper-arm-circumference of less than 230 millimetres, was 17.3 per cent.\textsuperscript{90} In some states, such as Jonglei, GAM prevalence was as high as 28.8 per cent.\textsuperscript{91} Only 45 per cent of children aged 0 to 6 months are exclusively breastfed and only 16 per cent of children aged 6 to 8 months were fed solid/semi-solid foods.\textsuperscript{92} In addition, only 4 per cent of children aged 6 to 59 months were found to have received vitamin A supplementation in the last six months. Chronic malnutrition was reported to be 31 per cent, but due to the widespread lack of birth certification (and the need for accurate age recall for using the height-for-age chronic malnutrition indicator), this figure may be unreliable.\textsuperscript{93}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure4.png}
\caption{SAM prevalence by state, 2015–2018 (weight for height Z-Score greater than -3)}
\end{figure}

\begin{itemize}
\item \textsuperscript{88} World Food Programme, ‘Food Security and Nutrition Monitoring System Report – South Sudan’, WFP, 2016.
\item \textsuperscript{89} ‘Country Programme Document: South Sudan’ (2016–2018).
\item \textsuperscript{91} Ibid.
\item \textsuperscript{92} Republic of South Sudan Ministry of Health, ‘Maternal, Infant and Young Child Nutrition MIYCN Guidelines’, December 2017.
\item \textsuperscript{93} Government of South Sudan Ministry of Health, National Bureau of Statistics, ‘South Sudan – Household Health Survey 2010’, 2010.
\end{itemize}
3.2 NEEDS ASSESSMENT AND DATA QUALITY

Accessing reliable contextual data about needs is a problem across UNICEF’s programme in South Sudan. An underlying weakness of data in South Sudan is the lack of a recent census and national survey data and the poor birth certification system. The last population census was undertaken in 2008 and the most recent household and health survey took place in 2010. Without these key denominators, much of the data is unreliable, with the exception of some trend analysis.

Even before the current crisis, there was a lack of quality and timely nutrition information to guide programming in South Sudan. Collaboration between WFP and UNICEF on technical assistance and resource allocation has generated some improvements. Today, South Sudan benefits from a number of inter-agency food security and nutrition assessment and analysis initiatives, including the IPC and the Food Security and Nutrition Monitoring System, as well as regular SMART surveys undertaken at the county level. These mechanisms use multiple indicators, such as food consumption, livelihoods, market price data, malnutrition, morbidity and mortality, to provide situation analysis that supports evidence-based decision-making.

Through its partners, UNICEF has access to other useful sources of nutrition information. Community nutrition volunteers collect mid-upper-arm-circumference screening data, and implementing partners undertake outreach activities from static outpatient therapeutic programme (OTP) sites. This data, if collected consistently, could be useful for trend analysis and as early warning indicators. The nutrition information system, which collects data on OTP admissions and trends, can also act as a useful point of comparison for nutrition assessments and surveys. The growth in OTP admissions between 2014 and 2018 reflects both the increased need in 2016 and 2017 (around the localized famine period) and the scale-up in services.

UNICEF leads the Nutrition Information Technical Working Group as part of the Nutrition Cluster, which coordinates, validates and disseminates nutrition surveys undertaken by cluster members. Despite efforts to validate surveys, a number of key informants have raised concerns about the reliability of survey data and gaps in the available data, as reflected in Figures 3 and 4. It was suggested that greater efforts are needed to increase capacities to undertake surveys, focusing on field-level partners that provide enumerators. There may also be a significant problem of bias in reporting: Surveys are often carried out by NGOs that may have interests in declaring high malnutrition rates to secure funding and programme resources. Some steps have been taken to minimize this risk by asking such organizations to lead surveys in areas in which they are not operational.

The implications of unreliable survey data go beyond the nutrition sector, since the results are used in the IPC analysis, which is relied upon by the entire humanitarian community in South Sudan for targeting and prioritization. This raises the need for an independent

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96 The nutrition information system is an overall reporting system for programme service activities such as targeted supplementary feeding programmes and OTPs. Recording of programme performance data reported by partner organizations started after the 2013 crisis in South Sudan.
97 Key informant interviews conducted in Juba, May 2018.
assessments and analysis unit for South Sudan with no operational or financial interests relating to the data collected and reported. Such a unit has operated successfully for many years in relation to Somalia.  

### 3.3 UNICEF’S NUTRITION STRATEGY

UNICEF’s nutrition strategy is detailed in the CPD 2016–2018 and the supporting nutrition programme component strategy note for that same period. UNICEF’s nutrition interventions supported three of the five objectives of the Interim Cooperation Framework, namely: 1) resilient communities; 2) strengthened social services for the most vulnerable; and 3) improved status of women and youth. UNICEF’s strategy also contributes to the achievement of the Government of South Sudan Health Policy 2016–2026, which has as one of its objectives to strengthen health service organization and infrastructure development for effective and equitable delivery of the basic package of health and nutrition services.

South Sudan joined the Scaling Up Nutrition movement in 2013 with UNICEF support. The movement aims to combine the work of civil society, the United Nations, donors, businesses and researchers in a collective effort to improve nutrition. Key informants and reports suggest that progress has been slow, however, with many of the necessary platforms still to be established or revitalized, including the multi-stakeholder platform.

UNICEF’s interventions in South Sudan are aligned with its Global Nutrition Strategy. Interventions such as SAM treatment and nutrition education also reflect the organization’s mandate under the global Memorandum of Understanding signed between WFP and UNICEF in 2005 and updated in March 2011. This global partnership is further detailed in the partnership framework between WFP and UNICEF in South Sudan on reducing malnutrition (July 2017–December 2018).

UNICEF’s nutrition strategy in South Sudan clearly addresses key needs, such as high SAM prevalence, the need for IYCF and promotion of child care practices to prevent malnutrition. It is aligned with existing country strategies and the work of United Nations partners such as WFP, which provides MAM treatment. The lack of government capacity at the national and state levels, as well as the high levels of instability and population movement, make achievement of a nationally owned and managed nutrition programme a medium- to long-term goal. The current emphasis is appropriate: to ensure that basic nutrition services are delivered to as many of those in need as possible and to strengthen local capacity during delivery.

#### The life-cycle approach

The consequences of poor nutrition begin in utero and affect a person throughout their life cycle. There are two dimensions to this. First, poor nutrition increases health risks: undernourished children fall ill recurrently and fail...
to develop optimally – both physically\textsuperscript{102} and mentally. This cycle has likely contributed to the high infant and child mortality rates in South Sudan of 59.2 and 90.7 per 1,000 live births, respectively.\textsuperscript{103} Second, poor nutrition increases the likelihood of damage to future generations through foetal growth retardation. Girls who survive malnutrition may grow up to produce low birth weight\textsuperscript{104} babies who may have a lower chance of survival than normal weight babies. Studies have also found that maternal weight is a key risk factor associated with low birth weight. According to a 2004 study, improved food intake during pregnancy reduces the incidence of low birth weight, as does the control of diseases such as malaria.\textsuperscript{105}

Given the link between maternal and child nutrition outcomes,\textsuperscript{106} UNICEF should consider the life-cycle approach to addressing malnutrition and either directly target or advocate with key partners (such as WFP) to target interventions to each stage of the life cycle. Figure 5 describes the life-cycle approach and UNICEF’s current nutrition and health activities targeting children at each stage of their development, through to adulthood.

WFP implements activities that complement UNICEF’s interventions in South Sudan, as mandated by the 2005 global Memorandum of Understanding. These include MAM treatment for children aged 6 to 59 months and pregnant and lactating women, and seasonal blanket supplementary feeding provided during lean periods. To reduce the risks associated with poor in-utero nutrition and low birth weight, blanket supplementary feeding should be provided to all pregnant and lactating women from the last semester through to when the child reaches 6 months to reduce the risk of low birth weight. This could target counties with emergency GAM levels (i.e., with GAM rates above 15 per cent). UNICEF’s role would be to advocate with WFP to expand the blanket supplementary feeding programme.

Figure 5 highlights that there are currently no nutrition activities in South Sudan that target school-aged children or adolescents.\textsuperscript{107} UNICEF’s data suggests that 52 per cent of girls in South Sudan are married by age 18, and 9 per cent are married before age 15. The high burden of early marriage in South Sudan and the risks associated with child marriage reinforce the need to address school and adolescent nutrition.\textsuperscript{108} Interventions to reduce this inter-generational cycle of hunger could include targeted nutrition messaging and counselling in communities and schools, and the provision of micronutrient supplementation alongside WFP school meals.\textsuperscript{109} In addition, incentives could be used to encourage the school enrolment and attendance of adolescent girls.

\textsuperscript{102} Stunting starts in utero and is irreversible beyond age 2; hence the importance of the first 1,000 days after conception.


\textsuperscript{104} Data on low birth weight is not available for South Sudan. However, a study from 1995 indicated that 18.2 per cent of community-based deliveries were low birth weight. Taha, T.E.T., et al., ‘Distribution and Determinants of Low Birthweight in Central Sudan’, Paediatric and Perinatal Epidemiology, vol. 9, issue 2, April 1995.


\textsuperscript{107} Key informants indicated that UNICEF is starting a corporate process to develop guidance on how to address nutrition for these two specific target groups.

\textsuperscript{108} For example, in 2017, the share of pregnant and lactating women under 18 years who delivered with a skilled attendant was only 8.6 per cent, suggesting that greater effort is needed to promote appropriate health-seeking behaviour.

\textsuperscript{109} WFP school feeding targets primary education; however, it is evident that a number of older children attend primary education due to the lack of previous educational opportunities.
3.4 IMPLEMENTING THE STRATEGY: RESULTS AND EFFECTIVENESS

Delivery against targets

UNICEF has largely delivered against the output targets detailed in the Humanitarian Action for Children and Nutrition Cluster plans. Table 1 provides UNICEF’s targets for SAM treatment for children aged 6 to 59 months and its achievement against those targets (i.e., the number of children treated in OTPs and stabilization centres).

Table 1 shows improvements in terms of achievement against the targets from 2015 onwards, with the exception of 2016, in which only 86 per cent of targeted children were reached. UNICEF and partners still admitted approximately 50 per cent more children for treatment in 2016 than in 2015, however. UNICEF reported that the low achievement against the 2016 target was due to renewed fighting across the country, particularly in Western Bahr el Ghazal, Western Equatoria, Pibor and Malakal, which restricted humanitarian access.\(^{111}\)

<table>
<thead>
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<th>Year</th>
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</tr>
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<td>% achieved</td>
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<td>100</td>
<td>86</td>
<td>102</td>
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</tbody>
</table>

Source: Data provided by the UNICEF South Sudan Nutrition Section, 2014–2018.

\(^{110}\) The 2017 target for SAM treatment was lower than the 2016 target due to a reduction in the caseload. See Figure 6.

UNICEF also conducted IYCF counselling during the evaluation period. Table 2 provides the number of caregivers targeted and reached by implementing partners.

The results provided in Table 2 include individual IYCF counselling for caregivers of children aged 0 to 23 months, which totalled 724,500 and 1,028,804 in 2016 and 2017, respectively.\(^\text{112}\) In those years, UNICEF and its partners demonstrated an ability to exceed targets for IYCF counselling. However, UNICEF did not follow up on this success by setting more ambitious targets for 2018; the 2018 target is less than 50 per cent of the total number of beneficiaries reached in 2017. It is unclear to the evaluation team why this should be so: standard practice is that the appropriate target should be at least as high as the actual result for the previous year.

UNICEF also engaged in vitamin A supplementation through routine health facility activities and vaccination campaigns. More than 1.5 million children aged 6 to 59 months received vitamin A supplementation in 2017.\(^\text{113}\)

### Effectiveness against stated objectives

According to UNICEF’s programme component strategy note for nutrition for 2016–2018, the expected outcome of UNICEF’s interventions was “improved and equitable provision of evidence-based nutrition interventions for children and women of child-bearing age, including pregnant and lactating women.”\(^\text{114}\) The strategy also details five outputs:

- Sustained availability of accessible nutrition services in vulnerable areas, integrated into health facilities by 2018;
- Increased availability of IYCF counselling and improved hygiene practices at household and facility levels with emphasis on behaviour change by 2018;
- Improved policy and knowledge management at national and state levels, including local communities and civil society by 2018;
- Effective nutrition preparedness and response for emergency-affected populations delivered in line with the CCCs; and
- Nutrition programme outputs effectively implemented and technical support provided at national and state levels by the nutrition section.

### TABLE 2

<table>
<thead>
<tr>
<th>Year</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<td>UNICEF target</td>
<td>567,366</td>
<td>590,134</td>
<td>1,013,536</td>
</tr>
<tr>
<td>UNICEF result</td>
<td>975,330</td>
<td>2,211,929</td>
<td>N/A</td>
</tr>
<tr>
<td>% achieved</td>
<td>172</td>
<td>375</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: Data from the UNICEF Humanitarian Action for Children appeals for South Sudan, 2016–2018.

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\(^{112}\) Data provided by the UNICEF South Sudan Nutrition Section, 2016–2017.

\(^{113}\) Ibid.

\(^{114}\) ‘UNICEF South Sudan Programme Component Strategy Note: Nutrition’.
Output 1: Sustained availability of accessible nutrition services in vulnerable areas, integrated into health facilities by 2018

Figure 6 demonstrates UNICEF targets for SAM treatment against the SAM caseload (number in need) during the evaluation period.

Figure 6 illustrates the marked increase in the proportion of children targeted for SAM treatment compared with the caseload during the evaluation period. The UNICEF target reflects the target set by the Nutrition Cluster and the complex nature of the South Sudan context, including the fluctuating nature of the conflict and the difficulties reaching displaced populations outside of PoC camps. However, the gap between those in need (the caseload) and those targeted, while decreasing, remains substantial: In 2017 and 2018, the gap was 69,086 and 53,828 children under 5, respectively. Given the access constraints that UNICEF has faced, this seems reasonable.

Figure 7 demonstrates the increasing proportion of children aged 6 to 59 months with SAM admitted for treatment. The graph shows an increase from 40 to 76 per cent from 2014 to 2017.\(^\text{115}\)

While the data presented in Figure 7 is not an accurate representation of coverage,\(^\text{116}\) it does demonstrate an increase in the proportion of children admitted for SAM treatment compared to the caseload. This is likely a function of factors such as the community-based screening and referral provided by community nutrition volunteers, the presence of mother-to-mother groups and the number of OTP sites opened during the evaluation period.\(^\text{117}\) The number of these sites providing standard treatment services for children with SAM rose from 380 in 2014, to 600 in 2016 and 800 in 2018. The opening of new sites provided greater geographical coverage and brought services closer to those in need.

115 Data for 2018 are not presented because data for the year were not available at the time of writing this report. First quarter 2018 data suggest that 25 per cent of children aged 6 to 59 months with SAM (25 per cent of the caseload) were admitted into UNICEF-supported therapeutic feeding programmes.

116 The Semi-Quantitative Evaluation of Access and Coverage method should be used to determine coverage. Discussions on conducting a coverage survey for nutrition services are ongoing at the cluster level. Semi-Quantitative Evaluation of Access and Coverage studies conducted by implementing partners at the county level have revealed coverage of between 34 and 80 per cent, often depending on the timing of the study (suggesting that seasonality is a key factor in coverage). Sphere indicators suggest coverage above 50 per cent should be achieved in rural areas. In May 2018, a bottleneck analysis undertaken by the UNICEF South Sudan Nutrition Section reported that geographical coverage of SAM treatment was 40 per cent in 2016 and 47 per cent in 2017, suggesting that coverage is low.

117 Key informant interviews with UNICEF partners, Juba, May 2018.
UNICEF has made commendable efforts to integrate services into existing health facilities wherever possible. However, this option has inevitably been limited given that over 57 per cent of health facilities in conflict-affected states have been looted or destroyed and are not functioning. Additional OTP sites have therefore been established, as noted. Yet despite the increased availability of OTP sites and community screening and referral, the prevalence of acute malnutrition remains high, and often above the emergency threshold. This is presumably due to insecurity and related population displacements, which have reduced access to food and health services, as well as limited access to clean water and poor hygiene and feeding practices.

The evaluation team found that there are fewer WFP target supplementary feeding programme sites than UNICEF OTP sites across the country. In January 2018, the Nutrition Cluster reported that there were 690 WFP-supported target supplementary feeding programme sites, compared with 771 UNICEF-supported OTP sites. This suggests that UNICEF's geographic coverage is greater than WFP's. Given the large MAM caseload it seems necessary that WFP at least match the number of UNICEF sites and potentially have more targeted supplementary feeding programme sites than OTP sites. This is key given that MAM treatment is a major contributor to SAM prevention.

The evaluation was not able to determine in detail who cannot access services and why. Only general reasons were identified, such as restricted access to assistance due to conflict, insecurity and lack of permission – which is reportedly a matter of deliberate policy by warring parties in some cases.

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120 The Nutrition Cluster facilitated an agreement on the use of expanded criteria. This is proposed to: reduce mortality associated with malnutrition by ensuring early detection and treatment of malnutrition; prevent MAM cases from deteriorating to severe; and scale up coverage of treatment services. In the proposed expanded criteria, both MAM and non-complicated SAM should be treated using the same product (ready-to-use therapeutic food/ready-to-use supplementary food). Key informants reported that this option was rarely used.
Output 2:
Increased availability of IYCF counselling and improved hygiene practices at the household and facility levels with emphasis on behaviour change by 2018

In 2017, the UNICEF and Save the Children regional offices for Eastern and Southern Africa undertook a regional capacity mapping of IYCF in Kenya, Somalia and South Sudan. The mapping aimed to provide a regional overview, identify capacity gaps and inform country action. A number of areas for improvement in IYCF in South Sudan were identified and validated, including: the need for IYCF policy/guidelines; human resource capacity; coordination and communication; IYCF information and knowledge management; and budgeting and funding.

Since the study, progress has been made on many fronts. Initially, the South Sudan Ministry of Health used UNICEF’s community-based IYCF package to conduct trainings; and by December 2017, South Sudan had developed its own maternal, infant and young child nutrition guidelines, with UNICEF and cluster partner support.

UNICEF and its partners have also contributed to increased knowledge and ability in South Sudan to support IYCF activities such as counselling and establishing community-based networks. This has been accomplished through trainings of government and NGO staff and the establishment of mother-to-mother support groups. Also, the number of trainers trained in 2018 reflects an increased commitment to address IYCF as an underlying cause of high malnutrition rates.

Output 3:
Improved policy and knowledge management at national and state levels, including local communities and civil society by 2018

During the evaluation period, through support from UNICEF, WFP and other Nutrition Cluster partners, the South Sudan Ministry of Health Nutrition Unit updated the community-based management of acute malnutrition guidelines and produced the maternal, infant and young child nutrition guidelines. The guidelines support the implementation of the Government of South Sudan Health Policy 2016–2026, which has as one of its objectives to strengthen health service organization and infrastructure development for effective and equitable delivery of the basic package of health and nutrition services. These guidelines have been widely distributed and have supported the implementation of OTPs. IYCF materials were present at all nutrition sites visited.

Output 4:
Effective nutrition preparedness and response for emergency-affected population delivered in line with the CCCs

Though IYCF practices are regularly assessed during SMART surveys, the sample size of those surveys has not generally been significant enough to be representative. Knowledge, attitudes and practices studies that can gauge behaviour change among the target population have not been undertaken to determine the efficacy of IYCF programming.


122 ‘Maternal, Infant and Young Child Nutrition MIYCN Guidelines’.

UNICEF South Sudan preparedness is based on context-specific, hazard-based preparedness plans reflected in the UNICEF Emergency Preparedness Platform. The Platform identifies risks such as armed conflict leading to famine if humanitarian access is prohibited for long periods. The pre-positioning of supplies (prior to the rainy season) and lessons learned from the previous famine, including the need for multi-sectoral engagement in the famine response, are critical to an adequate response. A scaled-up nutrition response will likely use mobile delivery mechanisms, an approach that proved successful during the last famine.

In addition to static and mobile SAM treatment interventions, UNICEF partnered with WFP and FAO on the IRRM to reach areas inaccessible to partners due to insecurity or other factors. Multi-sectoral IRRM assistance was provided via WFP air transportation.\(^1\) The nutrition-related activities undertaken during IRRM missions include mid-upper-arm-circumference screening, SAM treatment, maternal, infant and young child nutrition messages, vitamin A supplementation and deworming.

Less than 1 per cent of all children admitted for SAM treatment in 2016 and 2017 were admitted through IRRM missions, however, raising questions about the effectiveness and efficiency of this approach in terms of reach (see section 6.4 on the IRRM modality). In addition, unless a follow-up mission or a partner is able to operate in the newly accessed area, children receiving SAM treatment through the IRRM may not receive follow-up, making it impossible to determine whether the child responded to treatment. Follow-up IYCF messages also cannot be delivered since repeat visits are rarely possible.

### TABLE 3  Numbers reached with various nutrition services during IRRM missions

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children aged 6 to 59 months screened for acute malnutrition</td>
<td>92,715</td>
<td>131,545</td>
<td>84,099</td>
<td>114,674</td>
</tr>
<tr>
<td>Number of children aged 6 to 59 months identified as having SAM</td>
<td>4,715</td>
<td>2,391</td>
<td>1,542</td>
<td>2,800</td>
</tr>
<tr>
<td>Number of children aged 6 to 59 months with SAM admitted for treatment (cases not captured by partners)</td>
<td>2,886</td>
<td>1,275</td>
<td>382</td>
<td>1,797</td>
</tr>
<tr>
<td>Number of caregivers who received maternal, infant and young child nutrition messages</td>
<td>20,478</td>
<td>35,804</td>
<td>19,992</td>
<td>55,052</td>
</tr>
<tr>
<td>Number of children aged 6 to 59 months supplemented with vitamin A</td>
<td>47,057</td>
<td>74,808</td>
<td>24,772</td>
<td>52,999</td>
</tr>
<tr>
<td>Number of children aged 12 to 59 months who received deworming tablets</td>
<td>40,355</td>
<td>62,278</td>
<td>27,861</td>
<td>44,301</td>
</tr>
</tbody>
</table>

Source: Data provided by the UNICEF South Sudan Nutrition Section, 2014–2017.

\(^1\) Since March 2018, UNICEF has covered the cost of transporting supplies through the IRRM.
The proportion of children reached with vitamin A supplementation and deworming through IRRM missions was also low compared with the total number of children reached with these services through other modalities.

**Output 5:**
Nutrition programme outputs effectively implemented and technical support provided at national and state levels by nutrition section

The nutrition section has successfully engaged with and supported the Government to the extent possible and appropriate, particularly with the development of guidance for community-based management of acute malnutrition and maternal, infant and young child nutrition programming. UNICEF South Sudan has also disseminated guidelines through trainings for government staff and partners.

Field offices reported that the Juba office provided good support, though there were concerns about an imbalance between the number of technical staff at the Juba office versus at field offices. Key informants suggested that recent decentralization efforts, which placed more staff at the field level, should ensure that those placed in field offices are directly supporting programme delivery in the field rather than playing a national role. The partner survey reinforced this, suggesting that field level technical support was a useful asset for providing on-the-spot advice and inputs to improve programmes.

### 3.5 PROGRAMME QUALITY

**SAM treatment**

Figure 8 details the overall SAM treatment performance indicators over the evaluation period, which were consistent with the Sphere thresholds for cure (greater than 75 per cent), default (less than 15 per cent) and case fatality (less than 10 per cent).

Treatment results have been positive, with a cure rate above 80 per cent. Field observations and discussions with caregivers of children in stabilization centres and OTP sites suggest that ready-to-use therapeutic food and F-75 and F-100 milk are accepted by children. The provision of vitamin A supplementation and broad-spectrum antibiotics, malaria treatment and deworming have contributed to the effectiveness and quality of SAM treatment. The evaluation team also noted the trial integration of EPI services into nutrition centres, which key informants reported was successful.

![Figure 8](image-url)

**Percentage of SAM cases among children aged 6 to 59 months cured, defaulted or died**

Source: Data provided by the UNICEF South Sudan Nutrition Section, 2014–2018.
While overall default rates are below the Sphere threshold of 15 per cent, more detailed examination of reports suggests that this threshold was exceeded in certain sites. For example, in January 2016, a UNICEF situation report indicated that “the fluid movement of populations in and out of the PoC in Bentiu had also resulted in high defaulter rates, which now stand at 21 per cent.” According to informants, default often occurs during the planting and harvesting periods when caregivers have to prioritize agricultural production. Informants also noted that in some stabilization centres, meals for caregivers had only recently been provided by WFP, which may have contributed to default rates.

Stock-outs of key nutrition supplies also occurred during the evaluation period. For example, in a May 2017 situation report, UNICEF noted that “out of 530 OTP sites (82 per cent of all sites) reporting on stock status, 57 sites (10.7 per cent) reported experiencing stock-outs ranging from 1 to 30 days, with an average of 11 days.” Key informants reported a number of reasons for stock-outs, including: logistics, particularly transport difficulties and limited air transport capacity; delays by implementing partners in placing re-stocking orders; and lack of adequate storage facilities particularly for pre-positioning supplies for the rainy season.

All of the centres visited were well organized and had a systematic flow from registration and anthropometric measurement to the provision of feeding products. The evaluation team also observed psychosocial stimulation of children in OTP centres. The centres were clean and soap was available at handwashing points. However, the evaluation team observed that latrine construction was not of appropriate quality; and in one centre in the Bentiu PoC, the water supply was not working.

In its visits to primary health care centres and units where OTP and stabilization centre services were provided, the evaluation team observed that latrines were ‘emergency latrines’ not ventilated improved pit latrines. Given the permanent nature of primary health care centres and units, it would be more appropriate to have permanent latrines where possible; and a ventilated improved pit latrine design is more likely to encourage use due to odour control. While there were separate male and female latrines, consideration should be given to the spacing of the latrines; many of those observed were close to each other, raising protection concerns and the risk that the latrines would not be used.

The evaluation team also observed nutrition centres with demonstration gardens that were used to educate caregivers on growing diverse sources of nutrients. This is a positive example of integration and capacity building, ensuring that links are made between food security and nutrition outcomes.

**Infant and young child feeding**

The materials available for IYCF counselling have been adapted and are suitable for South Sudan. These materials were available and in use by community nutrition volunteers and mother-to-mother support groups at OTP sites.
and at the community level. However, mother-to-mother support groups did indicate the need for more IYCF counselling materials due to difficulties sharing one message book among an entire group. A mother-to-mother group also suggested the need for additional supplies, such as bags to protect the message book from rain, and boots and umbrellas to help them work during the rainy season.

The evaluation team saw little effort to engage with community leaders or religious leaders on IYCF messages, however. In a society dominated by men, it is crucial to engage these leaders in the discourse to achieve lasting behavioural change.

3.6 PROGRAMME EFFICIENCY

UNICEF nutrition programmes are dependent on two delivery modalities: delivery through national and international partners; and direct delivery through IRRM missions.

UNICEF signed PCAs with 38 nutrition partners in 2016 and 2017 (see Figure 9). Key informants indicated that greater efforts are being made to work with national partners in particular. However, informants also noted that some of the assumptions made about the ability of national NGOs to access areas that international NGOs cannot access may be incorrect. Civil society actors, particularly national NGOs, can face access challenges tied to suspicion by parties to the conflict about their neutrality and objectives.

Many partners indicated that the time taken to negotiate and agree on a PCA is too long, with some partners reporting that it took three to six months to receive a signed PCA. This has resulted in risk transfer from UNICEF to partners, who reported that they sometimes had to cover funding gaps with their own resources – which would be particularly difficult for national, local or community-based organizations. Key informants suggested that reasons for delays in approving PCAs were often related to the time taken to answer questions posed by the Country Office, which lacked understanding of the context or the partner. The time to approve PCAs has decreased since the negotiation authority has been transferred to field offices.

![Figure 9: Number of PCAs signed with nutrition partners](source: Evaluation team calculations from the PCA database.)

This and many of the subsequent points in this section are reinforced by the results of the online survey of partners undertaken for this evaluation. The delays in the PCA process, for the nutrition sector and other sectors, seem to occur primarily in the preparatory phase when results and activities are planned and agreed. It does not appear to be administrative or procedural rigidity that causes these delays but rather how effectively partners and UNICEF staff interact and make decisions together. See section 6 for additional detail.
The partners interviewed for the evaluation also noted that the length of PCAs does not exceed one year, and can vary from 6 months to 9 months, making it difficult to plan strategically. Partners believed that more strategic partnerships could lead to greater efficiencies, for example bringing together nutrition partners under a consortium arrangement where there are many partners operating in the same location. Some activities (e.g., partner training) could be undertaken by an experienced international NGO rather than directly by UNICEF, freeing up UNICEF’s time for monitoring. It is not clear from the interviews with UNICEF staff why exactly longer-term PCAs appear to be an exception rather than the rule in the South Sudan operation.

Having a core pipeline\textsuperscript{128} for SAM treatment products leads to economies of scale and prevents duplication of efforts. In addition, the use of partner warehousing facilities (where available) reduces operating costs (see section 6.6). The integration of programme activities across sectors has the potential to increase both efficiency and the achievement of more durable outcomes. UNICEF has made efforts in this regard through its nutrition activities, particularly by providing demonstration home gardens for diversifying food production to include vegetables. In addition, key informants reported that the recent piloting of EPI services within OTP centres has been successful. At the community level, however, UNICEF maintains different cadres of community workers, including health workers, nutrition volunteers and WASH outreach personnel. Greater efficiency could be achieved by merging these community volunteers; and this might also lead to better integration of community-based programming and outcomes.

### 3.7 UNICEF AND THE NUTRITION CLUSTER

The cluster system was activated in South Sudan in 2010. The Nutrition Cluster is led by UNICEF and functions through more than 60 active partners. The Strategic Advisory Group, which includes the Ministry of Health, United Nations agencies and national and international NGOs, sets the strategic direction of the Nutrition Cluster. Respondents and cluster partners shared positive feedback about UNICEF’s performance as cluster lead agency. UNICEF’s strength in this role was particularly evident in the pre-famine call for action\textsuperscript{129} launched in Rome by the Nutrition, Food Security and WASH Clusters. Cluster lead functions are also present in all key field hubs.

Several thematic working groups were formed to coordinate specific technical areas on behalf of Nutrition Cluster partners. These include the Nutrition Information Working Group, which is responsible for coordinating the collection, validation and analysis of emergency nutrition data; the Rapid Response Mechanisms (RRM) Task Force, established in 2015 to coordinate outreach services through the RRM implemented by UNICEF and WFP and short-term response approaches implemented by Medair and Action Against Hunger; and the Quality and Accountability to Affected Populations Thematic Working Group, which is responsible inter alia for ensuring the integration of the Nutrition Cluster AAP framework into partner projects.\textsuperscript{130}

\textsuperscript{128} Key informants suggested that having dedicated staff to manage the core pipeline was a key factor in its success.

\textsuperscript{129} ‘Inter-Cluster Operational Responses in South Sudan, Somalia, Yemen, and Nigeria; Promoting an Integrated Famine Prevention Package: Breaking Bottlenecks – Call for Action’, 19 May 2017. Signed by multiple agencies.

Cluster leadership recognizes that there are issues related to quality and accountability in nutrition services and is promoting the implementation of the Global Nutrition Cluster Framework on AAP. A more recent cluster initiative supporting quality programming is a surge mechanism through which a cluster partner steps in to work alongside an existing cluster partner that lacks the capacity to meet nutrition needs (e.g., due to a recent influx of displaced people).

The Cluster noted the following challenges:

- Implementation of the global nutrition accountability framework (leadership/governance; transparency; feedback and complaints; participation; and design, monitoring and evaluation) has not yet been completed and monitored/reported on by all partners;
- Some partners raised their own funds during the evaluation period and did not coordinate with the cluster about where assistance gaps existed;
- The linking of funding provision to an emergency threshold undermines the preventative aspects of nutrition responses; and
- Late funding by some donors can mean that implementation delays and gaps occur.131

3.8 RESILIENCE AND RISK-INFORMED PROGRAMMING

The evaluation team found good examples of UNICEF risk-informed programming, and the CPD 2019–2021 and nutrition strategy note for 2019–2021 reflect this. The nutrition strategy prioritizes the following four areas:

1. Care for children with SAM;
2. Early childhood, school-aged children, adolescent and women’s nutrition;
3. Maternal and child nutrition in humanitarian crises; and
4. Governance, partnerships, nutrition information and knowledge for nutrition.

The strategy considers two programming scenarios: 1) status quo: the current operating environment continues with some slow and steady deterioration; and 2) worst case: the situation deteriorates rapidly. In the status quo scenario, the nutrition strategy is explicit about the need to address chronic malnutrition (stunting) and improve adolescent nutrition. In the worst-case scenario, the strategy anticipates a total collapse of social services and mass displacement. In this situation, programming would be restricted to life-saving nutrition services implemented through the IRRM with the health, WASH, education and child protection programmes.

The strategy also highlights efforts to increase the integration of nutrition by promoting nutrition-sensitive programming, which has the potential to both improve efficiencies and nutrition outcomes.

The evaluation team endorses the priorities outlined in the new strategy. As noted, addressing stunting and maternal health and nutrition is key to breaking the inter-generational cycle of malnutrition. Behaviour change activities need to be implemented alongside efforts to address micronutrient deficiencies in pregnant and lactating women, and advocacy for blanket supplementary feeding for children aged 6 to 23 months and pregnant and lactating women.132

The proposed strategy draws on learning from

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131 Ibid.
132 UNICEF needs to conduct advocacy with WFP – which normally undertakes such activities – for the blanket supplementary feeding programme.
a recent inter-agency study,\textsuperscript{133} which emphasized the need to address maternal, infant and young child nutrition given the many factors that undermine nutrition outcomes, such as poor knowledge and practices, women’s workloads and poor health-seeking behaviour.

The evaluation team found that UNICEF was reasonably well prepared for contingencies. This included efforts to safeguard the core nutrition supply pipeline, conduct preparedness and contingency planning – including context-specific hazard-based preparedness plans through the Emergency Preparedness Platform – and pre-position stocks for the rainy season in hard-to-reach locations.

3.9 CONCLUSIONS AND LESSONS LEARNED

Strategy: UNICEF’s nutrition strategy clearly addresses priority needs in South Sudan and is well aligned with existing country strategies and the work of key United Nations partners such as WFP. The lack of government capacity makes the achievement of a nationally-owned and managed nutrition programme a medium-to long-term goal. The current emphases on ensuring that basic nutrition services are delivered to as many in need as possible and strengthening local capacities during service delivery are appropriate.

Targets: Given the consistently high levels of GAM in South Sudan, UNICEF and partner efforts to address the needs have been appropriate. UNICEF has addressed both treatment and prevention – its mandated areas – through SAM treatment and IYCF messaging and counseling, and has largely achieved its targets. Where targets were not achieved (e.g., the 2016 SAM treatment targets), this was due to the outbreak of conflict and reduced humanitarian access.

Despite UNICEF’s efforts and its relatively strong performance against outputs, malnutrition rates in South Sudan remain high. This is likely due to a combination of complex factors such as conflict and poor health services, water and sanitation, and hygiene and feeding practices. These factors vary geographically, however, and a more in-depth, geographically differentiated causal analysis, such as the 2016 Integrated Food and Nutrition Security Causal Analysis, is needed to prevent and control the high levels of malnutrition.

Assessments: Despite the wide range of assessments and analyses undertaken in South Sudan, there have been concerns regarding the quality of and potential bias in these exercises. UNICEF and its partners in the humanitarian community should consider whether to establish an assessment capacity that is independent of operational interests. This could be similar to the approach in Somalia, where food security and assessment analysis is undertaken by the Somalia Food Security and Nutrition Assessment Unit.

Programming: The quality of SAM treatment and IYCF programming was good given the constraints under which UNICEF and its partners were operating. Key areas for improvement include:

- UNICEF can be more ambitious in its target setting, particularly in terms of IYCF programming, for which 2018 targets were set lower than the numbers reached in 2017.

• While the integration of MAM and SAM treatment at the same locations is positive, UNICEF should continue to advocate with WFP for an equal number of targeted supplementary feeding programme and OTP sites (at a minimum; preferably more). This is key to addressing the large number of MAM cases requiring treatment and preventing MAM cases from becoming severe.

• Non-emergency ventilated improved pit latrines should be provided in primary health care centres and units and male and female latrines should be adequately segregated. In addition, the quality of emergency latrines should be improved to include ventilation.

• Community nutrition volunteers, community health volunteers and WASH community volunteers should be consolidated into a single cadre of volunteers with a common curriculum for training and community-based activities to increase efficiency, coverage and integration.

• There are currently no specific nutrition activities that target adolescent and school-aged children, other than school feeding programmes. Given the gender dynamics in South Sudan, the propensity for early marriage and the key role of adolescence in the prevention of malnutrition, it is important to include adolescents in nutrition programming.

• UNICEF should also advocate for and develop approaches to address chronic malnutrition in coordination with WFP.

Partnerships: UNICEF’s current partnership model is contractual. There is a need to explore more strategic partnerships that could allow for greater efficiency, including consortium models and strategic partnerships that address key areas such as training and capacity building.

IRRM and programme reach: The nutrition activities conducted through the IRRM raise questions about the efficiency of such an approach and the quality of programming given the lack of follow-up. The equity rationale is appreciated – these are populations not otherwise being reached with assistance, and limited assistance is better than none. In order to substantially increase the coverage and reach of its nutrition programme, UNICEF should consider expanding the nutrition component of the proposed integrated mobile health outreach approach beyond screening to include SAM and MAM treatment.

In February 2017, the Government of South Sudan declared famine in some counties of Unity state; and declared other counties at risk of famine. A famine is declared when at least 20 per cent of
households in an area face extreme food shortages with a limited ability to cope; prevalence of acute malnutrition exceeds 30 per cent; and death rates exceed 2 persons per day per 10,000 people.

Following the call from the Food Security and Nutrition Cluster lead agencies, partners who supported the humanitarian response in the four famine-risk countries (the others being north-eastern Nigeria, Somalia and Yemen) met in Rome in April 2017 to take stock of the ongoing responses and discuss solutions to existing bottlenecks. The pre-famine call highlighted the need to respond prior to the declaration of famine to save lives. Key informants suggested that this initiative helped raise awareness of the potential famine in South Sudan and mobilize resources for a response.

A paper on lessons learned suggested that UNICEF’s response to the famine was largely nutrition driven, and mainly based on the continuation of existing programmes, with adjustments related to scale and increasing the use of mobile approaches. The paper noted that “the response was timely when measured against the declaration, but earlier scale up could have been done against other early warning indicators.” Key informants supported this view and noted that the risk of greater famine was averted. The situation in 2018 remains precarious, however.

The lessons learned paper also noted that “the main drivers of the famine conditions are associated with the safety and protection of the civilian population” and the response could have benefited from a more integrated and robust protection response. This could have included advocacy, assessment, stronger engagement with UNMISS for expanded presence and applying the ‘do no harm’ principle to interventions.

Sector coordination was deemed adequate, especially for the Nutrition and Logistics Clusters, but there was room for improvement in multi-sectoral coordination. In general, coordination was at the national level; largely due to access constraints and reliance on mobile approaches. This is not optimally efficient, and does not sufficiently support the long-term objective of strengthening the sustainable presence of humanitarian actors in southern Unity.

Internally, coordination between the field and national levels was fluid and positive. However, UNICEF’s response could have benefited from greater clarity between the Juba office and field offices on responsibilities and accountabilities for meeting targets.

135 ‘Core Commitments for Children in Humanitarian Action’.
In South Sudan, most WASH challenges are structural and developmental in nature, including the long-standing practice of open defecation in rural areas and the lack of handwashing facilities and practices. Coverage gaps during the evaluation period can be traced, in part, to these structural deficits and the major constraints on humanitarian access. The evaluation found that more could have been done to address these gaps, however. This section considers the past and current WASH response in detail and suggests ways to strengthen it.

4.1 THE WASH CONTEXT

The 2017 report of the WHO/UNICEF Joint Monitoring Programme estimated that 50 per cent of the country population had limited or unimproved water sources or no direct access to water in 2015 (48 per cent in rural areas, 60 per cent urban areas). Sanitation coverage was considerably worse: the Joint Monitoring Programme estimated that in 2015, 61 per cent of the total population (6 per cent in rural areas, 28 per cent in urban areas) did not have access to any sanitation services (i.e., were practicing open defecation). These statistics are presented in Figure 10. There are indications that the situation has significantly worsened since these estimates were made.136

The 2017 Joint Programme Monitoring report did not include estimates on hygiene practices for South Sudan. Data collected through knowledge, attitudes and practices surveys conducted in Juba in 2016 and 2017 suggest that even in the urban centre, 67 per cent of households lacked handwashing facilities and 16 per cent did not use soap to wash their hands. The cost of soap was often cited as a reason for this.137

These results, combined with the high rate of rural open defecation (70 per cent), suggest a high-risk hygiene situation in South Sudan.

As noted, comparatively low coverage of water and sanitation services leaves South Sudan’s population particularly vulnerable to water-borne diseases and other water- and sanitation-related threats, including the documented effects on child nutrition. Annual cholera outbreaks have been documented since 2005,138 with a particularly severe outbreak in 2016–2017 (see Box 10). The data on the cholera response suggest that urban PoC sites were particularly at risk of outbreaks, though it can be argued that these outbreaks were more likely to be detected early, as agencies are continually present in PoCs.

These data, though not systematically updated, point to a widely under-developed sector with significant structural deficits. At the time of independence in 2011, development partners started investing in water infrastructure and sanitation coverage. A borehole drilling campaign that had begun during Operation Lifeline Sudan

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137 Ibid.
138 Ibid.
was expanded. These programmes were curtailed when conflict broke out in 2013, and have declined steadily ever since, with humanitarian WASH responses taking their place.

At the infrastructure level, however, humanitarian and development approaches overlap: the provision of water in emergency response relies on existing water sources, either directly or through repair, rehabilitation or upgrading. At the same time, as part of the emergency response, permanent water sources are established or improved. Both types of interventions (development and humanitarian) should be guided by a national inventory of water supplies – this existed at the time of independence but was not consistently continued. It appears that no fully updated inventory of water sources currently exists, curtailing the ability of WASH partners to factor existing water sources into their emergency response planning.

The WASH Cluster has recognized the integrated threats of WASH, nutrition and health and works closely with the Nutrition and Health Clusters on integrated services and co-mapping hotspots (i.e., livelihood zones and cholera hotspots). This approach acknowledges the crucial role of WASH in nutrition outcomes and supports priority action in areas at highest risk due to cholera outbreaks. A joint WASH and nutrition strategy was produced in early 2018 for the WASH and Nutrition Clusters.

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**FIGURE 10** Water and sanitation coverage for 2015

![Water and sanitation coverage for 2015](image-url)


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139 Key informant interview, May 2018.
140 Key informant interview, May 2018.
TABLE 4  Characteristics of typical improved water points in South Sudan

<table>
<thead>
<tr>
<th>Location / Environment and Example</th>
<th>Key Characteristics</th>
<th>Humanitarian / Development Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urban – PoC site</strong></td>
<td>Except where a piped urban water system exists, the PoC sites in urban centres rely on water trucking. Water is taken from boreholes, chlorinated and transported to overhead tanks in the camps from where it either serves public tap stands or facilities such as OTP centres or schools.</td>
<td>Though PoCs have a semi-permanent character at this point, they are part of the humanitarian response. Water trucking is the most transient humanitarian action, though it has been maintained for several years in PoC sites in South Sudan.</td>
</tr>
<tr>
<td><strong>Example: Juba United Nations House PoC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urban – medium to large town – POC site</strong></td>
<td>Using deep boreholes, water is extracted by electrically-powered submersible pumps and stored in an overhead tank. From the tank, water is fed into a piped system either to public tap stands in neighbourhoods or facilities such as OTP centres, health centres and schools.</td>
<td>Urban piped systems are generally seen as a development approach. However, with UNICEF support, in 2016–2017, Bentiu and Yambio PoCs now have piped systems that have replaced water trucking and brought down the cost of the humanitarian response at those sites.</td>
</tr>
<tr>
<td><strong>Example: Bentiu</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Small urban and rural towns</strong></td>
<td>Small towns may have deep boreholes similar to larger towns, where public tap stands and/or truck filling pipelines distribute the water at the borehole site. Daily production depends on aquifer capacity, pump size and the availability of fuel for generators. Some boreholes have been converted to solar-powered systems, where generators are only needed on overcast days. Outer areas of towns and rural villages may have drilled shallow wells with hand pumps operated by the community.</td>
<td>Small urban and rural systems are built, repaired or rehabilitated both for development and humanitarian purposes, depending on the population served and the local emergency encountered.</td>
</tr>
<tr>
<td><strong>Examples: Pibor town (urban borehole and hand pumps)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Iholong village (hand pump)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.2 NEEDS ASSESSMENT AND DATA QUALITY

Data on water and sanitation coverage in South Sudan are outdated and generally seen as unreliable. While the UNICEF/WHO Joint Monitoring Programme publishes coverage data for water and sanitation, these data are solely national level estimates, are not real-time and do not offer the granularity needed for programme targeting and planning purposes (i.e., data broken down by province, district, etc.).

Key informant interviews with WASH Cluster partners, May 2018. This was also expressed in documents related to the management of cholera responses in South Sudan, specifically ‘In-depth Cholera Epidemiological Report for South Sudan’.
Substantial investment was made in a water source inventory pre- and post-independence, however this dataset has been dormant since 2015 and became largely outdated due to the conflict that resulted in water sources being damaged, and to new water sources not being recorded in the inventory dataset. Therefore, the inventory dataset has become unusable for planning purposes.

While UNICEF keeps a record of the water sources it supports, this data is not incorporated into the inventory dataset and is not necessarily available to cluster partners. Knowledge of available water sources, their capacity/yield and management arrangements are vital to matching emergency interventions (e.g., in cholera outbreaks) with existing infrastructure. In addition, the response of any WASH Cluster partner would benefit from such basic inventory data. It was observed during the evaluation that such basic information is not available to UNICEF cooperation partners in the field, indicating the disruption of systematic data collection and sharing. While the optimum solution would be a central database, ideally maintained by the WASH Cluster, even incremental accumulation of well geo-referenced water point data and systematic sharing will gradually improve the response environment.

Other factors affect UNICEF’s and cluster partners’ capacity to conduct systematic and robust WASH needs assessment, in addition to the unavailability of regularly updated water inventory data. A recently conducted WASH humanitarian action review and key informants pointed to weak capacity for assessments, lack of common standards and limitations in the scope of needs assessment, with cross-cutting issues such as protection in relation to WASH being often neglected. The review also found that capacity for data analysis is weak, an observation also made by the evaluation team.

The situation in South Sudan makes assessments difficult to conduct. Access challenges are not only related to security, but also tied to weather, as well as social and cultural barriers that severely impede land travel throughout the country. A legacy of low investment in rural capacity poses severe challenges for agencies attempting to recruit qualified personnel for their programmes. Recruiting qualified staff from the capital to serve in rural posts of severe hardship is a challenge, and in some parts of the country, travel restrictions related to social, cultural or security factors also undermine recruitment. These barriers particularly affect WASH assessments, which require physical verification of infrastructure to ensure data quality and cannot rely on access to mobile populations like other sectors that work mostly with biometric or interview data.

UNICEF and the WASH Cluster have recognized these limitations and commenced an initiative designed to overcome them. In partnership with UNICEF and the WASH Cluster, the REACH initiative is currently rolling out two instruments. The first, the area of knowledge approach, involves rapid surveys with displaced

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143 Key informant interviews with section staff and WASH partners, Juba, May 2018.
144 Key informant interviews with WASH Cluster partners, Juba, May 2018.
145 Evaluation team observations from the field.
147 Evaluation team observation from the field.
148 Evaluation team observation from the field; and Key informant interviews with UNICEF staff and UNICEF partners, Juba, May 2018.
149 Key informant interviews with UNICEF staff and WASH Cluster partners, Juba, May 2018.
populations on the WASH situation in the area they have just vacated. Noting that interview data is not as reliable as physical verification, this approach nevertheless provides an overview of the state of systems in an area that can otherwise not be accessed, including through the use of phone interviews, where needed. The second instrument, the baseline assessment, uses a set of standardized indicators to systematically collect baseline data to be used across all WASH Cluster partners. The baseline assessment aims to overcome the lack of common standards in baseline data. Table 5 provides a brief overview of both approaches.

4.3 UNICEF’S WASH STRATEGY

At the time of South Sudan’s independence, there were ambitious plans to reverse the effects of decades of under-development and lack of investment. With the outbreak of conflict in 2013 and the steady deterioration in the following years, the development focus of WASH programming was gradually replaced by a stronger focus on humanitarian interventions. It appears that until very recently, the sector has not been able to establish a productive connection between the two. This trend is reflected in the consecutive UNICEF South Sudan WASH strategy notes for 2016–2018 and 2019–2021.

<table>
<thead>
<tr>
<th>Area of knowledge data is collected monthly and through multi-sector interviews with the following types of key informants:</th>
<th>Baseline assessment indicators\textsuperscript{151}</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Newly arrived internally displaced persons who have left a hard-to-reach settlement in the last month</td>
<td>A set of indicators\textsuperscript{152} will be used to collect baseline information in a decentralized way (i.e., by any partner in the cluster). These data will then be collated by the cluster and made available to partners.</td>
</tr>
<tr>
<td>• Affected people who have been living in or had contact with someone living in a hard-to-reach settlement in the last month (traders, migrants, family members, etc.)</td>
<td></td>
</tr>
<tr>
<td>• Affected people who are remaining in hard-to-reach settlements, contacted by phone.</td>
<td></td>
</tr>
<tr>
<td>• Selected key informants are purposively sampled and have knowledge from the last month about a specific settlement in South Sudan, with data collected at the settlement level.</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{150} REACH reports available at: <www.reachresourcecentre.info/countries/south-sudan>, accessed 29 January 2019; and interviews with WASH Cluster partners.

\textsuperscript{151} Key informant interviews with WASH Cluster partners, Juba, May; and draft baseline indicator list as of May 2018, obtained from REACH.

\textsuperscript{152} At the time of writing, this was five core indicators and 45 supplementary indicators, as well as a set of standard activity definitions to record for the cluster SW.
The strategy note 2016–2018\textsuperscript{153} reads like a development plan and makes only occasional reference to the impact of conflict on the regular programme. It presents three main areas of intervention: 1) service delivery: improving water supply and reducing open defecation; 2) system building and strengthening: building central and decentralized government capacity for stronger sector leadership and coordination; and 3) integration and technical support: strengthened community engagement for service delivery and behaviour change and stronger interfaces with other sectors.

Emergency preparedness and response are only explicitly referenced in one of the four outputs – much like a standard provision included in UNICEF sector programmes in more stable countries. Contrary to this dominance of regular programme elements in the strategy note, the 2015 Consolidated Emergency Report stated that “human and financial resources continue to be prioritized for life-saving emergency responses.”\textsuperscript{154} The notable lack of elaboration of the UNICEF South Sudan humanitarian response in its strategy note therefore does not appear to reflect the reality of the country programme; respondents referred to the situation as being in a “constantly responsive mode.”\textsuperscript{155}

Notably, the WASH strategy note 2016–2018 maintained a strong focus on community-led total sanitation, unlikely to be effective in situations of regular displacement. UNICEF staff realized that it was not a realistic approach to pursue in such context, and subsequently modified their approach.\textsuperscript{156}

This disconnect between development and humanitarian elements of the WASH programme during the evaluation period was further highlighted by a 2016 Overseas Development Institute study on the sector.\textsuperscript{157} The study found that “In South Sudan, humanitarian and development WASH programming and delivery have remained siloed, for a range of ideological and practical reasons.” This finding is not unusual; the same was found at the global level in several country case studies. A recent analysis of UNICEF humanitarian WASH responses globally also found that in general, the organization’s WASH humanitarian and development responses are not well connected.\textsuperscript{158}

The Overseas Development Institute study identified key examples for the prevailing silos. First, implementation modalities differed vastly, with emergency WASH providing basic water and sanitation services for free, and WASH development interventions establishing models of sustainable operations and maintenance that included cost recovery. Geographic separation in 2016 was another factor: WASH development programmes took place in stable areas, while emergency WASH interventions targeted areas affected by conflict or displacement. According to the study, coordination and communication between the two were limited, both within UNICEF and in the wider sector.

The study also found that in the context of escalating but geographically limited conflict up to 2016, WASH development programmes retreated rather than adapted, and a disconnect remained between WASH development and


\textsuperscript{155} This was repeatedly mentioned in conversations with key informant interviews with UNICEF staff, Juba, May 2018.

\textsuperscript{156} Key informant interviews with UNICEF staff, Juba, May 2018.

\textsuperscript{157} Mosello, Beatrice, Nathaniel Mason and Richard Aludra, ‘Improving WASH Service Delivery in Protracted Crises: The case of South Sudan’, ODI, August 2016.

humanitarian programmes. The overall scarcity of resources apparently did not encourage closer collaboration; rather, it bred competition over resources and mistrust between agencies, according to informants.\textsuperscript{159} From mid-2016 onwards, conflict affected virtually all areas of the country, challenging the earlier geographic distinction between development programming and humanitarian action.

The UNICEF South Sudan WASH strategy note for 2019–2021 shows a positive evolution towards a more integrated approach to the humanitarian-development nexus in South Sudan. It explicitly acknowledges that the WASH programme primarily serves conflict-affected and vulnerable people, effectively making each output a combined development and humanitarian effort, based on the respective situation. The new strategy also acknowledges the past difficulties with implementing a full community-led total sanitation approach and plans for a more flexible community-based – but not necessarily community-led – process for improved sanitation.

This more appropriately reflects the reality on the ground, as observed during the field visit in May 2018 and confirmed by staff and partners. Basic water facilities (i.e., drilled boreholes with hand pumps or motorized pumps) are lacking, and the majority of people resort to open defecation. Therefore, in almost any location, improved services inevitably and generally benefit both resident and displaced populations.

Given the prevailing risk of cholera and the worsening nutritional situation, which often have structural, development related causes, the emergency response (i.e., re-establishing WASH services) must be better linked with longer-term development programming (e.g., with a focus on the quality and sustainability of the service) – and the two must not be separated on the ground. Furthermore, a well-functioning water system and good sanitation infrastructure should be the aim of any humanitarian response serving either an increased population following displacement or a population at heightened risk following a disease outbreak.

In 2017, a dedicated cholera strategy supplemented the overall programme strategy (see Box 10 on the 2017 cholera response).\textsuperscript{160} The cholera strategy was developed based on the principle that an integrated approach between the UNICEF WASH, health and C4D sections was essential to the effectiveness of the overall programme strategy. The cholera strategy focused on containing outbreaks where they occurred. For WASH, this meant ensuring adequate access to clean water, especially for drinking and preparing food, through the establishment of new water points, where necessary, especially where unsafe practices (e.g., the use of untreated surface water) were observed. UNICEF would also work with authorities to guard rivers to prevent the use of unsafe river water. In addition to these measures, mass cleaning campaigns would be carried out, as would awareness-raising activities on the control and prevention of cholera, and training for home health promoters.

\textsuperscript{159} Key informant interviews with WASH Cluster partners, Juba, May 2018.

4.4 IMPLEMENTING THE STRATEGY: RESULTS AND EFFECTIVENESS

Delivery against targets

In its humanitarian response, UNICEF worked towards broader WASH Cluster targets. These were defined in the 2016 and 2017 HRPs. Table 6 summarizes the targets and the rational for setting them.

During the evaluation period, UNICEF achieved its targets on access to water but fell short of its targets on access to sanitation, as shown in Figure 11. While regular narrative reporting includes the delivery of hygiene promotion, the dedicated indicator for people reached with hygiene messages was discontinued in situation reports at the beginning of 2017 although hygiene promotion activities continued in 2017.

Given the extremely low coverage of basic sanitation, in the highly fluid security environment and limited seasonal access to large parts of the country, the current approach to improving sanitation in rural areas may not be sufficient. Funding constraints in WASH were a main reason for this poor coverage.

<table>
<thead>
<tr>
<th>Year</th>
<th>People in need (HRP)</th>
<th>People targeted (HRP/WASH Cluster)</th>
<th>Rationale for targeting</th>
<th>People targeted (UNICEF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>4.7 million</td>
<td>2.9 million</td>
<td>Most vulnerable by:</td>
<td>610,000 with access to water</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Severity of WASH needs</td>
<td>365,000 with access to sanitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Feasibility and capacity to response</td>
<td>860,000 with hygiene messages</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Access</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Protection-related vulnerabilities</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>5.1 million</td>
<td>3.2 million</td>
<td>Most vulnerable:</td>
<td>800,000 with access to water</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• All internally displaced persons</td>
<td>400,000 with access to sanitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 1 million people at high risk of acute watery diarrhoea, cholera, acute malnutrition and floods</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Taking into account capacity and anticipated resources</td>
<td></td>
</tr>
</tbody>
</table>

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162 Although UNICEF continued to provide hygiene messages in 2017, the target for this output was not included in the situation reports for 2017, and results were not systematically reported against. Country and regional WASH staff could not provide a rationale for this.

163 UNICEF humanitarian situation reports for South Sudan for 2016 and 2017.

164 Ibid.


Partners interviewed also pointed to a vicious cycle in the wider WASH community: Acceptance of latrines is comparatively low in South Sudan’s rural areas for social and cultural reasons,\textsuperscript{167} which has led to a certain intervention fatigue where efforts to overcome such resistance have been repeatedly defeated by low acceptance. This may have led humanitarian actors to focus on water systems instead of sanitation facilities.\textsuperscript{168} Despite these challenges, UNICEF had pursued community-led total sanitation until 2017 and continues to use community approaches to total sanitation\textsuperscript{169} where possible to achieve higher acceptance of safe sanitation. This shift happened in deviation from the UNICEF South Sudan WASH strategy, adapting to the reality on the ground.

Given the regular outbreaks of cholera in South Sudan, hygiene education also plays a particularly crucial role. Partners have noted that UNICEF hygiene messaging is less participatory; it focuses on providing messages to recipients who remain passive (i.e., not following the CLTS/community approaches to total sanitation).\textsuperscript{170} It has been claimed that this is a weakness in UNICEF’s approach to hygiene and sanitation and may lead to over-reporting of people reached. While participatory approaches were generally applied in hygiene and sanitation communication during the cholera response, in shorter-term interventions, including the IRRMs, UNICEF approaches were not consistently participatory and often involved a one-off transmission of key messages.

\textsuperscript{167} Key informant interviews with WASH Cluster partners, Juba, May 2018.

\textsuperscript{168} Ibid.

\textsuperscript{169} While CLTS is a generally un-subsidized process that requires communities to lead the change and determine the pace to an extent, in the wider community approaches to total sanitation, other, also partly subsidized models exist that may be more appropriate in less stable contexts.

\textsuperscript{170} Key informant interviews with WASH Cluster partners, Juba, May 2018.
Cholera cases have occurred sporadically in South Sudan over the past decade. Cases were initially confined to Eastern Equatoria, either in counties close to the border with Uganda or in Juba, but subsequently spread north to the Sudd swamp areas along the Nile towards Malakal. Case distribution and limited studies point to transmission through individual behaviours, including inadequate safe water supplies in houses, open defecation and interaction with cholera patients in health facilities.

In July 2017, a protracted outbreak that began during the 2016 wet season and continued through the following dry season developed into a localized emergency within the wider humanitarian response. By the end of 2017, 20,438 cases had been reported, with 436 deaths attributed to cholera – a case fatality rate of 2.1 per cent. UNICEF and its partners responded to the outbreak with dedicated resources.

In South Sudan, a national task force under the Ministry of Health oversees cholera prevention and response. The task force consists of sub-committees that demarcate the elements of the prevention and response as: 1) coordination; 2) logistics and security; 3) surveillance, laboratory, case management and oral cholera vaccine; 4) WASH; and 5) social mobilization and health education.

UNICEF participated in coordination, including through the Health and WASH Clusters; supported social mobilization and health education; provided capacity building for case management, testing and the use of cholera vaccines; and aided the pre-positioning of emergency supplies. Health and WASH appeared to work together closely in these efforts. According to UNICEF reports, WASH, health and C4D actions were programmed in an integrated manner, targeting households, communities, institutions and public places. Case management was also supported in high-risk areas.

At the end of 2017, UNICEF reported the following outputs of its contribution to the cholera outbreak response:

- 5 treatment centres established (2 oral rehydration points, 2 cholera treatment units and 1 cholera treatment centre);
- 79,311 households received water treatment products;
- 75,620 households received safe drinking water;
- 43,728 schoolchildren received cholera prevention messages and soap;
- 19 NGOs trained on cholera prevention and response;
- 1,740 suspected cholera cases treated, including 383 cases (22 per cent) among children under 5 years and 435 cases (25 per cent) among children aged 5 to 14 years; and
- Over 5,000 people reached with hygiene promotion messages.

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171 ‘In-depth Cholera Epidemiological Report for South Sudan’.
173 ‘South Sudan Consolidated Emergency Report 2017’; UNICEF cholera situation reports for South Sudan from June, July and August 2017.
174 ‘In-depth Cholera Epidemiological Report for South Sudan’.
175 ‘South Sudan Consolidated Emergency Report 2017’; UNICEF cholera situation reports for South Sudan from June, July and August 2017.
176 Ibid.
It appears that while UNICEF's direct involvement in case management was only for a small proportion of the total cases, UNICEF provided most of the vaccination and treatment and played a key role in addressing underlying hygiene deficiencies in cholera hotspots through its partners and WASH Cluster leadership.\(^{177}\) Reports indicate that the WASH core pipeline, particularly water safety products, was pivotal to reaching remote places where cholera was difficult to contain.\(^{178}\)

The experience has led UNICEF to invest in learning for future protracted outbreak responses; and there is evidence that relevant steps are being taken forward based on this learning: At the height of the response, in July 2017, an updated cholera response strategy was developed that incorporated these experiences.\(^{179}\) It also appears that dry season supply pre-positioning was reviewed and partnerships for the WASH core pipeline warehouses were optimized.\(^{180}\) An epidemiological study for cholera in South Sudan was also commissioned.\(^{181}\) In 2018 and beyond, WASH priority targeting has started using a combination of cholera hotspot data and IPC levels to identify locations for intervention, furthering the integrated approach.\(^{182}\)

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### Effectiveness against stated objectives

As noted in relation to the WASH strategy, there is no clear distinction to be drawn between the development and humanitarian objectives of most actions. In its reporting, UNICEF has not made this distinction; indeed beneficiary numbers from regular and humanitarian interventions are consolidated.\(^{183}\) Therefore, although UNICEF's humanitarian results are reported separately in humanitarian situation reports, overall effectiveness should be assessed for the entire WASH programme. Table 7 shows UNICEF's reporting against internal performance indicators for the sector.

It is clear from the data provided in Table 7 that 2016 WASH interventions were less effective than 2017 WASH interventions. In the 2016 UNICEF Country Office Annual Report for South Sudan, UNICEF points out the constraints in 2016 due to the July 2016 crisis in Juba and the consequent withdrawal of Country Office staff.\(^{184}\) Following this crisis, Juba office staff numbers declined significantly, and while the field offices remained staffed and operational,\(^{185}\) the reduction in support capacity from the Juba office appears to have affected implementation.

Despite the rise in insecurity and decline in stability in previously stable areas during the evaluation period, UNICEF achieved substantial results. Field observations however raised concerns about the quality of implementation in some instances. The following provides a brief review of reported progress against the outputs in the UNICEF South Sudan WASH strategy note for 2016–2018.

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\(^{177}\) Ibid.

\(^{178}\) Ibid.


\(^{180}\) ‘South Sudan Consolidated Emergency Report 2017’.

\(^{181}\) ‘In-depth Cholera Epidemiological Report for South Sudan’.


\(^{183}\) This conclusion was reached based on a comparison of beneficiary numbers provided in the 2016 and 2017 UNICEF South Sudan country office annual reports and the UNICEF internal results assessment module with the beneficiary numbers provided in humanitarian situation reports.


\(^{185}\) Key informant interviews with UNICEF staff, Juba, May 2018.
### TABLE 7 Reporting against internal WASH indicators, 2016 and 2017

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target year</th>
<th>Target</th>
<th>Indicator value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people accessing a sustainable drinking water service in the reporting year only</td>
<td>2016</td>
<td>76,000</td>
<td>104,000</td>
</tr>
<tr>
<td></td>
<td>2017</td>
<td>153,000</td>
<td>184,755</td>
</tr>
<tr>
<td>Number of WASH committees established in the reporting year only as a result of UNICEF direct support</td>
<td>2016</td>
<td>150</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>2017</td>
<td>300</td>
<td>189</td>
</tr>
<tr>
<td>Number of communities certified free of open defecation in the reporting year only as a result of UNICEF direct support</td>
<td>2016</td>
<td>70</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>2017</td>
<td>70</td>
<td>66</td>
</tr>
<tr>
<td>National monitoring systems reporting on equity of access to WASH services available</td>
<td>2016</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>2017</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Number of updated water policies in line with legislation in use</td>
<td>2016</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>2017</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>UNICEF-targeted population in humanitarian situations accessing sufficient quantity of water of appropriate quality for drinking, cooking and personal hygiene</td>
<td>2016</td>
<td>610,000</td>
<td>742,221</td>
</tr>
<tr>
<td></td>
<td>2017</td>
<td>800,000</td>
<td>811,462</td>
</tr>
<tr>
<td>Number of states with emergency contingency plans</td>
<td>2016</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>2017</td>
<td>All</td>
<td>10</td>
</tr>
<tr>
<td>People in humanitarian situations who access and use adequate sanitation and hygiene facilities</td>
<td>2016</td>
<td>365,000</td>
<td>252,764</td>
</tr>
<tr>
<td></td>
<td>2017</td>
<td>400,000</td>
<td>240,583</td>
</tr>
</tbody>
</table>

Source: UNICEF InSight system.

**Output 1:**

**Improved availability of affordable, sustainable safe water supply facilities in vulnerable areas, schools and health facilities by 2018**

Available reporting does not permit a clear analysis of the number and distribution of water facilities established with UNICEF support in 2016, or the management arrangements established for them. However, it appears that despite its reduced capacity, UNICEF was able to establish manual drilling as a more affordable technology, including with the necessary skill transfer, in northern parts of South Sudan. In 2017, despite increasing conflict and restrictions on access, UNICEF reported reaching more people than in 2016. To support the sustainable functioning of newly constructed or rehabilitated water sources, UNICEF established 32 water committees in 2016 and 189 in 2017. Sampled PCAs indicate that the water committees were equipped with skills, including how to plan and supervise necessary maintenance, and set and collect fees.

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187 PCAs retrieved from UNICEF South Sudan’s PCA repository.
The reality does not always match the reports, however. In a location where a UNICEF partner was about to hand over facilities to committees that were established with its support, the evaluation team observed that the nascent committees do not have access to basic technical data on the respective water sources (such as hand pump brand, borehole depth, yield etc.), and that the strategy for fee setting and collection was vague and fraught with obstacles, including a basic lack of willingness to pay.\footnote{Evaluator’s observation on site, and interaction with responsible partner staff, South Sudan, May 2018.} Considering these factors, it may be ambitious to expect a water committee to take over management of these sites in the near future. In this case, it appears that while there is intent to set up functional water committees, the committees were unable to perform the expected functions in practice.\footnote{Based on field observations.}

**Output 2:**
**Increased availability of sustainable sanitation facilities and improved hygiene practices at household and institutional level with emphasis on behaviour change and open defecation free communities by 2018**

UNICEF was able to achieve progress and results on open defecation free declarations during the evaluation period, though the community-led total sanitation approach was hindered by the mounting insecurity and displacement of previously triggered communities.\footnote{UNICEF Country Office Annual Report 2016: South Sudan; UNICEF Country Office Annual Report 2017: South Sudan; and data retrieved from UNICEF’s internal InSight system.} Despite the progress made, given the escalating conflict, UNICEF has moved away from a community-led total sanitation approach to broader community approaches to sanitation. Unlike community-led total sanitation, community approaches to sanitation do not require community leadership, can involve external support (e.g., for latrine building) and require less lead time, which is advantageous in a rapidly shifting context.

**Output 3:**
**Improved policy and knowledge management at national and state level including local civil society groups by 2018**

According to UNICEF reporting, no progress was made towards this output in 2016 and 2017 due to the conflict, the Government’s preoccupation with other priorities and the resulting shortage of funds among government ministries.\footnote{UNICEF Country Office Annual Report 2016: South Sudan; UNICEF Country Office Annual Report 2017: South Sudan.}

**Output 4:**
**Effective WASH coordination, disaster preparedness and response for emergency-affected populations delivered in line with the CCCs**

Output 4 covers the humanitarian response, the results of which were reviewed in the previous section. Overall, the humanitarian WASH response has been effective, with the exception of UNICEF’s hygiene messaging, which is not consistently participatory.\footnote{Key informant interviews with WASH Cluster partners, Juba, May 2018.} This is in stark contrast to the organization’s strong commitment to participatory approaches in sanitation in its community-led total sanitation and community approaches to sanitation, as well as to the practices of other WASH partners in their humanitarian responses and sector good practice.
Output 5: Enhanced integration of services with other UNICEF sections and technical support provided by the WASH section to enhance efficiencies and effectiveness in addressing child survival

Though this output is not associated to a specific indicator,\(^{193}\) it is a key supplementary result on the effectiveness, relevance, and efficiency of WASH programming. During the evaluated period, notable efforts were made to integrate WASH and nutrition interventions. This was most prominent in PoC sites,\(^{194}\) where OTPs and stabilization centres supported by UNICEF partners integrated WASH and nutrition interventions. The evaluation team observed that UNICEF WASH partners have also integrated hygiene education into nutrition education at OTPs at other sites.\(^{195}\) All OTPs visited during the evaluation displayed high WASH standards, with appropriate levels of hygiene and good handwashing facilities.

UNICEF uses nutrition analysis to determine targets for the provision of emergency WASH supplies and basic hygiene promotion and prioritize these interventions in the populations with the highest malnutrition rates.\(^{196}\) Cholera preparedness and prioritization uses IPC classification and outbreak history to identify and target areas of highest risk.\(^{197}\) The WASH and Nutrition Clusters explicitly acknowledge the need to closely link nutrition and WASH interventions in South Sudan, and in their joint strategy argue that diarrhoeal diseases and intestinal parasite infections, which are caused by poor WASH, directly affect nutrient intake. They also note the impact that long distances to water sources have on the ability of mothers to care for infants.\(^{198}\) Targeting WASH interventions to locations with high malnutrition levels is therefore a productive approach to the humanitarian response. The WASH and Nutrition Clusters are working to further integrate their responses, including by strengthening integrated targeting.\(^{199}\)

WASH in Rapid Response Mechanisms

The effectiveness of WASH in RRMs needs to be considered separately. RRM missions in South Sudan are designed to be integrated; the health, nutrition, WASH, child protection and education programmes all participate in the RRM and together conduct a joint campaign. WASH RRM interventions also follow nutrition-led targeting, though implementation is parallel rather than integrated.\(^{200}\) The evaluation team observed during an RRM that WASH plays a limited role and may not yet be optimized (see section 6.5 for detailed findings on RRMs). This is in line with the global findings of a recent analysis of humanitarian WASH responses.\(^{201}\)

WASH interventions usually rely on physical inspection of structures, while RRMs are carried out in a geographically very limited location\(^{202}\) and rely on beneficiaries coming from a wider catchment area to receive basic child-centred

\(^{193}\) Results data retrieved from UNICEF’s internal InSight system do not include an indicator for this output for WASH.

\(^{194}\) ‘WASH Humanitarian Action Review’.

\(^{195}\) Evaluation team observation from the field.

\(^{196}\) Key informant interviews with UNICEF staff and WASH Cluster partners, Juba, May 2018.

\(^{197}\) UNICEF planning documents and Key informant interviews with UNICEF staff, Juba, May 2018.

\(^{198}\) ‘WASH/Nutrition Strategy for South Sudan’.

\(^{199}\) Key informant interviews with UNICEF staff, Juba, May 2018.

\(^{200}\) Evaluation team observation from the field.


\(^{202}\) Most IRRMs take place in contested territory and staff cannot move around freely and, in any case, only on foot.
services from the UNICEF portfolio, not unlike Child Health Days. Therefore, while WASH staff may be able to inspect, implement or propose solutions for water and sanitation infrastructure at the point of RRM delivery (e.g., the repair of hand pumps in the RRM location), this will only represent and serve a small proportion of the catchment area. While RRMs do involve the distribution of hygiene products (e.g., soap and water purification agents) and dissemination of hygiene messages, support for water supply and sanitation infrastructure is severely curtailed.

Some of the WASH Cluster partners interviewed compared the UNICEF RRM and the role of WASH in it with other rapid response approaches practised in South Sudan that include WASH. Most prominently, the Emergency Preparedness and Response Mechanism, which is funded by the Directorate-General for European Civil Protection and Humanitarian Aid (ECHO), is different from the RRM in that it allows teams to spend more time on the ground, which facilitates more substantial behaviour change and follow-up interventions. As pointed out in a recent review of the sector, no standardized approaches exist between these mechanisms, and given that they cannot rely on WASH baseline data (which doesn’t exist), their targeting is not comparable. WASH Cluster partners have also pointed out that UNICEF IRRM reports are not as easily or readily available as Emergency Preparedness and Response Mechanism reports, which are released within five days of the intervention.

4.5 PROGRAMME QUALITY

The evaluation team found that programme implementation quality varies, and observed examples of poor quality implementation. According to the WASH Humanitarian Action Review, “construction quality (is) very variable, often not fit to purpose.” Based on observations made during the evaluation and partner interviews, it appears that these quality issues are more significant for sanitation infrastructure than water infrastructure. For example, the evaluation team visited a school latrine that lacked adequate privacy for girls, had only rudimentary handwashing facilities and exhibited poor quality construction.

UNICEF staff also reported that the quality of contractors is low, particularly in rural areas. However, the evaluation team posits that rather than accepting poor construction standards, UNICEF should address this through closer monitoring. UNICEF is aware of these concerns and is in the process of developing a long-term agreement with engineering supervisors to provide closer supervision of adherence to minimum technical and social standards for WASH infrastructure.

In the case of a motorized water system and several hand pump systems, the evaluation team observed that the implementing partner had no knowledge of basic performance data, which is a fundamental requirement when operating a borehole. Such information, especially the daily production of a water source, and the number of users per day, is critical to

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203 Key informant interviews with WASH Cluster partners, Juba, May 2018.
204 ‘WASH Humanitarian Action Review’.
205 Key informant interviews with WASH Cluster partners, Juba, May 2018.
206 The evaluators visually inspected sub-standard latrine buildings in two distinct locations; a partner has been found in one location to be poorly informed of water system parameters that are generally recognized as essential requirements for implementers in the sector.
208 Key informant interviews with UNICEF staff, Juba, May 2018.
making judgement on the adequacy of a water source capacity in relation to the population being served.

The latrine example also points to issues beyond construction quality. Latrine designs must go beyond designating three out of six identical cubicles for female use. They must incorporate the need for dignity for menstruating school-aged girls who require reasonably private space at school. In the observed example, the latrines were also locked to avoid use by the nearby village, which, in a school environment with only male teachers, brings up issues of stigma for girls who must request access to the latrine.

Protection is an important consideration in WASH, but not prioritized as such. Key informants at a Juba PoC site noted that while clean water is supplied, some of the therapeutic food given to mothers at the OTP requires cooking (e.g., fortified porridge). To cook the food, women recipients must travel outside the camp at least once a week to forage for firewood. This is a journey of several hours and can expose women to sexual violence. The evaluation team heard an anecdote to this effect – of a mother whose child was enrolled at the OTP but stopped coming. The child was subsequently brought by a relative after the mother had gone for firewood and never returned. She is presumed to have been abducted or killed.

4.6 PROGRAMME EFFICIENCY

During the evaluation period, the WASH response in South Sudan was significantly underfunded against fundraising targets. Funding gaps were 27.5 and 40.2 per cent in 2016 and 2017, respectively. Other evaluations of WASH responses point to the fact that insufficient funding can lead to reduced quality or coverage. Lack of funding is also explicitly given as a reason for limiting the number of people targeted in the 2017 HRP. According to the HRP, the targeting reflects anticipated resources. It would therefore be prudent to strive for the most efficient use of resources.

The operating environment in South Sudan is costlier than in many other countries, mostly due to the restrictive working environment, with many sites only accessible by air. Opportunities for reducing costs and increasing efficiencies are therefore not always available. In WASH, the conversion of the PoC water trucking operation into fixed piped systems is one such opportunity. At the Juba PoC, the average daily cost of water trucking is US$5,000, for an annual cost of nearly US$2 million. Given that the PoC has now existed for four years, even a small investment in a piped water system would have significantly increased efficiency. During the evaluation period, such systems were completed in Bentiu and Yambio and were underway at the PoC sites in Juba, Rubkona and Malakal.
The WASH core pipeline is another example of minimizing cost – in this case for the WASH Cluster as a whole. The core pipeline provides a limited standard set of basic supplies, enabling advanced planning and compensating for long lead times for parts (see section 6.6 on lead times and obstacles to the supply chain).

4.7 UNICEF AND THE WASH CLUSTER

During the evaluation period, UNICEF leadership of the WASH Cluster faced challenges,\(^{215}\) which reflected badly on the organization as a whole and reduced confidence in the cluster itself.\(^{216}\) The cluster was seen as favouring UNICEF cooperating partners in the cluster over non-UNICEF partners in the allocation of WASH core pipeline materials.\(^{217}\) UNICEF rectified the situation in early 2018 by enhancing the cluster coordination leadership capacities.\(^{218}\)

Despite this issue, a mid-2017 survey of cluster partners in South Sudan expressed overall satisfaction with UNICEF’s cluster leadership.\(^{219}\) UNICEF has now largely re-established trust and is performing well in its role. In interviews, WASH Cluster partners expressed a marked return of confidence in UNICEF’s cluster leadership since the issue was addressed.\(^{220}\)

Since then, confidence in UNICEF cluster leadership has remained high among cluster partners. Partners appreciate UNICEF’s management of aspects of the core pipeline for WASH supplies,\(^{221}\) which is a good example of how UNICEF has acted as a provider of last resort

\(^{215}\) Key informant interviews with UNICEF staff and WASH Cluster partners, Juba, May 2018.
\(^{216}\) UNICEF reportedly lost funding for the WASH core pipeline from two major donors as a result.
\(^{217}\) Key informant interviews with UNICEF staff and WASH Cluster partners, Juba, May 2018.
\(^{218}\) Key informant interviews with UNICEF staff and donors Juba, May 2018.
\(^{220}\) Key informant interviews with WASH Cluster partners, Juba, May 2018.
\(^{221}\) Ibid.
as per the cluster principles. Equally, UNICEF’s investment in the REACH baseline assessment methodology reflects its strong leadership in supporting a process that closes a vital gap in the sector and benefits all partners.

4.8 RESILIENCE AND RISK-INFORMED PROGRAMMING

When asked about UNICEF’s emergency response, a WASH Cluster partner named the WASH core pipeline and the IRRM as the two key elements of the organization’s humanitarian action in South Sudan.222 This perspective leaves out UNICEF’s fundamental function in South Sudan of supporting stationary water systems across the country to ensure that people in crisis have access to clean water, which tends to be perceived as a development function. These elements of the WASH response cannot be separated and need to be considered together to gauge their effect on resilience and recovery.

Although the new UNICEF South Sudan WASH strategy note for 2019–2021 more explicitly integrates infrastructure development and humanitarian action, substantial room for improvement remains. There are arguably two dimensions to sustainable and resilient systems: 1) operation and maintenance of facilities; and 2) safe WASH behaviour. Operation and maintenance of facilities is a basic requirement in both development and humanitarian programming to keep infrastructure in working condition. Safe behaviours must complement functional facilities to ensure that they are used appropriately (especially in sanitation) and that clean water is managed safely at the household level.

Findings point to gaps in both elements of the UNICEF response. It was observed that partners charged with establishing community water system management did not have the basic data (e.g., water yield, pump capacity, borehole performance and condition, etc.) to establish a basic cost per unit of water. Particularly in humanitarian situations, willingness to pay is essentially non-existent. Nevertheless, water management committees will only succeed if they have the means to know the cost of providing water, and consequently their financial shortfall. Without a meaningful and credible way to seek subsidies from humanitarian partners, emergency water provision will be an imprecise and ad-hoc intervention.

Regarding safe behaviour and behaviour change, UNICEF is, for the most part,223 investing in disseminating key messages and household hygiene products, such as soap and water purification agents.224 While these interventions reach a large number of beneficiaries, message dissemination is often conducted in a single event, and arguably cannot have the same impact as the more collaborative, community-based processes that other WASH Cluster partners pursue.225 One partner noted, “they [UNICEF] tend towards a focus on mass hygiene promotion that may reach a lot of people, but with uncertain results in terms of motivation towards behaviour change.”226 This perception is based on the role of WASH in the RRM, which is currently restricted to such

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222 Key informant interviews with WASH Cluster partners, various field locations, May 2018.
223 A noted exception is the cholera response in 2017 where UNICEF also worked through social mobilizers and hygiene promoters that engaged communities and households beyond just providing information.
224 Evaluation team observation from the field; sampled work plans and PCAs mostly refer to ‘campaigns’ and ‘messages’.
225 Key informant interviews with WASH Cluster partners, Juba, May 2018.
226 Ibid.
one-off events. UNICEF is aware of the need to invest in an integrated community extension worker system that can work more sustainably on behaviour change in a given location. A similar approach was practiced during the 2017 cholera response, suggesting that the organization did not feel that the previous model was achieving the required change.

4.9 CONCLUSIONS AND LESSONS LEARNED

Strategy: UNICEF South Sudan strategy and approach to WASH during the evaluation period was at odds with the demands of the situation. The WASH strategy note for 2016–2018 reads more like a development plan than a humanitarian plan and includes some approaches (e.g., to community-led sanitation) that have proven unrealistic. But more importantly, the separation between development and humanitarian WASH now appears artificial and counterproductive. The recent generalized insecurity and displacement have rendered the distinction unhelpful; the same basic principles apply to both. For example, any water system or sanitation facility, whether constructed or rehabilitated through regular or emergency funding, needs a clear concept for operation and maintenance, including a full set of technical, performance and usage data. In the new WASH Strategy 2019–2021, UNICEF is moving in the right direction towards better integration of development and humanitarian WASH approaches.

Targets: During the evaluation period, UNICEF achieved its targets on access to water but fell short of its targets on access to sanitation, which were over-ambitious given the structural and developmental challenges involved. Regarding sanitation-related behaviour change, there has been a discrepancy between UNICEF and partner practice. While there seems to be a general understanding, including within UNICEF, that behaviour change requires engagement, dialogue and time, UNICEF still widely practices one-off campaign style hygiene information sessions. Given how pivotal hygiene is in a country such as South Sudan, with its high rate of open defecation, this represents a weakness in implementation practice.

Quality: The quality of work delivered by UNICEF’s WASH partners is a concern. Emergency infrastructure should not be of lesser quality than regular infrastructure unless there are compelling reasons, such as limited time windows for intervention (e.g., in shifting conflict environments). There is no justification for the reduced quality of sanitation infrastructure in facilities such as schools and health centres, as was observed during the evaluation. Quality concerns also extend to the collection, sharing and use of basic technical data on installation, as well as support for operation and maintenance. UNICEF needs to invest more in technical oversight and quality assurance.

Assessments: Engagement with REACH on WASH baseline assessments is essential and should be prioritized. This should help fill a crucial data gap, and the standardized set of indicators should be used consistently and widely. The gathering of baseline data could easily be added to the RRM responsibilities for WASH, as the sector currently plays a comparatively minor role in these missions. More generally, UNICEF and its partners need to find more consistent ways of assessing water supply and sanitation needs in South Sudan.

227 Globally, the role of WASH in RRM is not yet well defined. ‘UNICEF WASH Action in Humanitarian Situations: Synthesis of Evaluations 2010–2016’.

228 Key informant interviews with UNICEF staff, Juba, May 2018.
THE HEALTH RESPONSE
South Sudan has some of the worst health indicators in the world, including one of the highest maternal mortality rates. High levels of vulnerability are compounded by multiple factors, such as conflict and displacement, multiple causes of morbidity, lack of services or infrastructural investment and poor nutrition, as well as the more general effects of poverty. Children under 5, particularly infants, are especially vulnerable.

Though UNICEF’s role in the sector is modest, the organization plays a central role in immunization and cold chain provision, as well as in managing the core pipeline for supplies. UNICEF, alongside WHO, has also played a central role in supporting the Ministry of Health to strengthen health emergency preparedness. This section reviews UNICEF’s contribution to the health sector during the evaluation period, the relevance and effectiveness of its interventions and possible options for future engagement.

5.1 THE HEALTH CONTEXT: THREATS, VULNERABILITIES AND NEEDS

Though there has been some progress in recent years, South Sudan has some of the world’s worst health indicators. In 2016, infant and child mortality rates were 59.2 and 90.7 per 1,000 live births, respectively. Maternal mortality was estimated at 789 deaths per 100,000 live births. Communicable diseases remain a major public health problem and the leading cause of death. Malaria, diarrhoea and pneumonia constitute 77 per cent of all outpatient diagnoses for children under 5 years. South Sudan is also prone to outbreaks of disease such as cholera, measles and meningitis; and the country lies in the yellow fever belt.

Some of the main factors behind South Sudan’s high level of health vulnerability relate to inadequate water supplies and sanitation facilities. Recent surveys show that more than 50 per cent of people in South Sudan lack access to safe water and 61 per cent of the population did not have access to adequate sanitation facilities (i.e., were practicing open defecation). Only 45 per cent of South Sudan’s 3,349 basic primary schools have access to safe water and 17 per cent have adequate sanitary latrines for both girls and boys.

Immunization levels remain dangerously low in South Sudan despite some recorded progress. A 2012 survey showed that only 7.3 per cent of children were fully immunized, with high levels of drop out; while a 2017 survey showed that

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18.9 per cent of children were fully immunized. As of the end of December 2017, the Health Cluster reported (with regard to routine EPI) that only 38 per cent of children received measles vaccination, 45 per cent received polio vaccination and 29 per cent received pentavalent 3 before the age of 1. This low coverage will affect herd immunity against vaccine-preventable diseases.

Tuberculosis and HIV are other key causes of morbidity and excess mortality in South Sudan: tuberculosis prevalence is at 146 per 100,000 and HIV/AIDS prevalence is estimated at 2.6 per cent, and classified as a generalized epidemic, though the number of new HIV infections has declined, from 550,000 in 2001 to 260,000 in 2012. Progress has been made on improving access to antiretroviral therapy for pregnant and lactating women living with HIV. In 2016, 29 per cent (17 to 42 per cent) of pregnant women living with HIV were accessing treatment or prophylaxis to prevent the transmission of HIV to their children; the Joint United Nations Programme on HIV/AIDS (UNAIDS) reported an increase to 60 per cent (40 to 86 per cent) in 2018. The expansion of antiretroviral therapy coverage has been slower for children, however.

There has been severe under-investment in health services in South Sudan. As of 2013, only 44 per cent of the population lived within 5 kilometres of health services, only 46 per cent of counties had hospitals, and 56 per cent of payams had primary health care facilities. In the past, South Sudan has relied heavily on external funding for health service provision; and the conflict has reduced what little health service capacity existed. Since 2013, over 57 per cent of health facilities in conflict-affected states have been looted or destroyed and are no longer functioning. The country is also facing a lack of health workers, many of whom have fled due to insecurity or unpaid salaries.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total people in need</th>
<th>Refugee target</th>
<th>Internally displaced persons target</th>
<th>Host target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>4.73</td>
<td>0.3</td>
<td>0.77</td>
<td>1.43</td>
</tr>
<tr>
<td>2017</td>
<td>5.4</td>
<td>0.3</td>
<td>1.4</td>
<td>1.3</td>
</tr>
<tr>
<td>2018</td>
<td>5.1</td>
<td>0.3</td>
<td>1.9</td>
<td>0.2</td>
</tr>
</tbody>
</table>


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233 Mbabazi, William, et al., ‘Maiden Immunization Coverage Survey in the Republic of South Sudan: A cross-sectional study providing baselines for future performance measurement’, The Pan African Medical Journal, vol. 16, no. 110, 2013. Coverage for specific antigens was found to be as follows: bacillus calmette-guerin: 28.3 per cent; diphtheria tetanus pertussis (DTP)-1: 25.9 per cent; DTP-3: 22.0 per cent; measles: 16.8 per cent. The drop-out rate between the first and third doses of DTP was 21.3 per cent. Immunization coverage estimates based on card and history were higher, at 45.7 per cent for DTP, 45.8 per cent for meningococcal vaccine and 32.2 per cent for full immunization. Most immunizations (80.8 per cent) were received at health facilities compared to community service points (19.2 per cent).


237 ‘UNICEF South Sudan Programme Component Strategy Note: Health’.

238 Ibid.

239 Ibid.
According to the Health Cluster, in July 2017, 17 per cent of health facilities reporting were non-functional.\textsuperscript{240}

Overall, the humanitarian health response has fallen well short of the needs. Table 8 shows the population in need and the affected population targeted with health assistance in the 2016–2018 HRPs.

During the evaluation period, the agreed targets for health assistance never exceeded 56 per cent of the needs. This reflects the difficult operating environment, including regular attacks on health facilities, attacks on health workers and shortages of drugs and skilled professionals. The 2018 HRP indicated that a number of factors were considered for prioritization and targeting, including “levels of displacement, disease burden, outbreak potential, need of reproductive health care, morbidity from AIDS and tuberculosis, IPC status and levels of severe malnutrition among children with medical complications. Geographical locations considered include epidemic-prone, conflict-affected and seasonally hard-to-reach areas. Contextual analysis will include issues related to WASH provision in health facilities, attacks on health care services and health funding constraints.”\textsuperscript{241}

The Health Pooled Fund set up by the United Kingdom Department for International Development (DFID) in 2012 initially provided health system support in six states of South Sudan. The £120 million partnership with the Ministry of Health built on previous health system strengthening programmes, such as the Sudan Health Transformation Project, the Multi Donor Trust Fund and the Basic Services Fund. While managed and coordinated by the private sector, NGOs managed programme delivery at the state and county levels. The other four states were covered by two other fund managers. By the time the fund’s second round was initiated in 2016, it covered 8 of the 10 states in South Sudan with Jonglei and Upper Nile covered through the World Bank.\textsuperscript{242}

UNICEF’s role in health system strengthening was therefore largely complemented by the Health Pooled Fund. In coordination with partners, UNICEF supported outreach and community engagement, cold chain management and vaccination and filled gaps in medication stocks and funding as they arose due to the limited funding available through the Health Pooled Fund. UNICEF also trained NGO partners on emergency preparedness and response. More recently, UNICEF has successfully advocated for the fund’s third round to include enhancing capacities of community health workers in line with the Boma Health Initiative.

5.2 NEEDS ASSESSMENT, MONITORING AND DATA QUALITY

The weakness of data in South Sudan is tied to the lack of recent census and national survey data and the poor birth certification system. The last population census was undertaken in 2008 and the most recent household and health survey took place in 2010. No Multiple Indicator Cluster Survey has been recently undertaken. Without a key population denominator, much of the data are unreliable unless used for trend analysis.

UNICEF contributes to the Food Security and Nutrition Monitoring System, an inter-agency initiative that collects data on the three most prevalent morbidities – malaria, pneumonia and diarrhoea. UNICEF also participates in inter-agency rapid needs assessments in addition to data collected during IRRM missions.


\textsuperscript{241} ‘South Sudan: 2018 Humanitarian Response Plan’.

\textsuperscript{242} The evaluation team learned that UNICEF would be administering the two states formerly supported by the World Bank.
WHO supports disease surveillance systems that are operating in camp settings (e.g., the Early Warning and Alert Response System – EWARS) and outside the camps (e.g., the Integrated Disease Surveillance and Response system). EWARS is designed to improve disease outbreak detection in emergency settings.\textsuperscript{243} The completeness of reporting varied between EWARS and the Integrated Disease Surveillance and Response system, however, with counties covered by EWARS regularly reporting a higher completeness rate.\textsuperscript{244} Key informants indicated that WHO is currently working to consolidate the two systems into one.

UNICEF can make good use of such assessments and data collected for planning and decision-making.

5.3 UNICEF’S HEALTH STRATEGY

UNICEF’s health strategy for the evaluation period is detailed in the CPD 2016–2018 and the supporting health programme component strategy note for that same period. UNICEF’s health interventions supported three of the five Interim Cooperation Framework objectives: 1) resilient communities; 2) strengthened social services for the most vulnerable; and 3) improved status of women and youth. UNICEF’s specific roles in support of these objectives included:

- Strengthening routine immunization and polio response;
- Focusing on three of the major killers of children under 5 years – malaria, pneumonia and diarrhoea;
- Enhancing maternal and newborn health;
- Responding to disease outbreaks and humanitarian needs; and
- Supporting the creation of an enabling policy and institutional environment.

UNICEF’s health strategy was also aligned to the achievement of the Government’s Health Policy 2016–2026, which has as one of its objectives: to strengthen health service organization and infrastructure development for effective and equitable delivery of the basic package of health and nutrition services, which consists of:

- Integrated reproductive health care;
- Community-based health and nutrition care, with emphasis on child health and nutrition; and
- Health education and promotion.

The Government began implementing the Boma Health Initiative in 2017. The Initiative was intended to replace the fragmented community health and nutrition services – including a variety of preventive, curative and promotional services – provided by NGOs with donor funding. A lack of coordination among partners and the Government has led to problems, such as duplicated and fragmented training, supervision, reporting and incentives, which have contributed to resource wastage and a lack of clarity on the roles and responsibilities of community health workers. The Initiative focused on empowering each community to select three Boma health workers to be trained, equipped and empowered to deliver high-impact, cost-effective primary health care services.\textsuperscript{245} However, key informants suggested that the initiative has yet to be implemented.


\textsuperscript{245} Republic of South Sudan, “The Community Health System in South Sudan: “The Boma Health Initiative“”, March 2016.
fully, primarily due to the lack of support it has received and despite government legislation and parliamentary budget approval. UNICEF is currently supporting the revision of the community health worker training package.

UNICEF’s health interventions are complementary to the Health Pooled Fund objectives, which are:

- To improve the access, use and quality of primary health care and emergency obstetric and neonatal care services;
- To increase accountability and effectiveness by working with community mechanisms to improve health and health education; and
- To support the strengthening of key stewardship functions of the Ministry of Health, including: planning, management, coordination, supervision and monitoring at all levels, in accordance with Ministry of Health guidelines and tools.

The second phase of the Health Pooled Fund operated in 8 of the 10 former states and funded 21 implementing partners (often the same implementing partners supported by UNICEF) to support primary health care services in 1,063 health facilities, including 14 hospitals, across 55 counties.

5.4 IMPLEMENTING THE STRATEGY: RESULTS AND EFFECTIVENESS

Delivery against targets

During the evaluation period, UNICEF delivered against the outputs detailed in its Humanitarian Action for Children appeals and in the Health Cluster plan. In 2016 and 2017, in collaboration with the Ministry of Health and implementing partners, UNICEF ensured that services were provided at both the health facility and community levels. Table 9 provides the targets and achievements for 2016 and 2017.

A comparison of health partner presence in South Sudan between 2015 and 2016 showed a decrease from 60 to 37 partners. This was the result of increased insecurity caused by the upsurge in conflict, even in areas that were previously calm, and ultimately undermined the achievement of 2016 targets.247

<table>
<thead>
<tr>
<th>Indicator</th>
<th>UNICEF target 2016</th>
<th>UNICEF result 2016</th>
<th>% achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of preventive and curative consultations provided to children under 5 years of age</td>
<td>600,000</td>
<td>557,588</td>
<td>93</td>
</tr>
<tr>
<td>Number of children aged 6 months to 15 years in conflict-affected areas vaccinated against measles</td>
<td>1,171,904</td>
<td>1,232,000</td>
<td>147</td>
</tr>
<tr>
<td>Number of children, pregnant women and other vulnerable people receiving a long-lasting insecticide-treated net</td>
<td>400,000</td>
<td>235,374</td>
<td>59</td>
</tr>
</tbody>
</table>

Source: South Sudan country office annual reports (2016 and 2017)

246 Gender disaggregated data was only available in 2017 and is therefore not presented in Table 9.
The low achievement against 2016 measles vaccination targets was also associated with the renewed conflict and reduced access, as well as frequent attacks on and destruction of cold chain facilities. For example, key informants reported that 153 out of 200 newly installed solar fridges were destroyed during the upsurge of violence in 2016. In 2017, as access improved, UNICEF was able to exceed its 2017 measles vaccination target through the implementation of a two-part vaccination campaign.\(^{248}\) Overachievement of the 2017 target for preventive and curative consultations (189 per cent) may be the result of setting a lower target than the previous year.

Though the Health Cluster reported that there were breaks in the health core pipeline in 2017 due to limited funding and long delays in procurement processes,\(^{248}\) UNICEF was still able to meet its targets for consultations and measles vaccination. However, late requisition of long-lasting insecticide treated nets led to delays in the delivery of the nets in the country.

**Effectiveness against stated objectives**

**Output 1:**

**Strengthening routine immunization and polio response**

Routine EPI coverage is low in South Sudan. At the end of December 2017, the Health Cluster reported that “only 38 per cent of children received measles vaccine, 45 per cent received polio vaccine and 29 per cent received pentavalent 3 before the age of 1 in 2017.” The report went on to say that “low routine immunization coverage will affect herd immunity against vaccine preventable diseases.”\(^{250}\) UNICEF’s own data for routine immunization suggests that measles vaccination coverage for children under 1 year and pregnant women was 52 per cent in 2016 and 53 per cent in 2017,\(^{251}\) which is notably below herd immunization coverage and the CCC target of 95 per cent.\(^{252}\)

While UNICEF surpassed its 2017 targets for vaccinating children aged 6 months to 15 years against measles (see Table 9),\(^{253}\) evidence suggests that results for routine polio immunization are not as positive. In 2016, UNICEF only achieved 16 per cent of its target for polio vaccinations and even fewer children were reached in 2017 than in 2016 (no target was available for 2017).\(^{254}\)

Continued attacks on cold chain facilities, including looting and damage, have reduced coverage and heavily impacted the effectiveness of routine immunization. Key informants report that these attacks – such as the attack that occurred on Koch in Unity State in April 2018 – occur continuously. Between 2016 and 2017, the number of functional cold chain facilities only increased from 401 to 481 (from 29 per cent to 35 per cent).

In addition to routine immunization, in 2016, UNICEF, the Ministry of Health, WHO and other partners provided social mobilization and communication support to four national immunization days. All of these efforts led to the national immunization days reaching more than 3 million children under 5 years with polio vaccination (bivalent oral polio vaccine) (95 per cent coverage of all children in that age range).


\(^{249}\) ‘South Sudan Health Cluster Bulletin No. 12’.

\(^{250}\) Ibid.

\(^{251}\) Data from the UNICEF Routine EPI Database, 2016–2017.

\(^{252}\) ‘Core Commitments for Children in Humanitarian Action’.

\(^{253}\) Table 9 combines routine immunization data and campaign data.

\(^{254}\) Data provided by UNICEF South Sudan for 2016 and 2017.
Nearly 2.4 million children aged 6 to 59 months received vitamin A supplementation (78 per cent coverage) and more than 1.8 million children aged 12 to 59 months received deworming treatment (albendazole) (68 per cent coverage). In addition, more than 34,000 long-lasting insecticide-treated nets were distributed through the EPI system.

Output 2:
Focusing on three of the major killers of children under 5 – malaria, pneumonia and diarrhoea

UNICEF continued to address the three major morbidities affecting children under 5 years. Figure 12 shows the proportion of people treated for malaria, pneumonia and diarrhoea through health centres and iCCM.

As illustrated in Figure 12, malaria remains the most prevalent morbidity. In 2016 and 2017, 36 per cent and 46 per cent of those treated at health centres and by iCCM in were children under 5 years, respectively.

Table 10 details the number of children treated for the three main morbidities and the number of those children that died. In 2016 and 2017, malaria caused the highest number of deaths. UNICEF malaria prevention efforts, as reflected in long-lasting insecticide-treated net distribution, fell short of the targets in both 2016 and 2017 (see Table 9). This has been tied to funding gap and the late requisition of the nets. As a result, the long-lasting insecticide-treated nets arrived in country during the rainy season when road access is severely limited in the context of South Sudan. Despite these constraints, UNICEF South Sudan managed to distribute more than 250,000 bed nets in the last few months of 2017.

FIGURE 12 Proportion of people treated for malaria, pneumonia and diarrhoea through health centres and iCCM, 2016 and 2017


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256 Data provided for 2016 as data for 2017 were not available.
### TABLE 10  Number of children treated for and that died from malaria, acute respiratory infection and diarrhoea, 2016 and 2017\(^{258}\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Morbidity</th>
<th>&lt;5 treated</th>
<th>&gt;5 treated</th>
<th>Total treated</th>
<th>&lt; 5 cases dead</th>
<th>≥ 5 cases dead</th>
<th>Total cases dead</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Diarrhoea</td>
<td>86,313</td>
<td>70,549</td>
<td>156,862</td>
<td>52</td>
<td>30</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>Acute respiratory infection</td>
<td>142,946</td>
<td>182,448</td>
<td>325,394</td>
<td>81</td>
<td>30</td>
<td>111</td>
</tr>
<tr>
<td></td>
<td>Malaria</td>
<td>187,504</td>
<td>341,514</td>
<td>529,018</td>
<td>115</td>
<td>70</td>
<td>185</td>
</tr>
<tr>
<td>2017</td>
<td>Diarrhoea</td>
<td>163,056</td>
<td>101,363</td>
<td>264,419</td>
<td>185</td>
<td>21</td>
<td>206</td>
</tr>
<tr>
<td></td>
<td>Acute respiratory infection</td>
<td>202,737</td>
<td>169,278</td>
<td>372,015</td>
<td>55</td>
<td>19</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>Malaria</td>
<td>361,927</td>
<td>722,318</td>
<td>727,318</td>
<td>122</td>
<td>84</td>
<td>206</td>
</tr>
</tbody>
</table>


As planned for 2016, iCCM of childhood illness support was scaled up from three payams in Mingkaman to 26 payams in 12 counties (Yambio, Bor, Bor South, Aweil North, Malakal, Wau Shilluk, Nasir, Pariang, Abiemnom, Koch, Guot and Mayom). This may have contributed to the increase in the number of treatments provided in 2017.

### Output 3: Enhancing maternal and newborn health

During the evaluation period, UNICEF also focused on maternal and newborn health, including through prevention of mother-to-child transmission of HIV, antenatal care and safe delivery practice. Table 11 provides the number of pregnant and lactating women reached with counselling and testing and the number of pregnant women who accessed delivery by skilled attendants.

### TABLE 11  Number of pregnant and lactating women tested and counselled for HIV and delivered by skilled attendants

<table>
<thead>
<tr>
<th>Year</th>
<th>Activity</th>
<th>Pregnant and lactating women &lt;18 years</th>
<th>Pregnant and lactating women &gt; 18 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Tested and counselled</td>
<td>N/A(^{259})</td>
<td>N/A</td>
<td>33,077</td>
</tr>
<tr>
<td></td>
<td>Delivery by skilled attendants</td>
<td></td>
<td></td>
<td>17,184</td>
</tr>
<tr>
<td>2017</td>
<td>Tested and counselled</td>
<td>973</td>
<td>40,741</td>
<td>41,714</td>
</tr>
<tr>
<td></td>
<td>Delivery by skilled attendants</td>
<td>1,675</td>
<td>17,797</td>
<td>19,472</td>
</tr>
</tbody>
</table>


\(^{258}\) Data provided by UNICEF South Sudan for 2016 and 2017.

\(^{259}\) Ibid.
In South Sudan, HIV and AIDS awareness is low and HIV-related stigma is high. UNICEF reported that these factors affected the uptake of prevention of mother-to-child transmission of HIV services and compliance with HIV treatment protocols. The conflict and subsequent displacement have rendered maternal and newborn health and prevention of mother-to-child transmission of HIV services, including awareness-raising activities, inaccessible to significant proportions of the population.\textsuperscript{260}

By December 2016, UNICEF South Sudan had supported the more than 1,000 members of 36 mother-to-mother support groups. In UNICEF-supported sites, acceptance of HIV testing among pregnant women after health education increased from 58 per cent in 2015 to 82 per cent in 2016.\textsuperscript{261}

In 2016, more than 155,000 pregnant women accessed at least one antenatal care visit (114 per cent of the target), though only 22 per cent completed the recommended four or more antenatal care visits. As part of antenatal care, UNICEF also provided tetanus toxoid vaccination, though adolescent girls were less likely to receive the vaccination. Forty-one per cent of targeted pregnant women delivered with skilled birth attendants, exceeding the national average of 12 per cent.\textsuperscript{262} In 2017, more than 40,000 pregnant women attended antenatal care four or more times. However, cultural constraints significantly hindered the uptake of recommended antenatal care services and facility-based deliveries by skilled birth attendants.

Community-based deliveries are still very common in South Sudan, and usually lack the assistance of skilled health personnel.

In 2016 and 2017, the share of pregnant and lactating women tested/counselled and who gave birth safely that were under 18 years was 2 and 9 per cent, respectively. Given how common early marriage is in South Sudan, these numbers suggest that greater efforts are needed to reach women under 18 years.

\textbf{Output 4: Responding to disease outbreaks and humanitarian needs}

During the evaluation period, UNICEF regularly responded to disease outbreaks, including outbreaks of measles and cholera (see Box 10 on the 2016–2017 cholera outbreak). UNICEF contributed to 15 outbreak response immunization campaigns in 2016, reaching nearly 610,000 children (52 per cent of the target) with measles vaccination and nearly 1.4 million children with polio vaccination in conflict-affected areas.\textsuperscript{263}

UNICEF also responded to basic health needs through the IRRM. The number of curative consultations undertaken through IRRM missions totalled nearly 29,000 in 2017.\textsuperscript{264} RRM missions contributed a relatively low proportion of all curative consultations in 2017, however, at 1.5 per cent. In 2016 and 2017, RRM missions accounted for 10 and 5 per cent of measles vaccinations for children aged 6 months to 15 years, respectively.\textsuperscript{265} Polio vaccinations were also administered through IRRM missions. Data from 2016 show that RRM missions reached 32 per cent of those vaccinated against polio.

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{260} UNICEF Country Office Annual Report 2016: South Sudan.
\item \textsuperscript{261} Ibid.
\item \textsuperscript{262} Ibid.
\item \textsuperscript{263} Ibid.
\item \textsuperscript{264} Data for 2016 were not available in the same format and were therefore not presented.
\item \textsuperscript{265} Data from the UNICEF South Sudan health section, 2016–2017.
\end{itemize}
\end{footnotesize}
during the year. This suggests that the IRRM played a critical role in increasing the number of children vaccinated against polio; this was not the case for measles vaccination, however.

UNICEF also provided tetanus toxoid vaccination to women through the IRRM. In 2016, 18 per cent of the total number of women vaccinated for tetanus toxoid-1 were reached through the IRRM; and in 2017, 34 per cent were reached through the IRRM. However, a single dose of tetanus toxoid does not provide complete protection; the assumption was that women vaccinated had either been vaccinated previously or would have the ability to access health services in the future. In 2018, the IRRM also began piloting the provision of maternal and neonatal tetanus elimination by vaccinating non-pregnant women.

UNICEF also distributed long-lasting insecticide-treated bed nets during IRRM missions. In 2016 and 2017, 8,980 and 43,333 such bed nets were distributed during missions, respectively, making up 4 and 17 per cent of the total bed nets distributed during those years. Despite this increase in the proportion of bed nets distributed through IRRM missions from 2016 to 2017, bed net distribution fell well below the targets for both years, due to lack of stock. WHO and WFP have agreed to distribute bed nets during food distributions, including during air drops, which should increase coverage. In 2018, UNICEF also negotiated and reached an agreement with Population Services International to deliver Global Fund-supported bed nets through the IRRM. This has helped to fill critical gaps.

Output 5:
Supporting the creation of an enabling policy and institutional environment

UNICEF supported the Ministry of Health to develop, revise, produce and disseminate a wide array of key health policies and costed plans to scale up evidence-based interventions. This included a costed multi-year plan for expanded immunization, a national cholera prevention and response plan, the National HIV and AIDS Strategic Plan 2017–2022 and the Every Newborn Action Plan 2018–2022, which is informing the development of a national reproductive, maternal, newborn, child and adolescent health strategy. However, the escalating conflict and increased focus on life-saving interventions have meant that policy implementation and health system strengthening activities were deprioritized. As a result, this output was discontinued in December 2017.

266 Ibid.
267 Ibid.
268 Key informant interviews with WHO staff, May 2018, Juba.
269 Population Services International is a principle recipient of a malaria grant focusing on South Sudan from the Global Fund to Fight AIDS, Tuberculosis and Malaria.
In 2018 and beyond, UNICEF has put additional effort and resources into supporting local health actors to plan and budget for essential interventions. UNICEF has supported the Ministry of Health at multiple levels, including with partner coordination and scaling up community health systems to ensure the resilience and sustainability of basic health care in South Sudan.

During the evaluation period, UNICEF supported the Ministry of Health to finalize guidelines for integrated maternal, newborn and child health. A national training of trainers was also conducted on the subject in Juba. The planned development of a costed integrated maternal, newborn and child illness scale-up plan could not be completed during the second half of 2017 due to overriding emergency response priorities.\(^{270}\)

In 2016, UNICEF, WHO and the South Sudan Red Cross participated in a joint effort to support the Ministry of Health to develop a training package for community health workers and home health promoters, which informed the development of the Boma Health Initiative. In 2016 and 2017, UNICEF South Sudan also supported improved health data collection across the country with the printing of registers for antenatal care, prevention of mother-to-child transmission of HIV and maternity care. These registers have been disseminated to field locations and are currently in use as part of ongoing efforts to improve administrative data collection.

In an effort to provide much needed demographic health data, in 2016, UNICEF South Sudan supported the Ministry of Health to conduct the Expanded Maternal Mortality Survey. UNICEF support included the deployment of a technical expert and survey coordination. Though the questionnaire has been developed and the sampling frame has been updated, lack of funding, insecurity and limited communication equipment in rural areas have stalled survey implementation.

UNICEF also supported the development of the Boma Health Initiative policy and the implementation strategy. The initiative seeks to provide sustainable delivery of essential health care and public health programmes at the community level.\(^{271}\) UNICEF also printed copies of the strategy for advocacy purposes. The national Boma Health Initiative Strategy for community health care was launched in March 2017.

### 5.5 PROGRAMME QUALITY

#### Immunization

The quality of immunization has been impacted by the low coverage of routine immunization, which has resulted in outbreaks of diseases such as measles. Coverage has been severely hampered by the regular attacks on health facilities, including the cold chain mechanism, the looting of materials and the number of non-functional health facilities.

Access to services has also been a key issue. Only 44 per cent of the population lives within 5 kilometres of health services; only 46 per cent of counties have hospitals; and just 56 per cent of payams have primary health care facilities.\(^{272}\) Out of 156 sampled health care facilities, only 6 per cent recorded satisfactory performance by

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\(^{272}\) ‘UNICEF South Sudan Programme Component Strategy Note: Health’.
health care professionals and only 16 per cent had adequate staff numbers, with many staff leaving their posts due to insecurity and lack of salary payments.273

Consultation and treatment of malaria, pneumonia and diarrhoea

The health facilities that the evaluation team visited were hygienic and well organized. Water sources had been rehabilitated and health centres had piped water available from reservoir tanks. Medications were available in all health facilities visited.

While treatment efforts both at facilities and in communities through iCCM targeted the three main morbidities, the numbers reached through iCCM were low and only made up 6 per cent of the total number treated in 2017. Given the lack of access to static facilities, there is a clear need to increase the reach of services in communities.

The evaluation team noted the need to increase refresher trainings to overcome potential misdiagnoses by iCCM workers. Some of the materials (e.g., respiratory counters and torches) no longer worked and had not been replaced; and the iCCM workers would need materials such as boots and bags to use during the rainy season. These issues have, however, been discussed and are being considered by donors and the Government as part of a cost analysis on the resources needed to support community health workers.

Maternal and newborn health

A 2017 study274 on the barriers to uptake of antenatal care services suggested a number of key issues, including: 1) difficulties accessing health facilities, including due to long distances to health facilities, lack of transportation, land barriers such as flooding and poor roads and the cost of health care; 2) conflict and the socio-cultural context, including insecurity, the heavy burden of domestic chores and the negative influence of husbands reluctant to allow their wives to attend antenatal care; 3) perceptions about pregnancy, including misperceptions about antenatal care and low perceived risk of pregnancy-related complications; and 4) perceptions about the quality of care and the efficacy of medical treatment.

The quality of maternal and newborn programming has also been impacted by the inability to reach adolescent girls, who should be a primary target of activities due to the widespread practice of child marriage in South Sudan.

Responding to disease outbreaks and humanitarian needs

In November 2017, a measles outbreak was confirmed in Panyijiar county, Unity state, with 78 per cent of the cases reported to be children under 5 years. None of the affected children had been vaccinated for measles.275 In order to stem the spread of this measles outbreak, UNICEF and partners supported a measles immunization campaign through the provision of vaccines and cold chain management. In addition, 2,460 households and 12,300 individuals in Panyijiar


were reached with messages on the importance of measles immunization. Follow up measles campaigns were conducted in Jonglei state, where nearly 108,000 children aged 6 months to 5 years were immunized, and in Upper Nile state, where nearly 59,000 children aged 6 months to 5 years were immunized.

UNICEF supported 15 measles outbreak response immunizations in 2016 through vaccine provision, logistics and social mobilization. Supplemental immunization activities were also conducted at PoC entrances and within host communities in areas that were cut off from services.276

IRRM missions are inherently limited in quality due to the lack of follow-up missions, and it appears that immunization efforts conducted through the IRRM were also limited in terms of the numbers reached. The exception is polio vaccination, for which IRRM missions made up 32 per cent of the total number reached in 2016. Tetanus toxoid vaccination is given on the assumption of previous vaccination or that women will be able to access health services in the future. Consultations and treatments reached very few people when compared to those reached through iCCM and static facilities. However, given the context in South Sudan, such an opportunistic approach to programming is appropriate.

5.6 PROGRAMME EFFICIENCY

In addition to system support for cold chain management, UNICEF delivers its health programme through two main modalities: 1) delivery through national and international partners; and 2) direct delivery through IRRM missions. Figure 13 describes the number of signed PCAs that UNICEF had in 2016 and 2017, and reflects that UNICEF engaged with a greater proportion of national partners in 2017 than 2016, though the total number of partners decreased in 2017. UNICEF South Sudan staff also highlighted that national partners do not necessarily have access to areas that international partners cannot reach due to suspicions held by parties to the conflict concerning their motives and political affiliation.

FIGURE 13 Number of signed PCAs with national and international partners

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>International partners</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>National partners</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Total partners</td>
<td>33</td>
<td>22</td>
</tr>
</tbody>
</table>

Source: Evaluation team calculations from the PCA database.

As noted in section 3, implementing partners often underwent long periods of negotiation that resulted in gaps between contracts. The length of PCAs was too short to allow for joint strategic planning.

Having a core pipeline for immunization products leads to economies of scale and prevents duplication of efforts. However, attacks on cold chain facilities undermine efficiency gains. The UNICEF EPI team indicated that the recent introduction of solar fridges in the cold chain had enabled dramatic savings on fuel costs: fuel costs decreased from US$2.5 million per year to US$2 million per year during the evaluation period. UNICEF is also making an effort to introduce innovative cold chain devices, such as Arktek, which are less vulnerable to looting and vandals and can expand cold chain coverage in hard-to-reach areas.

The provision of vitamin A supplementation and deworming as part of the EPI programme is a good example of integration. The provision of EPI services in OTP sites suggests the intention to integrate health and nutrition activities, though key informants from the EPI team noted that this is taking place in only 30 OTP sites. There is scope for expansion of integrated approaches to capture missed children, especially in urban areas.

5.7 UNICEF AND THE HEALTH CLUSTER

WHO leads the Health Cluster in South Sudan and is a core pipeline provider, while UNICEF South Sudan plays a major role in immunization activities and as manager of core pipeline supplies. Field activities are implemented in partnership with Health Cluster partners, WHO and national and international NGOs. Key informants (WHO and other cluster partners) noted that UNICEF collaborates well with the cluster and is a key member, particularly in regard to its management of the core pipeline for immunization.

In 2016, working through partners and supporting direct implementation with the Health Cluster and WHO, UNICEF ensured that robust preparedness activities took place in 11 counties across five states previously identified as being at high risk of cholera. Critical supplies (diarrhoeal disease kits, oral rehydration solution, tents and beds) were procured and pre-positioned at the county level; supplies were distributed to 45 possible oral rehydration point sites; 222 frontline health workers were trained in cholera case management at both referral and referring facilities; and 149 community health workers and home health promoters were trained on early case detection and referral.

5.8 RESILIENCE AND RISK-INFORMED PROGRAMMING

During the evaluation period, UNICEF South Sudan increased the capacity of services to address health vulnerability. This is demonstrated through its support to health service provision at facilities and at the community level through iCCM, as well as its efforts to train both government and civil society organizations. UNICEF has also addressed underlying vulnerability through its community mobilization, health messaging and vaccination work with partners. UNICEF’s contributions to ensuring the core pipeline for immunization and enabling preparedness planning are good examples of risk-informed programming.

The health component of the 2016–2018 country programme was originally designed to provide supply, capacity and technical support for maternal, newborn and child health and EPI in the context of recovery and to strengthen primary
health care. However, the health strategy note 2019–2021 states that “given the escalating conflict, critical shortage of human resources and supplies and widespread population displacement, this new programme (2019–2021) will focus on expanding the provision of basic commodities and essential, life-saving IMNCH [integrated maternal, newborn and child health] interventions at the peripheral level.”277 The strategy goes on to say, “this means that, in addition to bolstering primary health care, the programme will strengthen mobile outreach services and community resilience, including the adoption of key family care practices and safe behaviours.”278

The health strategy note prioritizes the following areas:

- Ending preventable maternal, newborn and child mortality;
- Immunization, vaccine preventable diseases and disease outbreaks;
- Cholera;
- Community engagement and demand creation;
- Prevention of new HIV infections;
- Gender-based violence;
- Strengthening a fragile health system; and
- Health policy and governance.

Results for 2016 and 2017 suggest that the coverage of activities is low and while this is exacerbated by the conflict and the population’s lack of access to services, the programme delivery modality should change. Given this, the new approach of increased mobile service delivery and expansion of capacity at the community level is appropriate.

With this in mind, following the strategic moment of reflection in November 2017, UNICEF developed a concept note for the Integrated Mobile Health Outreach Initiative.279 The initial geographic focus will be Greater Equatoria and Western Bahr El Ghazal, with an overall objective of contributing to significant improvements in the health and nutritional status of poor and marginalized women and children. The proposed strategy is to use enhanced or intensified outreach through mobile teams to increase and expand coverage. Mobile teams will be deployed for periods of five to seven days per month to provide an integrated package of services. The use of monthly re-visits will distinguish this mobile approach from the IRRM. This new initiative is not yet funded, and in the meantime, UNICEF is focusing on intensifying its outreach through static centres.

5.9 CONCLUSIONS AND LESSONS LEARNED

Quality of programming: Routine immunization coverage is low. While IRRM missions are essential to achieving coverage in otherwise inaccessible areas, a more regular mobile outreach solution – such as the proposed Integrated Mobile Health Outreach Initiative – is needed in more secure areas.

While access to health services in South Sudan is generally difficult, it is evident that adolescent girls are not accessing antenatal care – in 2016 and 2017, only 2 and 9 per cent, respectively, of those tested and counselled for HIV were under 18. In addition, girls under 18 were less likely to receive tetanus toxoid vaccination. UNICEF should find ways to encourage adolescent attendance at antenatal care facilities.

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278 Ibid.
and in vaccination, which may require greater outreach, expanded C4D and incentivizing traditional birth attendants to refer pregnant women to health facilities.\textsuperscript{280} Given the severe shortage of skilled care at birth, additional attention should also be placed on task-shifting of emergency maternal and newborn care to mid-level cadre, transitioning facility-based traditional birth attendants to community health workers, and scaling up institutions to promote community midwives into professional midwives.\textsuperscript{281}

There is a need to expand the delivery of health promotion at the community level. The potential expansion of personnel and coverage by the proposed consolidation of community nutrition volunteers, community health volunteers and WASH community volunteers would address this to some extent and could prove to be an important contribution to the Boma Health Initiative.

Malaria treatment and prevention should be priorities for UNICEF. However, UNICEF failed to achieve its targets for the distribution of long-lasting insecticide-treated bed nets in 2016 and 2017. UNICEF should explore all available means for distribution, including joining forces with WHO and WFP to distribute bed nets through general food distributions. UNICEF’s efforts to engage with Population Services International to overcome procurement and stock shortfalls for long-lasting insecticide-treated bed nets are commendable.

**IRRM:** The IRRM has contributed to greater coverage of UNICEF’s health activities, with the exception of polio vaccination. Given the cost of the IRRM and the need to reach remote and isolated parts of South Sudan with regular health services, UNICEF should prioritize the adoption of a new mobile approach. The evaluation team is aware of the Integrated Mobile Health Outreach Initiative, which, if implemented, would serve this purpose.

**Integrated Mobile Health Outreach Initiative:**
This new initiative recognizes the need to address the access and coverage challenges of health interventions by expanding outreach. However, in addition to mid-upper-arm-circumference screening and referral, UNICEF should consider integrating nutrition through the delivery of SAM treatment and targeted supplementary feeding in collaboration with WFP.

\textsuperscript{280} In Somalia, some actors are providing cash incentives to traditional birth attendants to refer pregnant women for safe delivery at health centres. This would replace the lost payment that a traditional birth attendant would incur for having not undertaken the home delivery.

PROGRAMME SUPPORT AND OPERATIONAL MODALITIES
This section presents key features of UNICEF's operational systems in South Sudan. It offers an overview of the strengths and weaknesses of its community engagement efforts through C4D and the trade-offs implied in its increasingly localized approach of partnering with civil society organizations. The section also assesses the benefits and limitations of the direct service delivery approach through the IRRM and offers reflections on its supply and logistics and monitoring and information management systems in South Sudan.

### 6.1 RESOURCE MOBILIZATION

While UNICEF's programme in South Sudan is generally well resourced – the funding deficit is 15 per cent[^282] – that figure masks serious imbalances between the sectors. Nutrition and education are well funded, and their scale of the funding dwarfs other areas of UNICEF’s work. Health and WASH are significantly less funded. Given the very close linkages between nutrition, WASH and health, this is both concerning and puzzling.

UNICEF has pushed a multi-sector approach in South Sudan, but with limited success. WASH interventions such as water trucking tend to be expensive. While donors are locally supportive, capital-based donor interest in South Sudan is declining (see Box 11).

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[^282]: Key informant interviews conducted in Juba, May 2018.
Donors are said to be “tired of funding where they see no change, or inputs disappear with new conflicts.”\footnote{Ibid.} This sense of donor fatigue, combined with the number and scale of other humanitarian crises globally and the relatively low political priority given to South Sudan by major donors, makes for a very challenging fundraising environment.

The South Sudan Representative and his resource mobilization and communications team have worked hard to counteract this negative funding tendency, with some success. Due to releases of children associated with armed forces and groups, and related advocacy and communications work, funding for child protection has increased, though overall funding for the sector remains low. Given the direct and instant nature of the results achieved through the IRRM, that modality has been easier to fundraise for, particularly with National Committees.

This suggests that demonstrating and communicating results in terms of lives saved, children protected and families reunited is critical to successful resource mobilization. It may prove easier to sell nutrition, WASH and health as part of an integrated child survival package by arguing that missing any one component undermines the entire effort. This is part of a wider argument about integrated packages, which extends to WFP’s closely related work on MAM treatment. Work on resilience clearly has some appeal for donors, but it needs to be made tangible and demonstrable if local donor representatives are to make the case to their respective ministries.

6.2 COMMUNICATIONS AND ADVOCACY

Much of UNICEF’s communication work in South Sudan is appropriately concerned with highlighting the desperate situation of children and promoting UNICEF’s related work. In that sense, it is an essential component of awareness-raising and resource mobilization efforts.

UNICEF has a more directly engaged role as the leading advocate for children and their safety, well-being and rights. In the context of South Sudan, this includes advocacy with the Government and warring factions on the massive abuses and protection threats to children highlighted in section 1. In addition to the threats of violence and coercion, the denial of access to humanitarian assistance constitutes one of the gravest threats to children’s well-being. UNICEF has a history of prominent humanitarian advocacy on this issue in South Sudan, dating back to the days of Operation Lifeline Sudan and the negotiation of the related ground rules.

The evaluation team was unable to assess the communications and advocacy function of UNICEF in detail, and its conclusions are therefore tentative and limited.\footnote{These interviews were conducted prior to the August 2018 peace deal.} There was some concern regarding advocacy on access that UNICEF was not playing as proactive a role as it could and as it has in the past. However, the same concern might be raised about the United Nations Country Team as a whole. This is seen as a shared endeavour, particularly with other United Nations agencies, and the current ceasefire may provide an opportunity, both nationally and locally, to re-engage with the parties concerned and gain agreements on
secure access. This applies equally to bureaucratic impediments, which are also a major factor in securing vital supply chains (see section 6.5 on supply and logistics).286

A review of the 2017 advocacy tracking matrix strategy suggests that more could be done on the access issue. The actions on this topic in UNICEF’s advocacy strategy include building United Nations support to address access issues by proposing that WFP, UNICEF and UNHCR issue a joint statement; and making humanitarian access and the removal of both physical and bureaucratic obstructions a public issue. In both cases, the evaluation team suggests that a high-level course of action with relevant authorities is warranted, such as a strong, private advocacy initiative by United Nations senior management, backed by the strongest possible evidence. Whether done jointly or individually, this appears to be the necessary corollary to any public statements on this issue.

286 UNICEF South Sudan is recruiting an access specialist, which should help strengthen its policy and advocacy capacity in this vital area.
UNICEF South Sudan uses C4D to increase insight, awareness and engagement among various stakeholders, including government partners, the wider public and media, on matters of concern to women and children in South Sudan.\textsuperscript{287} C4D is also a crucial support to (and component of) UNICEF’s country programme in South Sudan.

C4D supports different programmes and works closely with the relevant sections, providing them with evidence and technical guidance on specific interventions. For example,\textsuperscript{288} the C4D section worked closely with the education section during the launch of the national Back to Learning initiative in Kapoeta, developing key messages and communication materials for use at the event.\textsuperscript{289} Further engagement was seen with the health/WASH sections in designing communication plans for emergency preparedness on cholera and child immunization. C4D has also worked closely with the health section to support birth notification for children under 5 years.\textsuperscript{290}

Community engagement and mobilization

C4D also works through community engagement and community mobilization platforms – distinct strategies that are intended to reinforce one another.\textsuperscript{291} Community engagement involves engaging communities in issues of social, cultural or economic concern to them; and thereby creating awareness that leads people to actively participate in a given process. This approach is people- or community-focused and aims to empower communities. Community engagement is not behaviour-focused; any such change derives from the empowerment of community members.

On the other hand, community mobilization involves engaging the community and its different stakeholders – including local government actors and civil society organizations – on an issue of central importance to them (e.g., health). The aim is to galvanize action on a common cause. Examples include campaigns on specific issues such as epidemic preparedness and response.

Key C4D activities undertaken during the evaluation period include:

- The birth notification project, which is implemented alongside the Ministry of Health, the main government partner. This project is part of a wider effort to build civil registration in South Sudan and protect children’s rights by providing them with an official identity. Community engagement is designed to allow people to view birth notification positively and embrace this cause. The South Sudan Civil Registration Bill (which had just been passed at the time of writing) will provide a legal basis for the enforcement of birth registration.


\textsuperscript{289} Ibid.


A household survey commenced in early 2018, with the first round completed in February and March 2018 in all 10 states. More than 403,000 respondents were surveyed, focusing on five thematic areas: hygiene promotion, health, IYCF, out-of-school children and birth notification. The data collected will serve as a baseline for subsequent interventions and be used to inform other programmes, such as gender, cash and work, social cohesion and youth engagement. The survey also captures community knowledge, attitudes and practices.

Social mapping is conducted to support the planning of C4D interventions, such as immunization campaigns. In 2016, a social mapping was conducted in Unity state to gather information on demographics, logistics, the communication facilities available, the partners on the ground, accessibility concerns and the challenges faced in these specific locations. This helps inform the planning and intervention phases of the respective campaigns.

The C4D section has worked closely with national partners in each state to recruit a network of volunteers who are critical to the implementation of their activities. This network of volunteers (also known as mobilizers) is known as the integrated community mobilization network. The network is supported by 60 county and 576 payam supervisors. This support network gives UNICEF C4D an extensive presence in the counties, payams and bomas, down to the smallest village, which allows it to effectively implement its activities.

One limitation of C4D is the unequal gender balance of mobilizers, only 23 per cent of whom are women. This is due to low female literacy in South Sudan. Efforts are being made through payam supervisors to increase the number of women mobilizers.

Part of the challenge faced by C4D lies in assessing its impact, particularly with regard to changing attitudes and beliefs. This takes time. As noted, informants expressed some doubt about the impact of hygiene messaging – partly because there seemed to be a lack of concerted community engagement and mobilization on this issue. This is also an area where long-standing practices (e.g., open defecation), are hard to change. In this and other areas, more regular knowledge, attitudes and practices surveys may be required, along with greater community engagement on WASH messaging.

Since 2017, UNICEF has strengthened access at the community level through its network of mobilizers. The network currently has more than 2,500 members targeting more than 450,000 households to promote behaviour change and demand for services. This network has the potential to generate evidence on attitudes and behaviour change for 3 million people in regard to health, education, protection, hygiene and nutrition. In a context that makes detailed research and surveys difficult to undertake, the network can provide monthly information on the populations concerned. UNICEF has also been working with communities to generate evidence on social profiles, community networks and local infrastructure.

UNICEF C4D supports other UNICEF programmes to achieve their outcomes. For example, it has supported the health section to increase

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293 Ibid. There were 2,024 mobilizers as of March 2018.
294 UNICEF conducted three knowledge, attitudes and practices studies during the period of 2015–2018.
routine immunization coverage through its behaviour change communications; and helped achieve 95 per cent polio vaccination coverage of the targeted 3.2 million children under 5 years. In nutrition, C4D has supported IYCF, and in WASH, it has supported hygiene promotion. The evaluation team found it difficult to judge the efficacy of these interventions, however, and concludes that work remains to be done to establish the effectiveness of particular behaviour change approaches. The integrated community mobilization network provides a basis for supporting behaviour change more regularly.

6.4 IMPLEMENTING PARTNERSHIPS

The effectiveness of UNICEF’s implementing partnerships is central to its overall effectiveness in South Sudan. Delivery through partnerships with civil society organizations, including both national and international NGOs, is UNICEF’s primary modus operandi in South Sudan, accounting for the great majority of people reached with services. This raises two key issues. One is strategic, concerning the partnership model itself, the balance of different types of partners and the coverage, reach, effectiveness, quality, efficiency and accountability of these partnerships. The other is more technical and concerns the mechanics of partnership (the PCA process, etc.) and related oversight processes (monitoring, etc.). These issues also have a significant bearing on effectiveness, quality, efficiency and accountability.

As noted in section 1, during the evaluation period, UNICEF shifted the relative balance of its civil society partnerships towards local and national NGOs, though the majority of its programme spending still goes to international NGOs (see Figure 14).

**FIGURE 14** Implementing partners: International vs. national civil society organizations


Implementing partner numbers:
- In 2017, 58% partners were national NGOs, up from 53% in 2016

Fund allocations:
- In 2016 and 2017 combined, UNICEF allocated 28% of funding to national civil society organizations
- In 2017, the allocation to national civil society organizations increased 83% per cent as compared to 2016
The shift in the partnership portfolio is a move towards the greater localization of the UNICEF programme. This is in line with the commitments made in the context of the World Humanitarian Summit and the Grand Bargain, and makes sense in the current context of South Sudan. This is particularly the case regarding potential reach and engagement at the community level. It raises some important challenges for UNICEF, however. One is to see whether the programme can be delivered as effectively and efficiently through national partners, including those that are untested. Many national partners are said to have significant capacity constraints, though international NGOs are also constrained in this regard and may have even less ability to access remote or unstable areas.

Key to this is UNICEF’s ability to effectively oversee the work of civil society organizations and provide training and technical support to ensure delivery according to quality standards. In this sense, the partnership question is linked to monitoring (see section 6.6) and building local capacity. It is possible that there are potential trade-offs between localization and efficiency – and the quality of response – that need to be recognized and managed. The need to build capacity may entail short-term loss of efficiency, and a balance must be struck. The evaluation was unable to reach any conclusion on whether such trade-offs exist in practice, though some informants suggested that they did. As suggested, one remedy may be to consider more consortium-based approaches to partnership, including peer-to-peer review of programmes, to foster more consistent delivery standards.

On the nature of partnerships, interviews with both national and international NGOs revealed a fairly consistent theme – that the nature of the UNICEF partnership was less a partnership in the true sense; but was highly instrumental, being designed to deliver on UNICEF’s programme commitments, and transactional. In the same vein, UNICEF was often referred to by its implementing partners as a donor. For their part, international NGOs tended to see the relevant programmes as their own, with UNICEF providing the funding. This suggests that at least in some cases, the necessary element of mutuality is missing. The evaluation team felt that there was potential in the relationships with international NGOs that was not being realized; and that a more genuinely mutual relationship with civil society organizations was needed.

Many of the points above were recognized in the UNICEF Country Programme Management Plan 2016–2018: “Attention will also be paid to building NGOs’ national staff capacity, not only through training but also sufficient supervision and monitoring to ensure that knowledge is effectively applied by implementing partners. In addition, UNICEF will further develop the quality of its partnerships by involving partners in key planning and review meetings.” Interviews and feedback to the evaluation suggest that much remains to be done in this regard. That said, overall feedback from implementing partners on UNICEF was positive (see Box 12).

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295 Key informant interviews with UNICEF staff in Juba, May 2018.
296 Key informant interviews with UNICEF partners, Juba, May 2018.
298 Online survey conducted by the evaluation team with UNICEF and partners as part of the evaluation process, July 2018.
As the feedback from partners makes clear, the PCA and associated contracting processes are the greatest source of concern for partners. In recent years, PCA guidelines have been streamlined and at the time of writing this evaluation, offered maximum flexibility irrespective of the level classification of a response. Globally however, UNICEF staff have been reluctant to fully apply the range of flexibility offered by PCA guidelines, including within the Level 3 Simplified Standard Operating Procedures. A global performance benchmark for UNICEF partnership management at the country office level is the lead time from PCA inception to signature. Historically, this process has been long. Partners interviewed for the South Sudan evaluation mentioned that PCA lead times delayed responsiveness. Data provided by UNICEF South Sudan show that PCA processing times ranged from 3 to 30 working days in 2017 and 2018.

However, processing the completed PCA is only the final step in the partnership process. The design of the programme of cooperation may take substantially longer, with partners citing cases of PCA development (i.e., the agreement between UNICEF and partner technical and managerial staff on content and budget) taking between four and six months. According to partners, these timelines may be different depending on which UNICEF section is in charge. In addition, while the process appeared to improve when field offices took over PCA negotiation responsibility, when more than one

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**BOX 12 Implementing partner feedback to the evaluation**

Partners were asked to comment on the strengths and weaknesses of partnership with UNICEF in an online survey. The strengths cited included technical assistance, realism, UNICEF staff accessibility and communication, and the smooth running of projects once established. Weaknesses included delays in processing PCAs, delays in fund disbursement, overly bureaucratic procedures, lack of cohesion across different sectors and gaps in programme implementation caused by slow PCA approval and amendment processes. Regarding the PCA-related weakness, one partner commented “While the PCA in theory is flexible to changes, to actually change any element of the signed PCA is an arduous process and is ultimately a barrier to achieving objectives... should a need arise to revise the PCA (e.g., conflict in area of implementation)” This is at odds with UNICEF’s stated aim to be flexible and adaptable to changing circumstances and new opportunities as they arise.

Among the other issues raised by implementing partners was the need for longer-term, multi-year agreements; for budgets to be in United States dollars rather than local currency; and for communication and guidance from UNICEF focal points to be clear and consistent across different sections. There was also a plea for more mentoring and supervision of local organizations, and for UNICEF to monitor rather than just report on local NGO coverage.

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299 Key informant interviews with UNICEF staff, Juba, May 2018.
301 Ibid.
302 Interviews with NGO partners.
303 UNICEF South Sudan PCA Tracker Tool as of February 2018.
304 Key informant interviews with NGO partners, Juba, May 2018.
The PCA approval process causes gaps between PCAs, and even minor amendments take multiple weeks, significantly impacting implementation.

Partner comment in the evaluation survey of UNICEF partners conducted in July 2018
and dedicated IRRM staff in field operations and technical sections. Access negotiations are generally conducted by WFP, but involve UNICEF staff when relevant, including chiefs of field offices and field-based staff.

At its inception in March 2014, the IRRM targeted areas where NGOs could not work, where the usual partnership model would therefore not be an option for reaching people. IRRM missions were initially designed to be flexible to follow populations on the move. Currently, the selection of target sites appears to be primarily based on presumed need, utilizing livelihood indicators – including IPC analysis and data from the Food Security and Nutrition Monitoring System – while factoring in displacement data and data from any local assessments. In 2016 and 2017, IRRMs primarily covered the 75 sites in the north targeted by WFP for general food assistance through airdrops. WFP uses IRRM missions to register beneficiaries for food assistance; and WFP and UNICEF use the same registration data for their respective programming.

Figure 15 provides an overview of the geographical coverage of IRRM missions in 2017.

**FIGURE 15** South Sudan IRRM missions, 2017

Source: Data from the UNICEF South Sudan RRM database, 2017.

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310 Key informant interviews with UNICEF staff, Juba, May 2018.
311 Ibid.
313 Key informant interviews with UNICEF staff Juba, May 2018.
IRRM missions have a distinctly ‘rapid intervention’ character and are limited in terms of the time spent on the ground and the nature of the services offered. A typical IRRM mission is on the ground for up to eight days and delivers services in what is best described as a campaign approach. The missions generally involve gathering beneficiaries at the IRRM location and providing one-off or time-limited services such as vaccinations, distribution of nutrition, WASH and education products and messages, and identifying needs in all sectors. Missions also attempt to document protection issues and cases in each location.

Effectiveness of the Integrated Rapid Response Mechanism in South Sudan

The IRRM was originally conceived to reach inaccessible locations where people were affected by conflict and not otherwise able to access services. A combination of poor road infrastructure, heavy and prolonged wet seasons and the conflict environment has meant that the majority of affected populations in isolated areas cannot be reached by usual means. The original objectives therefore were to assess and respond to rapidly changing needs on the ground to address critical gaps in humanitarian coverage and meet the needs of those otherwise cut off from available services. However, the scope of the IRRM modality has since expanded. Mission reports point to efforts to use IRRM missions to open areas up, connect with partners already on the ground and support or strengthen partner abilities to operate in these locations. UNICEF also counts the IRRM as part of the continuum of care, whereby if circumstances allow, it serves as a starting point for subsequent static or outreach services instead of just a one-off humanitarian mission.

Coverage and reach

In terms of coverage – that is, the number or proportion of people in need provided with essential services – the IRRM plays a relatively small role in the overall response. Figure 16 compares the coverage of IRRM missions with the overall coverage of the humanitarian response in 2017.

Based on numbers alone, the IRRM would appear to be of marginal significance in the wider programme. Nonetheless, its value lies in enabling UNICEF to reach people who cannot otherwise access its services in locations where it has no established service delivery partnerships. Thus, the IRRM allows UNICEF to extend its reach into and understanding of otherwise inaccessible areas. Its value as a bridge to establishing more regular service delivery through partners is less clear, and the evaluation team was unable to find clear evidence on this aspect of the IRRM’s utility.

It is difficult to provide exact numbers of people receiving services in a campaign approach, as some services overlap and others do not. For example, a teenage girl may only receive education supplies and child protection services, but a teenage mother with her child may receive those services as well as IYCF support and hygiene messages (plus nutrition

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314 Interview with UNICEF staff.
315 Evaluation team observations during an RRM mission in May 2018; and RRM reports for 2016 and 2017.
317 Ibid.
318 Reference was made to the IRRM as part of the continuum of care in feedback from UNICEF South Sudan on initial evaluation findings.
319 This focuses on 2017 figures as more IRRM missions took place in 2017 (51) than in 2016 (19).
and vaccination services for her child, which are counted separately). The numbers recorded for each sector can therefore not simply be added up as a total. Table 1 in Annex 6 shows the disaggregated figures from the IRRM database, which illustrate these differences.

Despite maintaining granular data on which demographic categories have received what services, UNICEF normally reports the overall numbers reached through the IRRM in its situation reports. For example, the end of year 2017 situation report on South Sudan makes a typical statement: “UNICEF together with WFP conducted 51 integrated Rapid Response Mechanism (IRRM) missions, reaching 781,128 people and 140,974 children in hard-to-reach and remote locations.”

This statement appears to over-report the actual number of people reached. Even adding up all sector totals (which includes double-counting of beneficiaries) only reaches an annual total of 480,595 beneficiaries. More generally, this form of reporting, which counts IRRM coverage within overall coverage, tends to obscure the particular (and limited) nature of the reach achieved through the mechanism. One-off distributions and service packages are conflated with more regular service provision in ways that are potentially misleading. As noted in the nutrition section, some of the claims made about life-saving interventions conducted through the IRRM must be qualified: while a vaccination campaign will likely have a lasting protective effect, a one-off distribution of ready-to-use therapeutic food may not be sufficient to save the life of a child suffering from SAM. Nor does current practice allow for follow-up visits to determine if children have responded to treatment.

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**FIGURE 16** Coverage of IRRM missions vs. overall coverage of the humanitarian response, 2017

<table>
<thead>
<tr>
<th>No. of people reached</th>
<th>RRM 2017</th>
<th>Total 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td>3,000,000</td>
<td>2,500,000</td>
</tr>
<tr>
<td>Health</td>
<td>2,000,000</td>
<td>1,500,000</td>
</tr>
<tr>
<td>WASH</td>
<td>1,000,000</td>
<td>500,000</td>
</tr>
<tr>
<td>Child protection</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Data from the UNICEF South Sudan IRRM database, 2017 and ‘South Sudan Humanitarian Situation Report January–December 2017’.

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320 ‘South Sudan Humanitarian Situation Report January–December 2017’.
With regard to reaching people in inaccessible locations, UNICEF asserts that the IRRM essentially reaches a large proportion of those internally displaced that the 2018 HRP defines as living in “areas where humanitarian assistance (is) not reliable and predictable due to access denials and conflict.” UNICEF staff refer to the 2018 HRP estimate of 800,000 people in such areas. The plan provides a density map of proxy indicators for access, such as the number of recorded conflict-related incidents during the period January to October 2017. Figure 1 in Annex 6 compares this map with a geospatial analysis of IRRM frequency in the same year. The comparison suggests that IRRM missions do not always cover the locations with the highest frequency of humanitarian access incidents. It can be said, however, that IRRMs mostly appear to target areas that are not easily reached by other means (due to poor infrastructure) or at other times (when targeting seasonal time windows or periods of low conflict).

In terms of the extent to which the IRRM is responsive to the severity of needs, Figure 2 in Annex 6 shows that a higher frequency of IRRMs in a county may, but does not always, coincide with a higher severity of needs. However, only 2 of the 15 counties targeted by IRRMs in 2017 have a comparatively low needs severity index of 2 out of 5, while the others are all at levels 3, 4 and 5. At the same time, at the highest level of needs severity, counties such as Wau and Ikotos only had two and one IRRM missions, respectively, in 2017. While there appears to be a stronger match between needs severity and IRRM targeting, it does not appear to be the overarching factor.

**Extending the reach of partnership-based programming**

As noted, one aspect of the rationale for the IRRM is to encourage new partners to come into an area and open space for more assistance. Figure 2 in Annex 6 also compares the density of humanitarian partners with the number of IRRM missions (darker colours denote higher presence and higher number of IRRM missions). Overall, those counties reached by IRRM missions in 2017 have lower partner densities. The IRRMs therefore appear to cover a gap in service provision. This impression based on spatial analysis is confirmed by the reviewed reports; while most IRRM locations find partners (and often UNICEF partners) on the ground, their presence is often mobile or temporary, and frequently constrained by an inability to consistently bring in even basic supplies and skills. At the same time, reviewed reports suggest that areas that are entirely without services are few within the total number of IRRMs conducted. Most targeted locations have some partner presence and at least some rudimentary services established in some sectors.

The evaluation team was unable to find sufficient evidence to conclude whether the IRRM provided an effective bridging mechanism, or what proportion of locations reached by an IRRM were subsequently served on a more consistent basis by UNICEF partners.

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321 This assertion was made in an updated analysis of the IRRM conducted by UNICEF and provided to the evaluation team in September 2018.

322 The 2018 HRP states that “In 2017, an estimated 800,000 IDPs [internally displaced persons] lived in areas where humanitarian assistance was not reliable and predictable due to access”. ‘South Sudan: 2018 Humanitarian Response Plan’, p. 12.

323 ‘South Sudan: 2018 Humanitarian Response Plan’, p. 12. It is noted that the number of incidents is a proxy for access and does not cover access restrictions due to seasonal infrastructure failure or non-existence of road access, a common restriction in South Sudan, in addition to conflict-related issues. Benchmarking the number of people reached by IRRMs against the figure of 800,000 internally displaced persons in areas characterized by high incident frequency is therefore not necessarily accurate.
Efficiency of the Integrated Rapid Response Mechanism

Like all operations, IRRM missions are affected by operational shortfalls. During one mission, the evaluation team observed that the IRRM team operated well on the ground. The campaign in the observed location was set up efficiently and achieved a maximum effect in the particular environment and under the specific circumstances. However, any operation’s success also hinges on the quality of its preparation and the availability of all necessary means to ensure it is conducted successfully. In the observed mission, the administrative side had several problems. The mission lacked a trauma first aid kit, a stock of emergency drugs and a spare battery or means to charge the battery of the satellite phone it relied on for communication. Most importantly, not all cargo was loaded at the origin, which led to an unplanned extension of the mission, and meant that beneficiaries had to come back on another day to receive the complete set of services. Given that in some cases, the mechanism relies on people from surrounding areas walking for hours to reach the services, requiring beneficiaries to make the journey twice violates the ‘do no harm’ imperative of aid. Evidence gathered during the evaluation suggest that this was not an isolated incident.\textsuperscript{324} Administrative obstacles were also named as a key issue for IRRMs in a 2017 comparative review conducted by UNICEF.\textsuperscript{325}

Regarding cost effectiveness, the actual cost of IRRM missions (based on the 32 IRRM missions conducted between January and August 2018), reveal that, on average, one mission costs US$60,000 (including staff time).\textsuperscript{326} While UNICEF calculated a cost per beneficiary of US$5.50 over these 32 missions, given the noted difficulties with the way beneficiary numbers are reported, this is questionable.

The evaluation team suggests that it would be more productive to put the total mission cost into perspective against the multiple benefits of the IRRMs. With this view, an average cost of US$60,000 appears reasonable given what IRRMs can achieve in most locations. The density of services provided in each IRRM is high compared to static or outreach activities, and significant volumes of food- and non-food items are given to people who often have no access to such goods and limited knowledge and information. Considering the potential benefits in terms of opening access, strengthening community support and supporting partners with skills and materials, the evaluation team concludes that IRRM missions in South Sudan provide good value for money.

Conclusions

The evaluation team found that the IRRM modality is essential for UNICEF, delivers multiple potential benefits and is of relatively good value for money. However, UNICEF needs to be clearer with itself and others about the specific value and limitations of direct service delivery through the IRRM. Its value needs to be more carefully articulated and the claims made for it should be more nuanced. To the extent possible, is also essential that UNICEF monitor the actual rather than presumed effects of its interventions as a basis for planning follow-up missions and adapting the IRRM approach and planning framework as necessary over time.

\textsuperscript{324} Key informants interviews with IRRM Teams (Juba, May 2018), and internal IRRM reports.

\textsuperscript{325} ‘Rapid Response Mechanism: Past, present, future – South Sudan section’.

\textsuperscript{326} Cost analysis data obtained from ‘IRRM Costing - Projections vs Costs Incurred up to August 2018.xlsx’ (internal), 19 September 2018.
The IRRM in South Sudan often serves different purposes in different locations. In a highly contested area, during a short window of peace, an IRRM mission may be the only lifeline that people have had for months. In a remote area with no access, an IRRM mission may be the only opportunity to get children immunized and checked for malnutrition. In a difficult-to-access area where local partners struggle with maintaining operations, an IRRM may be a very welcome injection of materials, skills and networking for subsequent scale-up through partnership. The purpose of the IRRM therefore does not lie solely in reaching inaccessible locations. It should be seen as an active equity tool and a means to ensure that no child is left behind.

All UNICEF offices in South Sudan are based in government-controlled areas. While UNICEF also provides services to all PoCs, the bulk of people in need in opposition-controlled areas are less directly reached. In terms of equitable (not equal by numbers) coverage, the IRRM can therefore be seen as an instrument of good will that may enable the safe operation of UNICEF staff and partners in opposition-controlled areas, and a practical expression of the need for equitable services in humanitarian action. In locations where some partner presence exists, the IRRM can be part of the continuum of care when followed up on with more sustained services and used to gather data for planning future interventions. The IRRM has also been used to open previously inaccessible areas. This was directly observed during the evaluation, when an IRRM mission to a previously unreachable location was used to establish a basic rapport and good will with local commanders and connect potential partners and nearby field office staff to the community.327

While recognizing these benefits, it should be acknowledged that the restricted nature of IRRM missions affects the overall life-saving effect of the mission. This is a prominent concern for the nutrition component, as temporary SAM treatment may not be sufficient for the survival of all diagnosed children. Behaviour change communication also has severe limitations during IRRMs. A typical mission would draw beneficiaries in need of basic services from areas surrounding the IRRM location, increasing total coverage but reducing the opportunity for community-focused support. These transient populations are more likely to internalize messages and advice when they are given in a settled community environment over a longer timeframe. On the other hand, children reached through IRRMs receive long-lasting protection from immunization, and their parents receive

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327 The IRRM mission that was accompanied by the evaluators targeted the location of Iholong, which is 50 kilometres south of Torit town, where UNICEF and partners have a presence. In addition to mounting the usual campaign, the IRRM explored more direct, outreach-type interventions through local NGO partners. The intervention and communication with local command structures may have created sufficient good will to support subsequent cross-line activities, provided the Government is supportive.
additional knowledge on safe nutritional and other choices. In other words, IRRMs provide a mix of short- and long-term benefits, a significant proportion of which can be said to be essential to protecting children’s lives.

Finally, while IRRM reporting mentions data collected during the missions, including data related to protection issues, it is less clear how data gathered through IRRMs are systematically analysed and shared with humanitarian partners. One WASH partner interviewed suggested that data sharing is neither timely nor consistent. There appears to be room for improvement in the systematic collection, analysis and sharing of data through IRRM missions.

6.6 SUPPLY AND LOGISTICS

The UNICEF response in South Sudan – and much of the wider system response – relies on a functioning supply chain. For nutrition, the procurement and importation of ready-to-use therapeutic food are pivotal to the response. For health, UNICEF’s supply and logistics role – including for the cold chain – is central to the operation of the wider immunization programme. In WASH, a key element for the cluster-wide response is the core pipeline of essential WASH items, the operation of which is shared by UNICEF and IOM. The total value of supplies dispatched to implementing partners in 2017 was nearly US$27 million, all of which was emergency-related. Figure 17 shows the value of supplies dispatched by sector.

![Figure 17: Supplies dispatched to implementing partners in 2017, by sector](chart)

Source: UNICEF dispatch data for 2017, extracted from VISION financial system.

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328 Key informant interviews with WASH Cluster partners, Juba, May 2018.
329 UNICEF dispatch and expenditure data for 2017, extracted from the VISION financial system.
330 Sector titles are indicated in line with how they are presented in UNICEF systems.
The UNICEF operation in South Sudan relies heavily on imported goods. In 2017, the value of international procurement by UNICEF was close to three times the value of local procurement.\textsuperscript{331} South Sudan is a landlocked country; and the primary port of entry is the Kenyan seaport of Mombasa. From Mombasa, goods are transported by road, usually through Uganda. Air cargo is used for perishable goods such as vaccines. UNICEF also provides procurement services for the Government of South Sudan, mostly to the Ministry of Health for vaccines.

In-country logistics are carried out by road or air, with the latter primarily conducted through humanitarian air services operated by WFP. UNICEF operates its own warehouses in Juba, Rumbek, Wau, Yambio and Malakal. The bulk of dispatches in 2017 were done from the Juba warehouse, with the value of goods dispatched from the Wau and Rumbek warehouses together amounting to approximately 40 per cent of the total value of dispatches from Juba.\textsuperscript{332} Supplies are shipped to partner warehouses, usually as part of a PCA. In some instances, partners manage warehouses on behalf of UNICEF.\textsuperscript{333}

Obstacles to the importation of goods are generally tied to bureaucratic barriers related to the slow application of overly-restrictive rules (when compared with other humanitarian situations in the region). A United Nations study found that the slow and sometimes inconsistent application of bureaucratic process, and the application of these processes in violation of prior agreements, are significant bottlenecks to the timely importation of relief goods.\textsuperscript{334} The UNICEF logistics team confirmed this impression.\textsuperscript{335} Often, despite timely application for import permits, exemptions and related processes, permits are not granted on time or goods are held at the border. UNICEF staff members report that they spend substantial time following up on permits.

These bureaucratic obstacles to the timely importation of goods have led to several consequences.\textsuperscript{336} First, to compensate for the substantial lead time needed for document applications, international orders must be shipped as soon as a pro forma invoice can be obtained and the pre-clearance process can be initiated. If goods arrive at the seaport before clearance has been obtained, demurrage for storage in the port transit area is incurred, which adds to the overall cost.

Similarly, if goods arrive at the land border and clearance has not yet been granted, trucks are held until they can be cleared. This forces long lead times for importation, adding to the already long lead time due to the distance to destination and the need to route between port and in-country warehouses. In effect, this appears to rule out the airlifting of any goods other than perishables (i.e., vaccines), as lead times are too unpredictable for international air cargo. According to UNICEF, a specific approach has been agreed with vaccine manufacturers to hold the stocks at the point of origin until clearance is granted and the cargo can be flown into Juba.

\textsuperscript{331} UNICEF procurement data for 2017, extracted from the VISION financial system. The ratio includes local procurement of services and procurement of imported goods through local vendors.
\textsuperscript{332} UNICEF dispatch and expenditure data for 2017, extracted from the VISION financial system.
\textsuperscript{333} For example, the evaluation team observed that this was the case for a nutrition supply warehouse managed by the NGO partner Joint Aid Management and a WASH core pipeline warehouse managed by the NGO partner Peace Corps, both in Pibor town.
\textsuperscript{334} Office for the Coordination of Humanitarian Affairs, ‘Bureaucratic Access Impediments to Humanitarian Operations in South Sudan’ (survey report), OCHA, June 2017.
\textsuperscript{335} Key informant interviews with UNICEF staff, Juba, May 2018.
\textsuperscript{336} Ibid.
While these importation challenges were not the only cause of stock outs highlighted during the evaluation, they appear to be a significant contributing factor, and raise the cost of procurement considerably, both financially and in terms of opportunity costs due to lost staff time.

Logistics are constrained by the virtual absence of all-weather roads in most of the country, in a region where the wet season can be up to eight months. The evaluation team observed that operations are effectively restricted to administrative centres because dirt roads leading into surrounding areas become impassable even for specialized four-wheel-drive trucks. On top of the physical challenges, insecurity and the increased fragmentation of parties to the conflict have posed high risks to drivers and the goods they are transporting. In addition to reducing the availability of willing transporters, these risks caused delays due to roadblocks and extortion of informal taxation from transporters.337

Within this challenging environment, and despite the significant burden on Juba staff to manage clearances and approvals, the supply and logistics function appears to be remarkably efficient. This is reflected in a comparison of the time it takes to dispatch goods to partners (i.e., loading from UNICEF warehouses under UNICEF control) and the delivery time to partners (which is outside of UNICEF control and affected by physical, bureaucratic and security obstacles). As illustrated in Figure 18, while most consignments (90 per cent) were dispatched within 15 days, just over half (54 per cent) were delivered within 15 days, with the remainder in transit to partner warehouses for considerably longer periods.

A 2017 regional workload comparison for the supply and logistics function concluded that the South Sudan supply and logistics team has insufficient capacity to handle their workload, which included the substantial time spent following up on bureaucratic processes. Despite these limitations, the team appears to work efficiently and effectively, with observed delays and stock outs falling mostly outside of their control.

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337 ‘Bureaucratic Access Impediments to Humanitarian Operations in South Sudan’. 

FIGURE 18 Comparison between dispatch and delivery times, 2016

<table>
<thead>
<tr>
<th>18.1. Number of days between recommended delivery date and dispatch date</th>
<th>18.2. Number of days between loading end date and acknowledgement date</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
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<tr>
<td>20%</td>
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Source: UNICEF dispatch data for 2016, extracted from VISION financial system.
6.7 MONITORING AND INFORMATION MANAGEMENT

According to the CPD 2016–2018, “monitoring for results will be strengthened within UNICEF, alongside improved programme planning and use of tools to manage information on partnership agreements and field operations for both development and humanitarian responses. The M&E [monitoring and evaluation] framework will help to ensure rigorous, results-based management, and specific evaluations will be undertaken to inform programme strategy and design.”

During the first phase of the evaluation, the team conducted an initial assessment of the monitoring and evaluation and information management functions. The assessment found that programme monitoring takes place in a data-scarce environment, which lacks basic population data inter alia and deprives target planning of reliable denominators; that frequent incidents of displacement further affect basic estimates of population figures; that access constraints and operational challenges reduce opportunities to collect primary humanitarian data, both for baselines and results measurement; and that UNICEF relies heavily on reporting from implementing partners – many of whom have limited capacity – for its results measurement.

The analysis suggested key actions for UNICEF, including further strengthening existing systems, increasing their coverage and investing in the analysis and utilization of monitoring data and other information flows to inform programme management. It also noted that focusing on output targets without sufficient emphasis on the quality aspects of the CCCs, the minimum standards or the real benefits for children, risks output monitoring becoming an end in itself. In addition, aiming for coverage alone may discourage UNICEF from focusing on key areas related to quality or policy development, which are critical, but may not have a strong impact on the number of beneficiaries reached.

The evaluation team confirmed these findings. Programme sections rely primarily on partner reporting for their monitoring data. Since the end of 2017, UNICEF has managed this using a monitoring database to systematically analyse the data against the targets by location, adult/child and gender (though gender and age-disaggregated data are not always available). Progress is only reported as reach (i.e., the number of people served), in line with the Humanitarian Action for Children indicators. Staff undertake project visits within the limitations of access constraints, which challenges systematic field monitoring. The consequent reliance on partner reporting for the bulk of monitoring calls into the question the degree to which UNICEF has control over implementation quality. The recent WASH Cluster action review raised the same question, with WASH Cluster partners agreeing that monitoring of interventions is weak.

Findings gathered during the evaluation mission complement this initial assessment. The ethnic and cultural diversity in South Sudan and the

340 Ibid.
342 ‘WASH Humanitarian Action Review’.
prevailing conflict make access extremely difficult and often dangerous, even for nationals, as evidenced in conversations with partners on the ground. It appears that to move freely and avoid security risks, people must be from the right group, age and affiliation. As a result, areas with freedom of movement are comparatively small.\textsuperscript{343} At the same time, the long history of insufficient investment in rural development has deprived rural South Sudan of skills. Identifying staff with sufficient skills to implement and monitor programmes is often impossible in rural areas. Partners confirmed this through anecdotal evidence.

In most cases, travel from Juba or any of the larger centres to remote parts of the country requires air travel, mostly through the United Nations Humanitarian Air Service. Movement around smaller rural centres is restricted by the long rainy season and the prevailing conflict, in addition to the constraints noted above.\textsuperscript{344} Therefore, any attempt to set up an external network of third-party monitors would either have to rely on an unusually low skill set when hiring monitors in the areas where they live; or would face the same high cost and travel restrictions that UNICEF staff face. A third-party monitoring system would therefore face the impossible choice between insufficient quality or unacceptably high cost.\textsuperscript{345}

UNICEF South Sudan has instead established a systematic, central system for collecting monitoring data through the Kobo platform and has strengthened monitoring by programme staff as opportunities for travel arise. This is a promising investment, as it facilitates on-demand analysis and the generation of results dashboards. However, these systems require training and support, for which the social policy, planning, monitoring and evaluation section is currently lacking capacity.\textsuperscript{346} A sentinel monitoring system is in the early stages of implementation, augmenting field monitoring data with baseline and situational information. A cloud-based centralized database of indicators organized by location and other dimensions is likely to add further rigour to field monitoring.\textsuperscript{347}

As the UNICEF strategic moment of reflection in October 2017 acknowledged, in part, strengthening the monitoring function depends on the harmonization of field monitoring systems and more frequent and consistent field visits by Juba-based staff: “Field monitoring systems should be harmonized across offices. Needs from the field and CO [country office] commitments require more frequent and predictable field monitoring missions and programme visits by Juba staff. Such missions should be implemented through a calendar of monitoring visits developed with each ZO [Zonal Office] Chief on a monthly basis to ensure more predictability.”\textsuperscript{348}

\begin{thebibliography}{99}
\bibitem{343} Key informant interviews with UNICEF staff and partners in Juba and field locations, May 2018.
\bibitem{344} Key informant interviews with UNICEF staff and partners in Juba and field locations, May 2018, and evaluation team observations during field missions.
\bibitem{345} The direct relationship between availability of skilled monitors and sufficient access and the quality of third-party monitoring systems is well documented. See, for example, Sagmeister, E. and J. Steets, ‘The Use of Third-party Monitoring in Insecure Contexts: Lesson learned from Afghanistan, Somalia and Syria’, SAVE, October 2016.
\bibitem{346} Based on a review of current systems by the evaluation team.
\bibitem{347} Interviews and conversations with UNICEF staff and partners in Juba and field locations.
\bibitem{348} UNICEF strategic moment of reflection, October 2017.
\end{thebibliography}
7 CONCLUSIONS AND RECOMMENDATIONS
This section presents the conclusions and recommendations from the evaluation findings and evaluative reasoning. The evaluation concludes that a complex web of factors has created a context of extreme vulnerability in South Sudan for millions of children and their families. The challenge is to tackle the most immediate needs of communities, while contributing to building the ability of communities to address and recover from shocks. While a resilience agenda through a closely integrated package of prevention and response is acknowledged as a priority, more clarity is needed on what exactly this entails and how it can be operationalized and measured. The section concludes with a set of specific recommendations for each of the topics addressed.

7.1 OVERALL CONCLUSIONS

Despite the recent internal re-classification of the situation in South Sudan from a Level 3 to a Level 2 emergency, the situation remains one of the most serious humanitarian crises in the world – and one that continues to pose major challenges for UNICEF and its partners. The relevant indicators for children’s health and nutrition have been declining steadily since the onset of the civil war in December 2013. The indicators were already alarming before that date, following decades of conflict and under-development; and many of the related challenges are essentially developmental in nature. Since the conflict began, the typical annual cycles of acute malnutrition have shown a continuous downward spiral – to the extent that localized famine occurred in 2017 and should be expected to recur, possibly on a wider scale. Likewise, the 2016–2017 cholera outbreak, which was serious enough in its own right, may be a warning of worse epidemics to come, particularly if the trend of population movement to urban centres continues. More generally, a range of factors – including generalized insecurity and exposure to violence, mass displacement, a collapsing economy, loss of livelihoods and a lack of government services – combine to form a context of extreme vulnerability for millions of children and their families. The aid agenda has become predominantly humanitarian and reactive, and constrained by limited access, limited funding and high levels of aid worker insecurity. Meanwhile the development agenda, at least at the national level, has stalled since 2013.

The August 2018 peace agreement does not change the immediate humanitarian outlook; though if the ceasefire holds, it may at least provide a window of opportunity in terms of access for needs assessment, service delivery and local capacity building. It may also provide an important advocacy opportunity, and allow for the release of increased numbers children associated with armed forces or groups. If the peace lasts, there is room for optimism for a sustained cessation of conflict and violence against civilians, particularly gender-based violence against women and girls; the potential return of the millions displaced within South Sudan and beyond its borders; and a
period of economic recovery. There might also be a re-orientation of the budget from military spending to development priorities, including desperately needed investment in education and health.

Past experiences make us wary of such projections, however. The potential for conflict is partly structural in South Sudan, past agreements have failed to last and there are armed elements that are not party to the peace agreement. Even if the peace holds, South Sudan is so damaged and chronically under-invested in that it will take many years for the country to recover – politically, socially and economically. Establishing good governance is a long-term project, and establishing social and ethnic harmony is an even longer one. Regarding displaced people and refugees, the perception of security is key: people will no doubt look for tangible evidence of stability – and the prospect of a viable livelihood and access to services – before committing themselves to returning home. It must be anticipated that many or most of those currently displaced or in exile may remain so for the foreseeable future. Those living in PoC sites may face particular challenges in returning home, given the political and security context.

The distinctions between humanitarian action and development programming start to break down in a context such as South Sudan, where the development base is so low and access to basic services is so limited. While tackling the most immediate threats to children and their families remains a priority, UNICEF and others are rightly concerned with building resilience – the ability of people and systems to withstand and recover from shocks. Resilience-building bridges the humanitarian and development agendas, but is too abstract a concept to be operationally useful, and needs to be better defined. Resilience is closely linked to concepts of quality, adaptability, ownership, localization and sustainability; and its measurement depends on reliable data from monitoring, surveillance and reporting.

The evaluation team found that UNICEF needed a more clearly defined, actionable and measurable resilience agenda, in close collaboration with the relevant clusters and other agencies. It noted that resilience in one domain (e.g., WASH) resulted in greater resilience in other domains (e.g., nutrition and health). It also noted that household economic resilience was linked to resilience in the child survival sectors. Household resilience also depended on families being equipped with the knowledge and understanding to keep children safe, well-nourished and healthy.

South Sudan represents an important test case for UNICEF in its ability to deliver on its stated commitment to risk-informed programming, in a particularly high-risk environment. In this regard, the preventive and responsive agendas need to be given equal priority. This is true both of short-term prevention, such as ensuring moderately malnourished children do not become severely malnourished; and longer-term prevention, such as averting developmental problems due to chronic malnutrition. Closely harmonized prevention/response packages across related fields – including those within UNICEF’s responsibility – are essential to achieving efficiency and impact at scale. Progress has already been made towards this end but more remains to be done, and the target is (literally) a moving one. As the new CPD 2019–2021 makes clear, flexibility will be essential, as will a sustained focus on linking interventions in areas of high vulnerability, building on the current ‘hotspot’ approach.

UNICEF is appropriately working to localize its response by increasing its work with local civil society organizations. Yet there are potential trade-offs in terms of the quality of
the response and accountability. The evaluation team suggests that the partnership model be revisited, including issues of monitoring, oversight and capacity building. The partnership model also needs to move away from the current instrumental approach – which is heavily transactional and designed solely to deliver on UNICEF’s programme commitments – to something that reflects genuine collaboration. This also applies to UNICEF’s partnerships with international NGOs, the potential of which are only partially realized. More use of consortium-based approaches might be part of such a shift. However, the shortage in local capacity is a real constraint, and one that can only be addressed by investing in capacity over time. In this regard, there is often little difference between the staff of local organizations and the local staff of international organizations – both of which face capacity challenges.

As the CPD 2019–2021 recognizes, all of this demands better data and evidence – about the baseline situation, including existing infrastructure, capacities, behaviours and attitudes; about priority needs and vulnerabilities; and about which approaches work best. UNICEF and its partners are currently operating blind in too many areas. For example, data on water and sanitation coverage in South Sudan are outdated and generally seen as unreliable. Nutrition information is better, but its reliability is often questionable and there are significant gaps. Health information (e.g., on immunization coverage) is inconsistent and often based on out-of-date child population estimates. UNICEF needs to devote more attention to this aspect of its role – both to inform its own programming and to inform the wider response. But it cannot do so alone. Its role in this respect is as much as convener as it is implementer; and as a leader and promoter of best practice, through the clusters and in its own programming.

7.2 TOPIC-SPECIFIC CONCLUSIONS AND RECOMMENDATIONS

Nutrition

The evaluation found that the content and quality of nutrition programming was good given the constraints under which UNICEF and its partners operated. It also identified several areas for improvement, including the need for:

• More ambitious target setting in IYCF programmes;
• An increased effort to prevent MAM cases from becoming SAM cases;
• Inclusion of adolescent and school-aged children (particularly girls) in nutrition programmes;
• The development of programme approaches and related advocacy to address chronic malnutrition.

Many of these agendas require concerted effort across agencies, particularly between WFP and UNICEF. To date, collaboration with WFP and FAO has been strong. This should be developed further, both in nutrition programming and more broadly as part of the resilience agenda, to help families tackle significant ongoing challenges.

The relatively limited nutrition outputs delivered through the IRRM raises questions about the effectiveness of this approach and the quality of related programming, given the lack of follow-up. The IRRM has also had a limited effect on overall nutrition programme coverage, though this can largely be explained by the isolated and vulnerable nature of the communities concerned. To increase coverage, UNICEF should consider expanding the nutrition component of the proposed Integrated Mobile Health Outreach Initiative beyond screening, to include SAM and MAM treatment.
**Recommendation 1:** Extend and enhance the nutrition programme

*For action by:* the UNICEF South Sudan nutrition section and field offices

*Coordinated internally with:* the health, WASH and C4D sections, as well as resource mobilization

*Coordinated externally with:* the Government, WFP, FAO, the Nutrition Cluster, implementing partners and community mobilizers

**R1.1** Ensure that target setting reflects achievements and is more ambitious, without compromising quality, particularly in IYCF.

**R1.2** Advocate with WFP and the Nutrition Cluster to increase the number of targeted supplementary feeding programme sites and the number of targeted children to reduce the number of children suffering from SAM.

**R1.3** Improve the quality of latrines at feeding centres by ensuring that emergency latrines are appropriately and safely constructed, ventilated and placed in facilities that are more permanent structures.

**R1.4** Consolidate the various cadres of community volunteers in health, WASH and nutrition into a single community-based volunteer programme with a single training curriculum that covers all necessary knowledge and skills, to increase efficiency.
R1.5 Include adolescents and school-aged children, particularly girls, as a target group of the nutrition programme, in collaboration with WFP.

R1.6 Advocate for and develop approaches to addressing chronic malnutrition in coordination with WFP, FAO and other partners working on food security, livelihoods, social protection and WASH.

R1.7 Explore more strategic partnerships that could allow for greater efficiency and coverage, including consortium models and partnerships to address key areas such as training and capacity building.

R1.8 Integrate nutrition into the proposed integrated Mobile Health Outreach Initiative, including the delivery of SAM treatment and targeted supplementary feeding in collaboration with WFP to increase coverage in more isolated areas.

Health

Routine immunization coverage is low, and increasing coverage is a clear priority. To substantially increase coverage, a more regular mobile outreach solution is required such as that proposed by the Integrated Mobile Health Outreach Initiative.

Key areas of improvement include:

- Only a small proportion of adolescent girls are currently accessing antenatal care. UNICEF should explore using outreach and health promotion mechanisms to encourage adolescent attendance and vaccination. Consideration should be given to the use of cash incentives to encourage traditional birth attendants to refer pregnant women to health facilities.
- The delivery of health promotion at the community level needs to be expanded. The potential expansion of personnel and coverage by the proposed consolidation of community nutrition, health and WASH volunteers would address this to some extent.
- UNICEF failed to achieve its targets for the distribution of long-lasting insecticide-treated bed nets in 2016 and 2017. Given that the prevention and treatment of malaria should be a priority, UNICEF should explore all available means for distribution (along with other anti-malaria interventions), including joining forces with WHO and WFP to distribute bed nets as part of general food distributions.

Recommendation 2:
Extend and enhance the coverage of UNICEF’s health programme

For action by: the UNICEF South Sudan health and C4D sections and field offices

Coordinated internally with: the nutrition and WASH sections

Coordinated externally with: the Government, donors, the Health Cluster, implementing partners and community mobilizers

R2.1 Increase immunization coverage as much as possible through mobile outreach (i.e., through the implementation of the Integrated Mobile Health Outreach Initiative).

R2.2 Increase the distribution of long-lasting insecticide-treated bed nets to vulnerable households, through other distribution mechanisms (e.g., WFP food distributions) and existing centres such as OTPs, targeted supplementary feeding programmes and primary health centres and units.
R2.3 Consolidate the various cadres of community volunteers from health, WASH and nutrition into a single community-based volunteer force, with a single training curriculum covering all necessary knowledge and skills, to increase the efficiency and coverage of health promotion.

R2.4 Increase the targeting of adolescent girls by making them a target group in the health programme, and ensuring that addressing their specific vulnerabilities (e.g., vulnerabilities associated with early marriage and pregnancy) is a strategy in the health programme.

R2.5 Integrate SAM and MAM treatment into the Integrated Mobile Health Outreach Initiative to increase nutrition coverage (cross-reference R1.8).

WASH

During the evaluation period, UNICEF’s strategy and approach to WASH was somewhat at odds with the demands of the situation. The CPD 2016–2018 reads more like a recovery plan than a humanitarian plan, and includes some approaches (e.g., to community-led sanitation) that were unrealistic. More importantly, under the circumstances, the separation between development and humanitarian WASH is artificial and counter-productive, as the same basic principles apply to both. In its WASH strategy note for 2019–2021, UNICEF South Sudan is moving in the right direction, towards better integration of development and humanitarian WASH approaches.

Key areas for improvement include:

• During the evaluation period, UNICEF achieved its targets on access to water but fell short of its targets on access to sanitation, which were over-ambitious given the structural and developmental deficits in South Sudan. In sanitation-related behaviour change, there was a discrepancy between UNICEF’s practice and that of other agencies. Behaviour change requires engagement over time; yet UNICEF’s primary mode of engagement is through one-off, campaign-style hygiene information sessions. Given the high rates of open defecation in South Sudan, a different approach is needed.

• The quality of the work delivered by UNICEF’s WASH partners is of concern. Emergency infrastructure should not be of lesser quality than regular infrastructure unless there are compelling reasons, such as limited time windows for interventions. There is also no justification for the lesser quality of sanitation infrastructure in facilities (i.e., schools and health centres). Quality concerns also extend to the collection, sharing and use of basic technical data. UNICEF needs to invest more in technical oversight and quality assurance.

• Engagement with REACH on WASH baseline assessments is essential and should be prioritized, and the standardized set of indicators should be used consistently and widely. The gathering of baseline data could be added to IRRM WASH responsibilities, as the sector currently plays a comparatively minor role in these missions. UNICEF and its partners need to find more consistent ways of assessing water supply and sanitation needs.

Recommendation 3: Ensure the quality and sustainability of UNICEF’s WASH programme

For action by: the UNICEF South Sudan WASH and C4D sections and field offices

Coordinated internally with: the nutrition, health, WASH and education sections
CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

Coordinated externally with: the Government, donors, the Health Cluster, implementing partners and community mobilizers

R3.1 Integrate humanitarian and development approaches to WASH programme infrastructure, ensuring minimum standards of implementation.

R3.2 Where possible, ensure the sustainability of WASH facilities, in terms of the quality of construction, operation and maintenance. Where conflict dictates rapid building or rehabilitation, such locations should be marked for more sustained follow-up when the situation permits.

R3.3 Transition from campaigns to targeted hygiene behaviour change promotion where possible and appropriate. Identify which parts of the programme could apply more invested means of delivery (e.g., the use of social mobilizers and hygiene promoters embedded at the community level).

R3.4 Where possible, support joint community worker approaches with other sections for cross-sector behaviour-change communication.

R3.5 Fully implement the external engineering supervision already planned and hold partners accountable for sub-standard implementation.

R3.6 Through PCAs, require partners to systematically document all relevant water source data, including visible and durable data boards at sources, and make data available at all levels. Advocate through the WASH Cluster for others to do the same, and for a central database to be established for this purpose.

R3.7 Through PCAs, require partners to strengthen operation and maintenance by systematically teaching water committees: a) the value and use of water source data; and b) how to design basic management plans and train committees in their use.

Coordination and the clusters
UNICEF has generally coordinated well with its peers in the United Nations Country Team and the HCT and has established a particularly strong working relationship with WFP – both on the IRRM and more broadly. Cluster lead functions are also present in all key field hubs. The cluster partners expressed positive views on UNICEF’s Nutrition Cluster leadership; and its role in the Health Cluster. The WASH Cluster has been problematic, however, but UNICEF has now largely re-established trust and is performing well in this role. Across these sectors, UNICEF’s role in managing the core pipeline for supplies is particularly appreciated.

Supply and logistics
The UNICEF South Sudan supply and logistics team performed well and worked as efficiently as possible in a highly challenging environment. Some issues were identified, including a time-consuming focus on following up on permits at the cost of more productive tasks. Internal studies suggest a relatively short-staffed unit. Given the central importance of UNICEF’s role in managing the core pipeline, this should be reviewed and additional capacity established as necessary.

Recommendation 4:
Review and supplement UNICEF’s human resources capacity in supply and logistics as necessary

For action by: the UNICEF South Sudan logistics section and field offices
Programme balance

Overall, it appears that roughly equal effort goes into the PoCs/displacement camps; static programmes; and outreach programmes, including the IRRM. Although it could not be confirmed by data, the impression gained by the evaluation team was that the programme balance among these three components was not optimal for achieving adequate reach and meeting priority needs, and that a shift was required towards greater outreach, using the kinds of integrated approaches noted above. More generally, UNICEF and other international agencies working in South Sudan need to be wary of the tendency to become bunkered in Juba and urban centres, or to privilege the relatively easier programme targets over the more challenging ones. The evaluation team found some evidence of this, for example regarding limited field monitoring conducted by UNICEF staff.

In reviewing programme balance, various linked parameters need to be considered. These parameters fall into two broad categories: those related to needs and those related to programming and operations. The first category includes the location and relative vulnerability of populations of concern, whether displaced and living in PoC sites or other camps; urban or peri-urban; accessible rural populations; or more remote or dispersed rural populations, including those who are displaced but not living in camps. There is also a question of balance between those located in government-controlled vs. opposition-controlled areas. Social and economic factors – including gender, age, livelihood group and ethnicity – also belong in this category. Operational and programmatic parameters include the balance of services provided; static vs. mobile/outreach modalities; and the choice of delivery agent, such as a United Nations agency, international or local NGO, government body, community volunteer or UNICEF itself through the IRRM.

The evaluation concludes that UNICEF should review its programme balance, in terms of its coverage of PoC/camp populations and more remote (and generally underserved) populations. This should be done with a view to shifting resources to the latter through outreach programmes, and thereby potentially increasing overall coverage and equity. To do so requires generating management information on the relative split in terms of expenditure, PCAs and staff time. This topic will be further explored – and related data sought – in part two of the evaluation.

**Recommendation 5:**

Review and progressively address the balance between camp, static and outreach programmes

*For action by:* UNICEF South Sudan senior managers and section chiefs

*Coordinated internally with:* field offices

*Coordinated externally with:* the Government, donors, the HCT, clusters and implementing partners

**Direct delivery: The Integrated Rapid Response Mechanism**

The IRRM modality is essential for UNICEF and delivers multiple potential benefits by extending programme reach to areas and populations otherwise unable to access critical services. While coverage through the IRRM is limited, this modality has a strong equity rationale. The IRRM also appears to be relatively good value for money. However, UNICEF needs to be clearer about the specific value – and limitations – of direct service delivery through the IRRM. This needs to be more carefully articulated and the claims made for it should be more nuanced, particularly claims about coverage. To the extent possible, it is also essential that UNICEF monitor the actual (rather than presumed) effects of its interventions, as a basis for planning and
follow-up missions and adapting the IRRM approach and planning framework over time in discussion with WFP and other partners.

**Recommendation 6:**
Review IRRM targeting, effectiveness, follow-up and reporting

*For action by:* UNICEF South Sudan operations/IRRM staff, section chiefs, the C4D section and field offices

*Coordinated internally with:* all those involved with the IRRM, including at UNICEF Headquarters

*Coordinated externally with:* WFP, FAO and implementing partners

R6.1 Review the targeting, effectiveness and efficiency of current IRRM practices bi-annually based on available data. Follow-up missions or partner visits should be planned wherever possible, in part to check the effectiveness of earlier interventions and re-assess needs.

R6.2 Systematically collate and share situational and needs assessment data from IRRMs with other relevant partners.

R6.3 Review how the results of IRRM missions are reported. Claims made about coverage should be appropriately qualified.

R6.4 Take stock of lessons from the South Sudan experience with the IRRM, acknowledging that this is a unique application of the model (and the only one that involves UNICEF in a direct delivery mode).

**Evidence and data quality**

The overall situational evidence base in South Sudan is very weak, which hampers every aspect of the programme. UNICEF has already identified this as a priority area for action, and the evaluation makes sector-specific proposals for action in the context of the child survival sectors. In particular, data on water and sanitation coverage in South Sudan are out-of-date and generally unreliable. Better baseline of WASH data, particularly on water sources, is urgently needed.

**Recommendation 7:**
Strengthen the sector evidence base, specifically in WASH and nutrition

*For action by:* UNICEF South Sudan senior managers, section chiefs, social policy, monitoring and evaluation staff, the C4D section and field staff

*Coordinated internally with:* all sections

*Coordinated externally with:* the Government, the clusters, WFP, FAO, the HCT, implementing partners and community mobilizers

R7.1 Invest in the WASH baseline, as follows:

- Make baseline data collection a key task of WASH field visits, especially as a key WASH function in IRRM missions;
- Train all WASH staff in REACH data collection methodologies and provide the necessary tools;
- Integrate WASH indicators into other data collection exercises, such as the national food and nutrition monitoring surveillance system;
- As part of the cluster lead agency role, facilitate collective data pooling and data availability for all partners to gradually rebuild a national water source database.

R7.2 Strengthen nutrition information and analysis, as follows:

- Given high GAM prevalence, lead cluster efforts to gain a greater understanding of the geographically differentiated underlying causes of malnutrition, building on
the experience of the Integrated Food and Nutrition Security Causal Analysis 2016 to focus prevention efforts.

- Given reported issues with data quality and bias, work with FAO and WFP to explore the establishment of an independent (of operations) assessment and analysis unit for food security and nutrition. This is pertinent given the wider humanitarian community’s reliance on food security and nutrition assessment and analysis for prioritization. At a minimum, UNICEF should engage with the Nutrition and Food Security Clusters to explore ways of strengthening current assessment and analytical practice, perhaps using several organizations to undertake food security and nutrition assessment outside of their own operational areas.

Monitoring and reporting

Just as the situational evidence base is weak, so too is the programme evidence base. The evaluation found that monitoring weaknesses were leading to uncertainty about output delivery and failure to identify poor quality implementation. Several clear quality control issues were observed, notably in relation to WASH construction (e.g., poorly built latrines). While programme monitoring is extremely challenging in the current context, staff noted that direct field monitoring can be increased, in conjunction with other methods of supervision (including third-party technical monitoring where appropriate). The new UNICEF field monitoring guide provides useful guidance on this.

**Recommendation 8:**

**Strengthen the programmatic evidence base, including through stronger monitoring and oversight processes**

*For action by:* UNICEF South Sudan senior managers, section chiefs, social policy, monitoring and evaluation staff, the C4D section and field staff

**Coordinated internally with:** all sections

**Coordinated externally with:** implementing partners, mobile community networks and third-party monitors

R8.1 Set more ambitious targets for regular field monitoring visits by UNICEF staff. These can double as programme and partner support visits. UNICEF staff need to be prepared to monitor across sectors beyond their own specialty to the extent possible.

R8.2 Consider alternative options to supplement and verify partner reporting, including peer-to-peer monitoring and technical review by third-party specialists. This has benefits for cross-sector learning as well as accountability and quality assurance.

Efficiency

While the evaluation was unable to make valid cost comparisons on the delivery of different programme components, it did draw broader conclusions on efficiency. Some of these conclusions are already clear to UNICEF and its partners: for example, the need to replace expensive water trucking with more sustainable alternatives, including piped water supply to camps and urban centres, as soon as possible. Others emerged from clear opportunities for streamlining processes, such as the agreement between WHO and WFP to use general food distributions to distribute long-lasting insecticide-treated bed nets. The evaluation team suggests that there may be many such opportunities for streamlining both within UNICEF’s own programmes and in collaboration with other partners. For UNICEF, this could involve joint PCAs across different sections, for example to provide health and nutrition services in feeding centres and training and using community volunteer forces across sectors.
**Recommendation 9:**
Take additional steps to increase efficiency through combined processes, both internal and shared

*For action by: UNICEF South Sudan senior managers, section chiefs and field offices*

*Coordinated internally with: all sections and support departments*

*Coordinated externally with: United Nations partners, the HCT and implementing partners*

**Accountability to affected populations**

While UNICEF has been slow to adopt a formal AAP policy framework, its practice in this area appeared to be reasonably consistent with accepted principles. This is an aspect of the programme that needs strengthening, however. The evaluation team suggests that rather than being treated in isolation, AAP should be part of a wider concerted effort at greater community engagement and mobilization that includes standard two-way communication approaches. While responsibility for AAP lies with C4D, wider responsibility for community engagement
needs to be shared across the programme, with community mobilization seen as a shared modality.

- Regarding internal accountability, UNICEF’s mutual framework of accountability sets clear lines of responsibility and represents considerable progress. The challenge appears to be to make this approach work in practice, and to manage the reporting and other bureaucratic demands that it can generate. The decentralization of responsibilities to hubs across the country is an important part of this, which is linked to localization, and recognizes the impossibility of managing all relevant processes out of Juba. Concerns were expressed that capacities may not be sufficient to meet expectations, however. The evaluation team was not able to examine the accountability process in enough detail to assess how it is progressing or might be strengthened.

- Accountability to donors is another area that needs continued attention. While UNICEF’s reporting is strong, its monitoring processes are not always sufficiently robust to inspire full confidence in the results reported. UNICEF needs to properly account for the funds spent and the delivery of outputs. Beyond that, it needs to have a stronger basis for claims about resulting impacts for beneficiaries. Finally, as noted, UNICEF must not lose sight of the overarching political accountabilities for people’s safety and welfare. The organization must use its advocacy and its work with government ministries to maintain and build the sense of state responsibility for service provision.

**Recommendation 10:**
Take additional steps to strengthen accountability to beneficiaries and support claims of programme effectiveness

*For action by:* UNICEF South Sudan senior managers, section chiefs, social policy, monitoring and evaluation staff, the C4D section and field staff

*Coordinated internally with:* all sections and field offices

*Coordinated externally with:* implementing partners and mobile community networks

**Communication**

UNICEF should review whether it is doing all that it can (in conjunction with others) to conduct advocacy, particularly on humanitarian access. The evaluation team was only able to gather limited evidence on this, particularly regarding non-public advocacy work by UNICEF and HCT members. The ceasefire agreement in place at the time of writing may present an opportunity for high-level advocacy with authorities on access and child protection. This topic will be further explored in part two of the evaluation.

**Communication for Development**

The C4D element of UNICEF’s response was strengthened significantly in 2017 and 2018, notably through the creation of a large network of community mobilizers. This network will play both a mobilizing and a pulse check function, potentially giving UNICEF and its partners a window into the evolving attitudes, behaviours and priorities of communities and households. That said, the achievement of sustained behaviour change is difficult to assess, and doubts were expressed by informants on the impact of C4D hygiene messaging in particular. More precise approaches to gauging the effectiveness
of behaviour change activities are needed. This topic will be further explored in part two of the evaluation.

**UNICEF’s partnership model and processes**

UNICEF should review its implementing partnership model and related processes. The relative shift to delivery through national civil society organizations raises questions about the support and oversight necessary to make this work. UNICEF needs to take stock of those requirements and invest in greater support as needed, including by getting buy-in from donors by reference to Grand Bargain commitments. A consortium approach and peer-to-peer reviews, in partnership with international NGOs, may be useful.

Partner feedback suggests that the current PCA model is perceived as instrumental and lacking the necessary features of true partnership, including joint strategic reflection and planning. The PCA process is also criticized for its lengthy processes, lack of flexibility and delays in fund disbursement. UNICEF should remedy this by reviewing its processes and the nature of its engagement with implementing partners. It should also reconsider the option of renewable annual contracts and multi-year funding in appropriate cases (as the nutrition section has started to do).

**Recommendation 11:**
**Review the current partnership model and strengthen related business processes**

*For action by:* UNICEF South Sudan senior managers, section chiefs and field offices

*Coordinated internally with:* all sections and field offices

*Coordinated externally with:* implementing partners

**Strengthening resilience in practice**

UNICEF and partner commitments to building resilience remain more conceptual than operational. The evaluation team suggests that for each of its main areas of intervention, UNICEF and its partners define clearer criteria for what constitutes resilient households, communities and systems. For example, measurable criteria for a resilient local water supply system might be set as a well-constructed water source (i.e., durable) able to cope with additional demands (e.g., newly displaced people) with a high degree of autonomy and local ownership (e.g., through water committees, trained mechanics, etc.) and secure access to spare parts. Appropriate monitoring indicators could be defined accordingly.

**Recommendation 12:**
**Take steps to make the resilience agenda actionable and measurable within and across sectors**

*For action by:* UNICEF South Sudan section chiefs, social policy, monitoring and evaluation staff, the C4D section and field staff

*Coordinated internally with:* all sections and field offices

*Coordinated externally with:* the Government, United Nations partners, implementing partners and mobile community networks.