

UNICEF

**South Sudan COVID-19 Emergency Response and Health
Systems Preparedness Project and its Additional Financing**

**Environmental and Social Management
Framework**

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LIST OF ABBREVIATIONS

AF	additional financing
BHI	Boma Health Initiative
CERC	Contingent Emergency Response Component
CERHSP	COVID-19 Emergency Response and Health Systems Preparedness
CHD	County Health Department
CMAM	Community Management of Malnutrition
COVID-19	coronavirus disease 2019
EHSG	Environmental Health Safeguards
EIA	Environmental Impact Assessment
ESCP	Environmental and Social Commitment Plan
ESF	Environmental and Social Framework
ESMF	Environmental and Social Management Framework
ESS	Environmental and Social Standards
GBV	gender-based violence
GDP	gross domestic product
GPAA	Greater Pibor Administrative Area
GRM	Grievance Redress Mechanism
HPF	Health Pooled Fund
IP	Implementing Partner
MOH	Ministry of Health
MWMP	Medical Waste Management Plan
NGO	non-governmental organization
OHS	occupational health and safety
PEHSP	Provisions of Essential Health Services Project
PHC	primary health care
PHCC/U	primary health care center/unit
PoC	protection of civilians
PPE	personal protective equipment
PSEA	protection from sexual exploitation and abuse
SEP	Stakeholder Engagement Plan
SES	Social and Environmental Standards
SESSP	Social and Environmental Sustainability Standards and Procedures
SGBV	Sexual and Gender-based Violence
SLT	Saving Lives Together framework
SPLA	Sudanese People's Liberation Army
SPLA-iO	Sudanese People's Liberation Army in Opposition
TPMO	third-party monitoring organization
UN	United Nations
UNICEF	United Nations Children's Fund
UNMISS	United Nations Mission in South Sudan

WASH water, sanitation and hygiene
WB World Bank
WHO World Health Organization

EXECUTIVE SUMMARY

This Environmental and Social Management Framework (ESMF) has been prepared by UNICEF to ensure the South Sudan COVID-19 Emergency Response and Health Systems Preparedness (CERHSP) project and its Additional Financing (AF1 & AF 2) is consistent with the [World Bank \(WB\) Environmental and Social Framework](#) (ESF) and UNICEF's Environmental and Social Standards (ESS).¹ The International Development Association has agreed to provide additional financing for the CERHSP. The project provides continued support for essential health services to the Upper Nile, Jonglei² and Unity states, including procurement of COVID-19 vaccines for the country, response to the needs of refugees and host communities, integrated health and nutrition services, and restoration of health and nutrition facilities affected by flooding in Upper Nile and Jonglei. For all WB-supported projects, the WB ESF requires risk assessments to be conducted, mitigation measures identified, and corresponding risk management procedures developed, disclosed, implemented and monitored.

The ESMF is intended to serve as a practical tool to guide identification and mitigation of potential environmental and social risks, and the impacts of proposed investments, and to act as a platform for consultations with stakeholders and potential project beneficiaries. The ESMF leverages agreed measures and lessons learned under the South Sudan Provision of Essential Health Services Project (PEHSP). The ESMF identifies the relevant ESS/Social and Environmental Standards (SES), the likely environmental and social risks and the mitigation measures to address those risks. It also assesses institutional capacity and outlines measures for filling capacity gaps.

Section 1 (Background) discusses transitioning from the previous PEHSP and its ESMF (under WB safeguarding policies) to CERHSP AF1 & AF2 (whose ESMF falls under the WB ESF and ESS). The CERHSP AF1 & AF2 ESMF has been updated to include new elements introduced as part of AF including procurement of COVID-19 vaccines, responding to the needs of refugees and host communities, and strengthening integration of health and nutrition services for all beneficiaries. The updated ESMF will be finalized, approved and disclosed before implementation of the new elements introduced through the AF. Section 1 sets out the project's objective: to prevent, detect and respond to the threat posed by COVID-19 in South Sudan, including procurement of COVID-19 vaccines, increased access to an essential package of health services in the states of Upper Nile, Jonglei and Unity (including Pariang county) and to develop the South Sudan government's health sector stewardship and system preparedness capacity. It also covers the rationale of applying the ESMF for the CERHSP AF1 & AF2 project to foster environmental sustainability and social cohesion in areas and communities benefiting from the project.

In Section 2, the project is presented and described, and the partners (UNICEF, World Health Organization [WHO], International Committee of the Red Cross [ICRC] and WB) identified. UNICEF, WHO and ICRC are responsible for their own subcomponents. The five components of the project and respective subcomponents and responsible partner are as follows:

- Component 1 has three subcomponents:

¹ UNICEF's Environmental and Social Standards is in the finalization phase.

² Please note that, for the purposes of this documentation, Jonglei state includes the Greater Pibor Administrative Area (GPAA).

- Subcomponent 1.1. Climate-friendly cold chain (UNICEF)
- Subcomponent 1.2. Vaccine procurement, deployment and climate-sensitive vaccine planning (UNICEF)
- Subcomponent 1.3. Community engagement and behaviour change (UNICEF)
- Component 2 is composed of two subcomponents, including:
 - Subcomponent 2.1. Support to the delivery of essential health and nutrition services in the Upper Nile, Jonglei and Unity states, including Pariang county (UNICEF)
 - Subcomponent 2.2. Support to delivery of high-quality secondary health services at hospital level (ICRC)
- Component 3 includes:
 - Subcomponent 3.1. Building institutional capacity and strengthening health emergencies preparedness (UNICEF)
 - Subcomponent 3.2. Strengthening health emergencies preparedness (WHO)
- Component 4 has 2 subcomponents, including:
 - Subcomponent 4.1, through which the project will finance third-party monitoring of COVID-19 vaccination deployment nationwide and delivery of health and nutrition services in the Upper Nile, Jonglei and Unity states (UNICEF)
 - Subcomponent 4.2, which includes developing a common monitoring mechanism covering both the WB and Health Pooled Fund (HPF) supported locations (WHO)
- Component 5 is the contingent emergency response component (all implementing partners).

The updated UNICEF ESMF applies to all the components and subcomponents under UNICEF accountability, including:

- Component 1
- Subcomponent 2.1
- Subcomponent 2.3
- Subcomponent 3.1
- Subcomponent 4.1
- Component 5.

In Section 3, the Policy, Legal and Regulatory Framework is presented through brief descriptions of key international and national laws and regulations that are relevant to social and environmental issues. The section introduces the WB ESF and UNICEF's Social and Environmental Sustainability Standards and Procedures (SESSP). Section 4 contains a synthesis of Environmental and Social Baselines in South Sudan, as well as specifically in the Upper Nile, Jonglei and Unity states. While Section 5 outlines the potential environmental, social and security risks, Section 6 spells out the desired environmental, social and security mitigation measures.

Section 7 presents the Stakeholder Engagement Plan (SEP). The ESMF concludes with Section 8, which describes ESMF implementation. ESMF implementation includes a description of the general management structure of the ESMF and its responsibilities, monitoring and reporting, and capacity-building and training. While WB provides financing for the project and, as such, has an

oversight role, UNICEF will be responsible for overseeing implementation and compliance with the ESMF, working closely with its implementing partners. UNICEF will be responsible for revisions or updates to this document during the implementation of the project, in consultation with WB. A capacity development plan to ensure ongoing capacity development related to ESMF implementation will be developed and led by UNICEF, working closely with WB.

1. BACKGROUND

1.1 Project background

The CERHSP AF1 & AF2 became effective on 1 July 2022, continuing to support essential health services in Upper Nile, Jonglei and Unity, while introducing new activities, including procurement of COVID-19 vaccines, responding to the needs of refugees and host communities in Maban, Upper Nile and Pariang county in Unity state, and strengthening the integration of health and nutrition services for all beneficiaries. The project also continued to support the nationwide cold chain infrastructure and COVID-19 response activities (including roll-out of the COVID-19 vaccination programme), which were first introduced in the original CERHSP project.

1.2 Project development objective statement

The objective of this ESMF is to prevent, detect and respond to the threat posed by COVID-19 in South Sudan, increase access to an essential package of health services in the states of Upper Nile, Unity and Jonglei, and to develop the South Sudan government health sector stewardship and system preparedness capacity.

1.3 Rationale for the Environmental and Social Management Framework

This ESMF has been prepared by UNICEF, to ensure that South Sudan's CERHSP AF1 & AF2 is consistent with the WB ESF and UNICEF's SESSP.³ The WB ESF requires that all projects funded by WB conduct risk assessments and develop, disclose, and implement risk management instruments. The SESSP also requires that UNICEF considers the potential environmental and social opportunities that its supported interventions may generate and ensures that adverse social and environmental risks and impacts are avoided, minimized, mitigated and/or managed. The ESMF also considers other existing documents and reports, such as the 2020 Social Assessment by UNICEF, relevant national legislation, policies, and guidelines.

The CERHSP project's activities could impact or trigger risks to the environment. The activities could also impact social interactions in the workplace and in the surrounding and beneficiary communities. These negative impacts could undermine the sustainability of the project, as well as its safety, security, and social welfare of the service providers and beneficiaries. This ESMF is therefore intended to serve as a practical tool to guide identification and mitigation of potential environmental and social risks and impacts of proposed investments and as a platform for consultations with stakeholders and potential beneficiaries of the UNICEF-supported CERHSP project components and their respective subcomponents. As detailed in section 3.6, all the 10 Environmental and Social Standards (ESS) except ESS 5,8 and 9 will be applied.

The overall risk rating is High. Like the parent CERHSP project and AF1, AF2 continues to deliver health services in one of the most challenging FCV contexts in the world and targets some of the most conflict affected areas in South Sudan. The project is implemented in one of the riskiest contexts in the World Bank's portfolio, and various aspects define the risks involved in supporting a project in South Sudan. Although the signed peace agreement and the transitional government

³ UNICEF's Social and Environmental Sustainability Standards and Procedures (SESSP) is in its finalization phase and is currently a draft document.

have resulted in some gains in stability, the security environment remains highly unstable and unpredictable. This results in greater risks than those found in non-FCV environments. More specifically, the acuteness of the violence and instability in the country set South Sudan apart from other FCV environments with even greater levels of risk. There are significant risks to implementing a project in South Sudan, as evidenced from the Provision of Essential Health Services Project. Throughout the implementation period of these projects, several facilities were attacked and looted leading to deaths of patients and health workers. Every effort has been made, however, to mitigate potential risks through the development of the security management plan of the parent project along with its implementation arrangements.

The ESMF was developed through a consultative process led by UNICEF – in close coordination with WB and other stakeholders in South Sudan covering the CERHSP project – starting 1 July 2022, the effectiveness date for the AF project. Subsequently, the ESMF will be updated in line with any future changes and/or updates to the design of the CERHSP.

The CERHSP AF1 & AF2 is for the benefit of the people of South Sudan, which has an estimated population of 12 million (National Bureau of Statistics, 2020). The total value of the UNICEF supported CERHSP Additional project components is USD233.5million.

2. PROJECT DESCRIPTION

The project supports preparedness for, and deployment of, vaccines in South Sudan as well as essential health service delivery in the states of Upper Nile, Jonglei, and Pariang county, Unity state, while developing the government’s capacity for health sector stewardship. The project has five components. The first, to be implemented by UNICEF, will support COVID-19 vaccine procurement, deployment, cold chain, logistics and delivery. The second component will support delivery of essential health services to Jonglei, Upper Nile, and Pariang county, Unity state and Unity state as a whole. This will be implemented by UNICEF and ICRC, building on service delivery in these areas under PEHSP. The third component will finance development of the government’s health sector stewardship capacity, to allow a gradual transition to a government-led implementation modality in future WB projects. The fourth component will support project management and monitoring. The fifth component details a contingent emergency response. It should be noted that the ESMF prepared by UNICEF only applies to activities being implemented by UNICEF.

Component 1: COVID-19 vaccine acquisition, deployment, cold chain equipment and community engagement.

The AF enabled inclusion of subcomponent 1.4, on acquisition of COVID-19 vaccines, with additional funding for the original subcomponents 1.1 to 1.3.

Subcomponent 1.1. Climate-friendly cold chain. This subcomponent will support investments to strengthen an energy-efficient, climate-friendly cold chain in the context of South Sudan’s climate

change vulnerability and will support planning and preparations for climate-friendly cold chain deployment, considering South Sudan's annual floods and droughts. The AF will finance solar direct-drive refrigerators for cold chain.

Subcomponent 1.2. Vaccine deployment and climate-sensitive vaccine planning. This subcomponent will build on the progress and achievements of the parent project and focus on accelerating the ministry of health's (MoH's) vaccination efforts to deploy the procured African Vaccine Acquisition Trust Teams vaccine doses along with some COVAX-delivered vaccines nationwide. This subcomponent will cover the same categories of expenditures under the parent project, including climate-sensitive vaccine planning and deployment. This will include prioritising vaccine distribution during the dry season and ensuring availability of vaccine supplies during the rainy season. Deployment of vaccines to populations impacted by the flooding will also be financed in this subcomponent.

Subcomponent 1.3. Community engagement and behaviour change. This subcomponent will continue to accelerate efforts to increase community awareness of: (1) information on the COVID-19 vaccination and its importance, with particular emphasis on increasing vaccine acceptance; (2) the risks of COVID-19, with the aim of addressing perceptions that COVID-19 is not a health risk; (3) awareness of the signs, symptoms and control measures for COVID-19; (4) messages on preparedness for climate shocks and awareness and containment measures for climate-induced, outbreak-prone diseases; and (5) evidence generation to inform ongoing vaccine deployment.

Subcomponent 1.4. Acquisition of COVID-19 vaccines. This subcomponent will finance COVID-19 vaccine acquisition through the African Vaccine Acquisition Trust Teams mechanism, to expand the coverage of COVID-19 vaccines by around 30 per cent. This will lead to an increase in the project target for COVID-19 vaccination coverage from 20 per cent to 50 per cent, including contributions from the COVAX facility of 20 per cent. Support for vaccine acquisition under the AF is part of the containment and mitigation measures to prevent the spread of COVID-19 included in component 1.

Component 2: Provision of essential health and nutrition services in selected states.

Subcomponent 2.1. Delivery of high-impact essential health and nutrition services in Upper Nile, Unity and Jonglei states. Under this subcomponent, the parent project financed the delivery of cost-effective, high-impact essential health and nutrition services to the general population living in the states of Upper Nile and Jonglei, implemented by UNICEF. In addition, this subcomponent will support strengthening of health system resilience and ensure the delivery of essential health and nutrition services to the populations affected by the flooding. Specifically, this subcomponent will finance expanding the scope of health and nutrition services to the communities displaced by

the floods and rehabilitation of flood-affected health facilities in the states of Upper Nile, Unity and Jonglei.

Subcomponent 2.2. Delivery of high-quality secondary services to vulnerable and conflict-affected populations by ICRC. This subcomponent will support delivery of hospital-level services to vulnerable, conflict-impacted populations in Akobo County, Jonglei state.

Subcomponent 2.3. Provision of an integrated package of health and nutrition services to refugee and host communities. This subcomponent will support the delivery of essential health and nutrition services in Pariang county in the Ruweng Administrative Area and Maban county in Upper Nile state, including refugees and host communities in these areas. Facility-based services and establishment and expansion of the Boma Health Initiative (BHI) community health worker programme will be financed through this subcomponent. The services will mirror those health services delivered in Upper Nile, Jonglei, Greater Pibor Administrative Area (GPAA) and Unity states, as described in subcomponent 2.1. These include maternal and child health services such as vaccinations, prenatal care, skilled birth attendance, neonatal care and preventive nutrition services. Priority services will also include mental health and psychosocial support and services for victims of sexual and gender-based violence (SGBV), which is particularly crucial in refugee contexts, where women are more vulnerable.

Subcomponents 2.1 and 2.3 will be implemented by UNICEF and will continue to finance costs related to: (1) essential drugs, medical and nutrition supplies; (2) technical supervision, monitoring and oversight by UNICEF of subcontracted non-governmental organizations (NGOs) implementing partners; and (3) programme management (e.g., transport costs, information technology support, software and platforms, management, monitoring and reporting) for UNICEF. Climate-sensitive planning will be used to help ensure delivery of essential health and nutrition services throughout the year, considering the access challenges faced during the rainy season. For activities in refugee-hosting areas, the AF will coordinate and seek to partner with United Nations High Commissioner for Refugees (UNHCR), both to benefit from UNHCR's expertise as the lead United Nations agency working on refugee issues and to identify ways to complement ongoing health activities that UNHCR and its partners are implementing in these areas.

Component 3: Building institutional capacity and strengthening health emergency preparedness.

Subcomponent 3.1. Building institutional capacity at the MoH. This component will continue to finance institutional capacity development at the MoH to support the gradual transition to government-led management of future WB projects through customized capacity-building activities in the core areas of effective project management.

Subcomponent 3.3. Strengthening surveillance systems and laboratory capacity by WHO. South Sudan remains prone to disease outbreaks, including climate-sensitive diseases. The risk of disease emergencies, including epidemics or pandemics, is high. Concerted and coordinated efforts at all levels are needed to enhance national health security. A strong surveillance system is therefore required to prevent, detect, investigate and respond to disease outbreaks and other public health emergencies.

Component 4: Monitoring, evaluation, and learning.

Subcomponent 4.1. Third-party monitoring and data analytics. This subcomponent finances third-party monitoring of COVID-19 vaccination deployment nationwide, and delivery of health and nutrition services in the Upper Nile, Jonglei, GPAA and Unity states (UNICEF). The scope of the subcomponent will be expanded to include third-party monitoring of the delivery of essential health and nutrition services to refugee and host communities in Upper Nile state and Ruweng Administrative Area. In addition, it will support the analytical work and knowledge management activities undertaken on the project-generated data to inform implementation of future projects. This subcomponent will also monitor the implementation of climate change response and resilience.

Subcomponent 4.2. Health service functionality platform by WHO. The project will maintain and build on the common monitoring mechanism to collect and visualize health service delivery and commodities data, across HPF and WB-supported zones. WHO will ensure the building of MoH ownership of the health service functionality, for decision-making and planning purposes. In addition, the AF will ensure interoperability with DHIS2 and ODK platforms to allow streamlined modelling of service availability/utilization patterns in a timely manner.

Component 5: Contingent emergency response component.

The contingent emergency response component (CERC) aims to improve the country's response capacity in the event of an emergency, following the procedures governed by paragraph 12 of World Bank Investment Project Financing (IPF) Policy (O.P 10). Disbursements under this component will be subject to the declaration of emergency and the preparation of an *Emergency Response Operational Manual* by UNICEF, agreed by WB. The actual activities and their potential implications for environment and social safeguards will depend on the nature of the emergency and response. Following the unprecedented nutrition crisis in the Greater Upper Nile region, UNICEF requested activation of the CERC. With the approval of the CERC on 10 October 2022, project implementation was additionally expanded to Unity state.

3. POLICY, LEGAL AND REGULATORY FRAMEWORK

This ESMF is aligned with the relevant South Sudanese national legislation, policies and guidelines, the WB ESF, as well as UNICEF’s draft SESSP/ESS.⁴

3.1 National requirements and policies

3.1.1 South Sudan’s Transitional Constitution, 2011

The Transitional Constitution of the Republic of South Sudan of 2011 takes precedence over all other laws and regulations in the country. It outlines provisions that advocate for effective environmental management. Article 41 sets out the basis for policies related to the environment, including the following provisions:

- The people of South Sudan shall have the right to a clean and healthy environment
- Every person shall have an obligation to protect the environment for the benefit of present and future generations
- Every person shall have the right to have their environment protected, for the benefit of present and future generations, through reasonable legislative action and other measures that prevent pollution and ecological degradation, promote conservation, and secure ecologically sustainable development and use of natural resources while promoting rational economic and social development to protect the biodiversity of South Sudan.
- Finally, the Constitution promotes local engagement in matters related to the environment. Article 166(6j) commits local governments to involve communities in decisions relating to the exploitation of natural resources in their areas, and promotion of a safe and healthy environment.

3.1.2 Environmental policy of South Sudan

In 2010, South Sudan enacted an environmental policy. A revised version of this policy covers the 2015–2025 period. This policy sets the stage for managing environmental shocks, assisting political leaders and policymakers to allocate resources wisely to promote development programmes that are economically efficient, socially equitable and environmentally friendly, to ensure sustainable progress. The South Sudan National Environment Policy promotes protection and conservation of the environment, and sustainable management and utilization of renewable natural resources to meet the needs of its population, both now and in the future. Specifically, the objectives of the South Sudan’s environmental policy are to:

- Improve the livelihoods of the South Sudanese people through sustainable management of the environment and utilization of natural resources
- Build the capacity of the government (at all levels) and other stakeholders to better manage the environment
- Integrate environmental considerations into the development policies, plans and programmes at the community, government and private sector levels
- Promote effective, widespread and public participation in the conservation and management of the environment.

⁴ UNICEF’s Environmental and Social Standards is in its finalization phase and is currently a draft document.

3.1.3 Environmental Protection Act, 2001

The Environmental Protection Act of 2001 has the following objectives:

- To protect the environment in its entirety, to ensure sustainable development
- To improve the environment and the sustainable exploitation of natural resources
- To create a link between environmental and developmental issues, and to empower relevant national authorities to assume an effective role in environmental protection.

Section III of the Act outlines general policies and principles for the protection of the environment. It is worth noting that these policies and principles are not legally binding, but are guidelines to be observed by the authorities concerned when setting development policies. These guidelines are summarized in articles 17 and 18 of the Act.

Article 17 calls on any individual who intends to implement any project that is likely to have a negative impact on the environment to present an Environmental Impact Assessment (EIA) for approval by the Monitoring and Evaluation Committee of the Sudan Higher Council for Environment and Natural Resources. This should contain the following information:

- The anticipated impact of the project on the environment
- The negative impacts that could be mitigated during implementation of the project
- Alternative options for the proposed project
- A clear undertaking that the short-term utilization of natural resources and the environment will not jeopardize their long-term sustainability
- The precautionary measures to be taken to mitigate the negative impacts of the project.

Article 18 details the duties of the authority tasked with overseeing general environmental policies and directives. These duties are:

- To lay down quality control standards for the protection of the environment
- To preserve water sources from pollution
- To protect air, food, soil and vegetation from pollution and degradation
- To preserve flora and fauna from extinction caused by illegal hunting or any other human activity
- To protect food from contamination or pollution by chemicals or any other materials
- To protect the air from pollution caused by physical operations or chemicals
- To protect the soil from pollution resulting from harmful industrial and/or other types of waste.

Environmental audits must also be undertaken for all projects for which an EIA has been completed. Thus, an individual or institution wishing to undertake a project must ensure that the obligations made in the EIA are complied with.

3.1.4 Environment Health Act, 1975

This Act covers prevention of water pollution, inspection of drinking water, disposal of waste and sewage, inspection of industrial areas and bakeries, prevention of air pollution, and inspection of waste dumping places and brick kilns. It also stipulates the management of waste and other activities that may pollute the environment, including medical waste.

3.1.5 Public Health Act, 2008

The Public Health Act, 2008 emphasizes the prevention air and water pollution, and encourages improved sanitation. Some of the key areas include the following.

- Pollution of water and air:
 - Measures to prevent pollution of water for consumption
 - Measures destined to prevent pollution of potable water
 - Anyone who offers the public water to drink or in food for human consumption, including frozen food, should ensure that the water conforms to potability regulations
 - Management and disposal of hazardous wastes
 - Storage of wastes on the premises of waste generators.

- Atmospheric pollution:
 - Enforce regulations and measures to combat all elements of pollution and protect natural atmospheric levels
 - Measures to prevent and combat noise and other nuisances to be observed at local premises and on a wider scale
 - Suitable toilet systems and excreta disposal methods
 - Rearing and straying of animals and pets
 - Activities and behaviour of individuals and institutions that cause or are likely to cause environmental pollution or vector breeding
 - Individual and communal recycling of wastes
 - Any other matters that demand local regulation to achieve and maintain a clean and healthy environment.

3.6 The World Bank Environmental and Social Framework

The 10 World Bank ESS and their application to the components and subcomponents of the CERHSP AF1 & AF2 is outlined in the following.

ESS1: Assessment and management of environmental and social risks and impacts

Environmental and social risks are, above all, the result of the existing political context in the project area, assessed under ESS1. This includes risks resulting from:

- Intra-communal tensions over implementation issues
- Assets and staff becoming targets of violent groups.

Violence (political, criminal, ethnic, etc.) and SGBV are two areas of escalating social risks. Potential adverse environmental impacts related to ESS1 are expected to be limited, site-specific, and reversible. These impacts are expected to fall within one or more of the following categories:

- Provision, transport, storage, use and disposal of medicines and vaccines
- Medical waste management
- Workers' health and safety

- Community health and safety
- Rehabilitation of public health facilities.
- Safety of potable water
- Wastewater disposal
- Indoor air quality
- Lack of efficient material usage (e.g., energy, water, etc),
- Existing soil or ground water contamination

The severe flooding that started in May 2021 and continued for most of 2021 and into 2022 affected the health and nutrition infrastructure, water sanitation and hygiene (WASH) infrastructure and cold chain equipment. The repair work likely ranges from minor to major, and will be determined through specialized assessments, costing and prioritization for support. The repair works will target rehabilitation of WASH in health facilities, including safe water supply, given the extensive contamination of ground water caused by flooding and open defecation and disposal practices, wastewater disposal, solid waste disposal, and medical waste disposal. Based on the assessment findings, advice will be shared with the county and state authorities to highlight the necessary improvements to the design of health and nutrition facilities. Most of the health-care facilities that are to be funded as a continuation of previous projects have a site-specific Medical Waste Management Plan (MWMP) in place as part of the health facility micro-plan. The key gaps in implementation include the lengthy process involved in securing government approval for the disposal of medical waste and related capacity gaps at state level. This includes installation of solar-powered appliances, the use of batteries for power storage and the need for a disposal plan for batteries.

Ensuring access to vaccines for the most vulnerable is vital, and the targeting methodology and logistical structure of vaccination programmes need to take this into consideration. A global discussion on this is included in the WHO Framework for Allocation and Prioritization of COVID-19 Vaccination. Those considered vulnerable include:

- Homeless people and those living in informal settlements or urban slums, including internally displaced person and refugees
- Disadvantaged or persecuted ethnic, racial, gender and religious groups, and sexual minorities and people living with disabilities
- Low-income migrant workers, refugees, internally displaced persons, asylum seekers, populations in conflict settings or those affected by humanitarian emergencies, vulnerable migrants in irregular situations, nomadic populations
- Hard-to-reach population groups.

It is also important to conduct vaccine-tailored outreach activities to address the spread of misinformation and to ensure that the vaccination campaign is ring-fenced from political tensions in the country.

The application of ESS1 will consider the above categories into which different environmental and social risks falls. The findings from the assessment of risks and impacts will be used to inform mitigation measures. The mitigation measures are captured as updates in the following tools:

- An ESMF, which includes a MWMP
- A SGBV action plan
- A Labour Management Plan (LMP), including a worker's Grievance Redress Mechanism (GRM)
- A SEP, including a community GRM.
- Commitments with binding timelines, as have been agreed with the Implementing Partners (IP), are included in the Environmental and Social Commitment Plan (ESCP).

ESS2 Labour and working conditions

ESS2 encompasses the occupational health and safety (OHS) of health system workers, and the overall security of workers. The project encompasses direct project workers, contracted workers as members of the IPs (NGOs) and short-term contracted workers for the rehabilitation works of the facilities following the large-scale flooding that took place in 2021. Incentivized civil servants are not subject to the LMP and will remain subject to the terms and conditions of their existing public sector employment agreement. OHS provisions, with a focus on infectious diseases in health facilities, as well as rehabilitation works, will be implemented for all workers, and included in the ESMF. This includes the provision of personal protective equipment (PPE), adequate health waste management, and precautions against accidents and pollution during the rehabilitation works, as detailed in the standards of care etc. More differentiated are provisions related to security, which also depend on the familiarity and integration of workers into local areas, ranging from international to national, to local personnel. Provisions are included in the project's security management plan, which outlines provisions for workers, as well as requirements for organizations, including support and referral structures in case of incidents, insurance claims, etc. A worker specific GRM allows workers to raise their concerns.

ESS3 Resource efficiency, and pollution prevention and management

Medical and chemical waste from COVID-19-related activities (i.e., medications, vaccines, clinical supplies, and medical equipment) can significantly impact the environment and human health. The severe flooding in 2021 affected the health and nutrition infrastructure, WASH infrastructure and cold chain equipment. The scope of the rehabilitation works will be determined through specialized assessments, costing and prioritization of support. The repair works will target rehabilitation of WASH in health facilities, including ensuring a safe water supply following the extensive contamination of ground water from flooding, open defecation, and disposal practices; improved climate-resilient toilets; wastewater disposal; solid waste disposal; and medical waste disposal. The wastewater disposal must meet applicable requirements e.g., onsite treatment, discharge to sanitary collection, discharge to water bodies and as applicable separate waste collection system in health care facilities and pre-treatment prior to disposal/discharge. The provision of sustainable and reliable potable water to health facilities is critical to the reduction in risks of using contaminated service water for drinking.

Pollution prevention and management will therefore be an important activity under the project. Shifting to use of solar power in health facilities will be promoted, to cut down use of fossil fuel-powered generators. However, the use of backup power generators will still be associated with

pollution risks, hence, relevant mitigation measures will need to be put in place as part of the health facility micro-plan. Medical waste, including chemicals, contaminated PPE and equipment, and laboratory testing kits from health-care facilities will need to be safely stored, transported, and disposed of. During transportation of goods or supplies, including delivery, handling and storage of vaccines, there are additional risks of COVID-19 being spread by drivers, and, of traffic accidents occurring. Waste generated from laboratories, screening posts and treatment facilities could include contaminated waste (e.g., blood, body fluids, or other contaminated fluids) and infected materials (e.g., used water, laboratory solutions and reagents, syringes, bed sheets, and most of the waste from laboratories and isolation centres, etc.) require special handling and awareness, as they may pose an infection risk to health-care workers. Proper sustainable management of medical and hazardous waste is constrained by limited access to the appropriate infrastructure, facilities and specialized companies for collection and treatment that operate in the country. Each site has a simple site-specific micro-plan which considers the features of each facility and catchment area and population. In the micro-plan all, potential environmental risks are identified, and mitigation measure specified including the availability and functionality of all waste management systems including Medical Waste Management Plan (MWMP).

ESS4 Community health and safety

Key community health and safety issues relate to:

- Infectious diseases
- Security and safety of services and beneficiaries including mitigation against GBV and Sexual Exploitation and Abuse (SEA)
- Infrastructure and equipment design and safety including Improvements to the design of health and nutrition facilities based on the assessment of the impact of flooding and other climate-related events.
- Emergency preparedness and response

The project follows WHO guidelines in terms of management of COVID-19-related risks of infection. This includes the preparation of related management plans (e.g., limiting exposure in closed rooms, social distancing, etc.) as well as the use of PPE and the application of other infection prevention and control including sanitation and hygiene. It also needs to proactively address stigma, to ensure that PPE is being used consistently. General safety provisions for the vaccination campaign need to be in place, e.g., the single use of needles, sterile environments, effective cold chains, monitoring of vaccine expiration dates, etc.

Effective waste management will be also relevant, including for materials used in vaccination campaigns, such as needles. The pervasiveness of SGBV and SEA in South Sudan is a significant challenge. In combination with project-related activities, SGBV is a risk during the provision of services. The project adopts a robust approach to address potential SGBV risks; including site-specific assessments of the availability of referral systems and their establishment if they are found to be insufficient. The project also includes capacity-building and training of relevant stakeholders, with a focus on primary health facilities and community-based services. Risks will be monitored throughout the project's implementation, through regular reassessment with the risk screening tool,

particularly as new project locations are determined, and through regular monitoring. A SGBV action plan has been prepared, and its implementation is a requirement in the ESCP.

ESS4 also covers the issue of security. It is not envisioned that project-specific security will be hired, hence the respective requirements under ESS4 on security personnel is not relevant. However, the high contextual risk threatens public health facilities and thus also beneficiaries. Specific provisions are included in the security management plan, but in general security measures focus strongly on stakeholder engagement and close coordination with local institutions and provisions on engagement with weapon-bearers. This allows timely reaction, including the temporary closure and evacuation of facilities if necessary. It must be noted that a significant residual risk remains for both communities and for the project.

Emergency preparedness and response will include establishment of a funding mechanism for eligible emergency/ humanitarian situations when they do arise while at the same time investing in the Identification and support to resilient systems for health with particular focus on integrated community systems, community engagement and planning. Such a mechanism include having a project component on contingent emergency response.

ESS5 Land acquisition, restrictions on land use and involuntary resettlement

This is not currently relevant, as no construction activities, other than minor repairs of existing facilities, will be financed.

ESS6 Biodiversity conservation and sustainable management of living natural resources

In response to the unprecedented flooding in 2021, varying levels of construction or rehabilitation activities are expected as part of the CERHSP AF1 & AF2 project that could affect protected areas, or flora or fauna. However, if supplies transportation, or medical and chemical waste are not properly disposed of, they can impact living natural resources. Appropriate mitigation measures will be built into agreements with IPs, contractors, and subcontractors. The enforcement of proper solid waste, wastewater and medical waste disposal will similarly be strengthened. Hence, the likely impacts of the project on natural resources and biodiversity will be minimized.

ESS7 Indigenous peoples/sub-Saharan African historically underserved traditional local communities

ESS7 applies to all beneficiaries of the project area, as assessed earlier by WB, in line with the application of OP 4.10. As such, no indigenous peoples' plan is required, and the social assessment applies to all beneficiaries. Many health facilities have been mapped to enable the selection of NGO partners. The selection process will consider ethnic sensitivities. The expressions of interest stipulate that each NGO partner has to: (1) show understanding of the local context and conflict sensitivity risks, which differ from county to county and within different groups, and demonstrate the ability to translate contextual understanding into effective interventions, including community engagement; and (2) outline access constraints and security considerations, and how the NGO will manage these, while integrating conflict sensitivity into the proposed interventions. The poor and underserved will remain central to the project, with the restoration of services in the areas most affected by the conflict that are consequently the least provided for. Monitoring will assess the

coverage and inclusiveness of health service provision and thus provide information that will constitute a basis for corrective actions, if necessary. The BHI enables adequate outreach to local communities in culturally sensitive ways, ensuring avoidance of discrimination in the provision of benefits, which will be provided culturally appropriately, and adapted to the respective needs and structures of the vulnerable groups involved.

ESS8 Cultural heritage

This is not currently relevant, as no new construction activities will be financed by the project.

ESS9 Financial intermediaries

This is not currently relevant, as no financing will be provided for financial intermediaries.

ESS10 Stakeholder engagement and information disclosure

Stakeholder engagement is essential in this project, due to the contextual risks resulting from political and communal violence, where it is important that project activities can be updated in real time to changing conditions. At the same time, this context does not allow for more traditional, stable stakeholder engagement structures, but instead needs to be more proactive and adjustable. The project will strengthen the approach established in the previous project to engage with stakeholders based upon meaningful consultation and disclosure of appropriate information, considering the specific challenges associated with COVID-19, including the vaccination campaign. Where there is likely to be more vulnerable groups (such as the elderly and those with compromised immune systems or related pre-existing conditions) present, stakeholder engagement shall minimize close contact. People affected by the project's activities shall be provided with accessible and inclusive means to raise concerns and grievances

At the centre of community engagement, including outreach to vulnerable peoples, is the BHI as a local health committee, supported by the project, which establishes strong linkages between primary health facilities and the local communities to identify people in need, as well as any potential grievances. A challenge for BHI is security as well as the effects of COVID-19, which are normally first felt by BHI.

Recent experience has been that, to ensure a smooth operational environment, close consultation with local government structures, as well as informal institutions such as elderly and youth groups is important. This is particularly important in terms of employment opportunities and the security of project structures. Specific provisions must be included in relation to the COVID-19 vaccine roll-out. Global and regional experiences have highlighted the importance of outreach activities in relation to the pandemic. This can counteract rumours, misinformation and stigma around the disease, inform the public about the mitigation measures being taken, and about the vaccine. This will ensure the collaboration of communities in the fight against the pandemic. Also, as noted above, as the vaccine campaign will be rolled out with support by UNICEF nationally, it will be important that proportionally efficient and effective provisions are in place beyond Jonglei, Unity and Upper Nile. The project includes GRMs that have been operational for a long time already under the predecessor project, which is sensitive to SGBV, as well as accessible for vulnerable people. Respective details are outlined in the SEP of the project.

Given the unprecedented flooding of 2021 and 2022, rehabilitation works for health and nutrition activities will be initiated or scaled up. The project will also apply the Environmental, Social, Health and Safety (ESHS) requirements in Appendix D, which are aligned to the following guidelines and Good Practice Notes:

- WB Environmental Health Safeguards (EHSG), for health-care facilities
- WB EHSG General, which is related to any rehabilitation works.

3.7 World Bank interim guidance on covid-19 considerations

WB has issued an interim guidance note for its projects. The projects will comply with the [WB EHS for health-care facilities](#) and the [WB EHSG General](#) related to any rehabilitation works. The note contains links to the latest guidance for health and safety measures related to COVID-19 vaccination and case management.

3.8 World Bank technical note on public consultations and stakeholder engagement

Due to the issues arising from face-to-face consultations associated with the COVID-19 pandemic, WB has prepared a technical note on public consultations and stakeholder engagement in WB-supported operations. This technical note has been taken into consideration when implementing the SEP.

3.9 UNICEF's Environmental and Social Standards

UNICEF developed ESS in 2019. These ESS, while still in draft, are already being applied, with initial experiences being used to finalize the framework. The UNICEF ESS sets out the basic tenets that guide and underpin UNICEF's approach to the ESS. At the programme and field levels, SES 1–8 are designed to help manage and improve UNICEF's social and environmental performance through a risk and outcome-based approach:

- SES 1: Labour and Working Conditions
- SES 2: Resource Efficiency and Pollution Prevention
- SES 3: Community Health, Safety and Security
- SES 4: Land Acquisition/Displacement and Involuntary Resettlement
- SES 5: Biodiversity Conservation and Sustainable Natural Resource Management
- SES 6: Indigenous Peoples
- SES 7: Cultural Heritage
- SES 8: Climate Change and Disaster Risks.

Given UNICEF's unique mandate, issues related to children's rights, disability rights and gender equality are mainstreamed into each of the eight SES.

The UNICEF ESS is broadly consistent with those of the WB ESF and ESS. Key linkages between the WB ESF and UNICEF's ESS and the supporting frameworks, strategies and policies are described below as they relate to environmental sustainability for children, SGBV, prevention of

exploitation and abuse, GRM, child labour, disease outbreaks and emergencies, and security and significant event management.

Environmental sustainability for children

UNICEF issued the Strategic Framework on Environmental Sustainability for Children (2015–2017), which is designed to significantly strengthen UNICEF’s policy, programmes, advocacy, research, and engagement on environmental sustainability, to deliver better results for children, especially the most disadvantaged. Its priorities for 2016–2017 were to:

- Strengthen UNICEF’s policy and guidance on environmental sustainability as a cross-cutting issue
- Strengthen the inclusion of environmental sustainability in UNICEF programming
- Advocate for the full recognition and inclusion of children in policy discourse on environmental sustainability
- Strengthen opportunities for children’s development and well-being, to allow them to benefit from environmental sustainability related public and private finance
- Incorporate environmental sustainability management into the organization.

Gender-based violence

UNICEF embraces and prioritizes gender equality and women’s and girls’ empowerment. Its Gender Policy (2021–2030) embeds gender equality as an essential element of the mandate of UNICEF, to promote the realization of equal rights for all children. Aligned to the Sustainable Development Goals, this policy commits UNICEF to a bolder and more ambitious vision for gender equality and the empowerment of all children, adolescents, and women. It mandates that UNICEF goes beyond simply responding to the manifestations of inequality, and instead works actively to remove the underlying structural barriers – such as harmful social norms and gendered power systems – that perpetuate inequalities. This transformative, values-based approach, which simultaneously empowers disadvantaged children, adolescents and women, positions gender equality as fundamental to child rights and seeks to chart a clear path towards a more just, equitable, empathetic and inclusive world for all. UNICEF, along with its partners, will undertake to identify SGBV risks and bottlenecks for women, girls, children and their caregivers, and to undertake further advocacy. This will ensure safe and meaningful access for vulnerable women and girls, who face restrictions and SGBV risks, while accessing basic services.

WB ESS4: Community health and safety was used to inform the development of a GBV action plan for the CERHSP project. UNICEF’s Health and Child Protection programmes and the respective IPs will work closely together to ensure an integrated approach to improving the well-being and safety of women, adolescents, and children, by administering clinical management of rape services and improving access to and provision of confidential and sensitive health services to survivors of all forms of SGBV. In addition to implementing essential, life-saving interventions, this will entail: building the capacity of front-line health and community workers, and local partners to deliver appropriate maternal and neonatal care messages; and generating demand for and drive towards social behaviour change, including during emergencies. Clinical management of rape services, including psychological first aid, will be scaled up to ensure health workers are not only able to provide the appropriate clinical services for survivors of GBV, but can also deliver care in a safe, confidential, and survivor-centred manner.

Prevention of sexual exploitation and abuse

UNICEF ensures that all its personnel in South Sudan are aware of the protection from sexual exploitation and abuse (PSEA) policies and the behaviour that is expected of them. It is the country offices' responsibility to ensure that all UNICEF personnel are aware of PSEA policies and that these are readily accessible and visible to everyone in the office. A PSEA information package has been developed, which includes all essential PSEA-related information. This is provided to all staff members as part of their inductions. This is also displayed in the country office.

UNICEF ensures that all partners, extenders, contractors and entities in a contractual relationship with UNICEF are expected to abide by the Secretary General's Bulletin. Given the critical role that UNICEF's partners and contractors play in programme implementation, UNICEF invests in capacity-building for those partners that do not have adequate capacity on PSEA. UNICEF's standard programme cooperation agreement (PCA) with IPs includes prohibitions of sexual exploitation and abuse (SEA) by vendor personnel. UNICEF's new standard terms and conditions of the contract with vendors include prohibitions of SEA by vendor personnel that align with the contract provisions used by United Nations Secretariat offices. These provisions will apply to corporate or institutional contractors (individual contractors and consultants are addressed in UNICEF's recruitment procedures).

UNICEF has developed and implemented a country office report mechanism that includes a community-based complaint protocol. All complaints should be reported verbally or in writing to their Head of Office (Representative, Regional Director, Division Director (or that person's supervisor if the Head of Office is not appropriate) or directly to the Office of Internal Audit and Investigation integrity1@unicef.org. This information on SEA reporting will be posted by the selected IPs at all health and education facilities. As part of standard UNICEF training for IPs, the expectation that IPs will cascade training to their employees, so they understand their role in reporting potential cases as per the contractual obligations in PCAs, which includes IPs to comply with of the Secretary General's Bulletin (ST/SGB/2003/13). All SEA cases are treated with strict confidentiality, this is included in the training package for the Implementing Partners (IPs).

Grievance Redress Mechanism

UNICEF has developed and implemented a country office protocol community-based complaint mechanism: the GRM. A detailed description of the GRM is given in the CERHSP SEP. The mechanism enables all complaints to be reported verbally or in writing to: designated PSEA focal persons; Chiefs of Field Offices; Country Representatives; via phone (+211 920 111 333 [English] or (+211 920 111 888 [Arabic]); or via email: SSD_PSEAinfo@unicef.org. This information will be posted by the selected IPs at all health facilities.

Community engagement and social accountability will also be fostered at the local level through community feedback mechanisms (e.g., BHI). The Chiefs of Field Offices and the Chief of the Health Section at UNICEF will have overall responsibility for addressing concerns brought to the attention of the field office health focal point regarding any environmental and/or social impacts resulting from subproject activities.

Complaints received through any of the above routes will be recorded and documented in the project file and progress reports from UNICEF to WB will include the number and type of complaints, and the results of their resolution. Responsible staff will ensure that complaints and questions are registered, tracked and promptly resolved. Through UNICEF's Communication for Development Section and Field Operations Section, the Health Section will coordinate with local field staff and local government officials and community leaders to ensure prompt follow-up action in response to complaints received.

Child labour

In line with WB ESS2: Labour and working conditions and WB ESS4: Community health and safety, UNICEF projects with IPs forbid engaging children in child labour and will therefore ensure that no children engage in project-related work that could negatively affect their health and personal development or interfere with their compulsory education.

Emergency preparedness

ESS3: Resource efficiency and pollution prevention and management; ESS4: Community health and safety; and ESS10: Stakeholders engagement and information disclosure cover elements of effective emergency response. UNICEF will ensure that IPs, in collaboration with appropriate and relevant authorities and third parties (e.g., WHO/Health Cluster), will be prepared to respond to emergency situations in a manner appropriate to preventing and mitigating any harm to people and/or the environment. The emergency preparedness and response activities will be periodically reviewed and revised as necessary to reflect changing conditions. In accordance with ESS1: Assessment and management of environmental and social risks and impacts, UNICEF will consider the differential impacts of emergency situations on women and men, the elderly, children, people with disabilities, and potentially marginalized groups, and strengthen the participation of women in decision-making processes on emergency preparedness and response strategies. Appropriate information about emergency preparedness and response activities, resources, and responsibilities will also be shared with affected communities, in line with UNICEF's Accountability to Affected Populations framework⁵ and ESS10: Stakeholder's engagement and information disclosure.

While this ESMF is aligned with the relevant South Sudanese national legislation, policies and guidelines, the WB ESF, as well as UNICEF's draft SESSP/ESS⁶ will apply as national legislation is less stringent on most of the issues.

3.10 Summary description of General Environmental Health and Safety (EHS) guidelines and EHS guidelines for Health Care Facilities

The General Environmental Health and Safety (EHS) Guidelines offers guidance on the management of environmental, Occupational Health and Safety (OHS), Community Health and Safety (CHS), and construction ad related issues. The Environmental issues include Air Emissions

⁵ Details of the UNICEF approach to Accountability to Affected Populations can be found in the project Social Assessment Report.

⁶ UNICEF's Environmental and Social Standards is in its finalization phase and is currently a draft document.

and Ambient Air Quality; Energy Conservation; Wastewater and Ambient Water Quality; Water Conservation; Hazardous Materials Management; Waste Management; Noise; and Contaminated Land. The OHS issues include Occupational Health and Safety; General Facility Design and Operation; Communication and Training; Physical Hazards; Chemical Hazards; Biological Hazards; Radiological Hazards; Personal Protective Equipment (PPE); Special Hazard Environments; and Monitoring. The CHS issues include Water Quality and Availability; Structural Safety of Project Infrastructure; Life and Fire Safety (L&FS); Traffic Safety; Transport of Hazardous Materials; Disease Prevention; and Emergency Preparedness and Response. Construction and Decommissioning affects the Environment; Occupational Health & Safety; and Community Health & Safety.

The EHS Guidelines for Health Care Facilities include information relevant to the management of EHS issues associated with health care facilities (HCF) which includes a diverse range of facilities and activities involving general hospitals and small inpatient primary care hospitals, as well as outpatient, assisted living, and hospice facilities. Ancillary facilities may include medical laboratories and research facilities, mortuary centers, and blood banks and collection services. Environmental issues associated with HCF include Waste management, Emissions to air, and Wastewater discharges. OHS Industry specific hazards include Exposure to infections and diseases, Exposure to hazardous materials / waste, Exposure to radiation, and Fire safety. Community hazards associated with health care facility environments, particularly related to hazardous health care waste, necessitate that members of the public receive adequate information regarding potential infection hazards within the facility, and at associated waste disposal sites (e.g., landfills). Guidance on community disease transmission is provided in the General EHS Guidelines. Environment, OHS, and CHS include performance indicators and industry specific benchmarks for use in monitoring the application of the EHS guidelines for health care facilities.

4 ENVIRONMENTAL AND SOCIAL BASELINES

4.1 National overview

South Sudan is one of the most fragile, conflict-affected countries in the world, with less than 20 years of interspersed peace since 1955. After independence in 2011, a civil war broke out in the country in 2013, leading to widespread violence. The South Sudan civil war ended in September 2018, with the signing of the Revitalized Agreement on the Resolution of the Conflict in the Republic of South Sudan. This was cemented through a power-sharing agreement that led to the establishment of a Transitional Government of National Unity in February 2020. However, peace remains fragile, and implementation of several key provisions of the peace agreement – including those related to unification of the armed forces of the different factions, disarmament, demobilization, reintegration of ex-combatants, and other measures related to displaced peoples, public financial management, and transitional justice – remains slow or stalled.

South Sudan remains one of the poorest countries in the world, with over 80 per cent of people estimated to be living in poverty in 2019. Since 2013, nearly half of urban households have experienced unemployment. Conflict and violence triggered the breakdown of food production

and worsening of food insecurity. Women and girls face a disproportionate burden of poverty, poor access to services and insecurity. South Sudan has the world's highest maternal mortality rate and a third of all women experience sexual violence by a non-partner in their lifetime. South Sudan has the highest proportion of children out of school. Youth comprise 70 per cent of the population; most of these are unemployed.

The country faces one of the world's worst multidimensional crises. The 2023 South Sudan Humanitarian Response Plan (HRP) will target 6.8 million people out of the 9.4 million people in need of humanitarian assistance, including internally displaced persons (IDPs), returnees and vulnerable host communities/non-displaced people in South Sudan. Some 7.6 million people in 66 of the 78 counties will experience extreme need and 1.7 million people in 10 out of the 78 counties will be in severe need. The Upper Nile and Western Equatoria states will contain the highest number of counties in critical need. The country ranks 172 out of 174 countries on the WB 2020 Human Capital Index.

South Sudan is highly dependent on oil, which is estimated to account for more than one third of South Sudan's gross domestic product (GDP), 90 per cent of central government revenue, and over 95 per cent of the country's exports. The civil war has also resulted in decreased oil production, which plunged the oil-rich and oil-dependent country further into economic crisis. South Sudan's per capita GDP dropped from US\$1,111 in 2014 to less than US\$200 in 2017. The COVID-19 pandemic and resulting reductions in oil production have resulted in a projected 3.4 per cent contraction in South Sudan's economy in fiscal year 2020–2021.

The contraction follows real GDP growth, estimated at 9.3 per cent in fiscal year 2019–2020, which pointed towards economic recovery following a crisis spurred by economic management challenges and the civil war. Recent estimates indicated an accumulated loss in real GDP per capita of US\$7,070 between 2012 and 2018 and aggregate GDP losses of US\$ 81.1 billion over the same period. Oil production is not expected to improve until 2022–2023, which, along with economic mismanagement, threatens to compromise economic recovery. Monetization of the fiscal deficit led to soaring inflation, adding to an economic crisis, with output contracting and widening the exchange rate premium, and cutting into the ability of civilians to purchase food and other staples.

SGBV remains a severe life-threatening problem affecting the physical safety and well-being of women and children in South Sudan. Studies conducted in 2016 by International Rescue Committee and partners indicate that some 65 per cent of women and girls have experienced physical and/or sexual violence in their lifetime, 51 per cent have suffered intimate partner violence and 33 per cent of women have experienced sexual violence from someone other than a partner, primarily during attacks or raids. Most girls and women experience sexual violence for the first time below the age of 18 (International Rescue Committee, 2017).

Child marriage practices are also common throughout South Sudan. In South Sudan, SGBV is rooted deeply in harmful social norms anchored in patriarchal traditions, such as strict gender roles and identities, patriarchal authority, women's low social status and power imbalance. This results in women's limited access to decision-making and reproductive rights, poverty, inequality in employment or education, and discriminatory practices. With overall reduced access to health

service by population, clinical management of rape services, including even the most basic SGBV services are also limited, ad hoc and severely compromised by a lack of the skills needed to deliver an effective response.

Displacement of populations is common throughout South Sudan. While some displacement is short in duration, in response to specific triggers, other patterns of displacement have become entrenched. Upper Nile, Unity and Jonglei have traditionally been the most volatile states, with displacements (temporary and more entrenched) occurring due to conflict, intercommunal violence and climate events (e.g., floods) occurring on a regular basis. For example, in the Malakal Protection of Civilians (PoC) programme, United Nations Mission in South Sudan (UNMISS) provides security, while other United Nations organizations such as UNICEF, the World Food Programme and the Food and Agriculture Organization of the United Nations provide services in nutrition, health, WASH and food security, with supplementary support from civil society organizations. Service provision is inadequate due to large numbers and inadequate funding. The Malakal PoC currently shelters around 34,000 internally displaced persons. Health services are being provided at primary health care (PHC) level by the International Organization for Migration and the International Medical Corps, which runs a primary health-care centre (PHCC) providing comprehensive services. Whilst secondary health care is provided by Médecins Sans Frontières' hospital, the International Medical Corps's reproductive and surgical centre inside the PoC site equally ensures adequate coverage for complicated deliveries and acute surgical emergencies. All of these are conducted with technical and in-kind support from UNICEF, United Nations Population Fund and WHO. However, unlike the PoC, Malakal town is striving to access quality health care with three under-equipped health facilities and a non-functional hospital. Despite the reopening of the paediatric hospital, referral of complicated cases remains the biggest challenge. Currently, the entire town depends on the PoC site for obstetric and surgical emergencies.

Community concerns about the ethnicity of humanitarian and development workers has always been a feature in South Sudan. Some communities are sensitive to certain international ethnicities, as well as domestic ethnicities working in their communities – often these issues are linked to economic hardship and lack of opportunity. In the past 1.5 years, there has been a marked increase in communities becoming organized to issue edicts and cause service disruptions related to the ethnicity of workers providing services. Health-care workers are perceived as being 'imported' from other tribes. Sensitivity to the ethnicity of health workers is particularly high in Upper Nile, Unity and Jonglei states and GPAA. Partners therefore need to sensitize local communities about why they may need to bring skilled staff from elsewhere, if qualified staff (such as clinical officers and midwives) are not available for local recruitment. Partners also need to make efforts to recruit unskilled local workers as much as possible (e.g., cleaning staff). This is particularly the case in areas where young people are unemployed and there is a lack of employment opportunities.

Flooding, violence, food insecurity and COVID-19 continued to increase humanitarian needs in the first half of 2021. The Office for the Coordination of Humanitarian Affairs estimates that 380,000 people have been affected by flooding in six states since May, with Jonglei and Unity the worst affected. According to the Office for the Coordination of Humanitarian Affairs, humanitarian access to people in need worsened between April and June 2021. A total of 188 access incidents were reported in the second quarter, a 15 per cent increase from the 163 reported

during the same period in 2020. The increase is attributed to a surge in attacks against humanitarian staff and assets and continued active hostilities and subnational violence, particularly in Eastern and Central Equatoria and Jonglei. Over half of all incidents in the reporting period took place in these three states. Violence against humanitarian personnel and assets more than doubled, from 52 to 111 reported incidents in the second, compared with the first quarter of 2021. Four aid workers were killed between April and June, bringing the total, since the conflict broke out in 2013, to 128.

Since May 2021, widespread, increasing and continued flooding – intensified by climate change – has continued to impact people across South Sudan. More than 835,000 people were reported to be affected by flooding in 33 of 78 counties, as of end the of December 2021. Jonglei, Unity and Upper Nile remain the worst impacted states, with some 80 per cent of the total cumulative number of affected people living in these states. Jonglei is the hardest hit with 305,000 people affected, followed by Unity, with 220,000 people affected, and Upper Nile, with 141,000 people affected.

Homes, nutrition and health facilities, water sources, schools and markets are submerged, impacting people’s access to essential services, eroding their coping mechanisms, and exacerbating their vulnerability.

Persistent roadside ambushes have had serious consequences for civilians and aid workers. These incidents severely impact pre-positioning of humanitarian supplies. More than US\$1 million worth of supplies and assets were looted and destroyed during armed attacks in the GPAA alone in May, impacting the delivery of humanitarian assistance. Looting is widespread across the country, often impacting on health facilities and other essential services in communities.

4.2 Jonglei, Upper Nile, and Unity states

Jonglei and Upper Nile are historically among the most conflict-affected states in South Sudan, receiving the least investment in infrastructure, and being the most difficult to access physically. As parties to the conflict have largely respected the revitalized peace agreement, contrarily, there has been a marked increase in the level of intercommunal violence. There is still a high degree of inter- and intracommunity violence, cattle raids and crime that has ravaged local and displaced populations. It is recognized that the Government of South Sudan has the primary responsibility to provide security to all communities. However, with limited resources and in the current political environment, incidents against communities and those conducting humanitarian activities occur regularly.

Jonglei and Upper Nile states are in the north-east of South Sudan and, along, with Unity state, were the hardest hit when the Sudanese People’s Liberation Army (SPLA)/ Sudanese People’s Liberation Army in Opposition (SPLA-iO) conflict spread from Juba in late 2013. Diverse ethnic populations characterize the two states. In Upper Nile, the three largest groups are the Shilluk, Nuer and Dinka, while in Jonglei they are the Dinka, Murle, Nanyak and Lou Nuer. Communal conflict has occurred between and within all these groups in recent years. Pastoralism is widely practiced in the region, which results in entire families or sections of families moving with their herds of livestock (mainly cattle) as well as for agricultural purposes. Pastoralists are highly mobile and adaptive to changing contexts associated with the availability of water, land and cattle grass, as well as inter- and intracommunal conflicts. Subsequently, most ethnic groups living in Jonglei

and Upper Nile (e.g., Dinka, Nuer, Murle) are nomadic or semi-nomadic in nature, with the Shilluk being amongst the most sedentary. Subsequently, this means that an agile mix of PHC delivery is required in rural areas of the project. That is, community-based approaches, whereby trained community health workers move with and provide basic health education and services to their communities; and mobile outreach services that reach pastoral communities with wider service provision when access permits.

The populations of Jonglei and Upper Nile are among the largest of all the states in the country. The populations in 2018 (as projected in 2015) were 1.44 million (Upper Nile) and 1.94 million (Jonglei) (National Bureau of Statistics, 2015). However, a recent study estimates that, of the approximately 382,900 excess deaths that have taken place in the country due to the conflict and accompanying socioeconomic crisis, 65,600 have taken place in Jonglei and 19,900 in Upper Nile (London School of Hygiene and Tropical Medicine, 2018). The two states have also suffered major displacement and, in May 2017 there were 428,000 internally displaced people in Jonglei and 277,400 in Upper Nile. Upper Nile was also home to about 137,000 refugees at the Maban camps (United States Agency for International Development, 2017). There are no statistics available on how many people from the two states are displaced elsewhere in South Sudan or across borders as refugees, but this is likely to be several hundred thousand. This makes performance monitoring difficult, because of the challenge of determining accurate numbers of people within the catchment areas reached with health services.

Most communities in Jonglei depend on agriculture for their livelihoods and, including agropastoralism and pastoralism, it provides more than 80 per cent of domestic employment (Food and Agriculture Organization of the United Nations, 2017). Cattle raiding and inter-ethnic clashes have historically been observed in Jonglei, particularly when the Lou Nuer, whose land was often affected by droughts, migrated to the territories of other ethnic groups, in search of water and pastureland for cattle grazing (Rands and LeRiche, 2011). Lack of dependable livelihood is a particular vulnerability for the Nuer. Areas where migrants and hosts confront each other often became conflict sites (Omondi, 2011). Migration of the Lou Nuer has been a constant trigger for inter-ethnic clashes in Jonglei and, over time, this has gradually sharpened hostilities between the groups. The clashes often occur when one ethnic group enters the territories of others, competing for scarce resources, such as land and water, which are necessary for cattle grazing. Deaths and child abductions have resulted from cattle raids; cattle being prized sources of wealth and sustenance for many pastoralist communities in Jonglei (South Sudan Bureau of Statistics, 2008, 2010, and 2014). The state lies along the Nile river and experiences seasonal flooding, which typically occurs between August and October each year, affecting low-lying areas. Periodically, the state experiences drought, which also affects crop production and, subsequently, food security in the area and can create competition for resources among various groups.

Upper Nile has become one of the most marginalized and impoverished regions in South Sudan because of the presence and activities of militias and harsh environmental conditions. Agriculture is the primary economic activity in Upper Nile, where people are nomadic agropastoralists that engage in both agriculture and the rearing of livestock, primarily cattle. Despite the number of private industry-based oil drilling sites in Upper Nile, the region remains extremely poor, with negligible service levels in basic development indicators such as education, health, sanitation and

access to clean drinking water. Upper Nile's dominant tribe is the Shilluk, but it also has residents from the Nuer and Dinka groups, the Bari-speaking groups, as well as Arabs. After years of war and instability, many areas of the state's border with the Gambella region in Ethiopia are prone to security issues and are dominated by armed groups, unresolved intercommunal disputes, multiple waves of displacement, and competition for land, water, services and citizenship. During the dry season, local water sources dry up and the area's various ethnic groups, including the Nuer-Lou, Nuer-Jikany and the Murle, drive their cattle toward the Sobat and Pibor rivers in Akobo County. The seasonal concentration of cattle, combined with the multitude of tribes and armed groups in a small area, often results in increased tension and inter-ethnic fighting, continuing well into the rainy season.

In Upper Nile, the effects of the ongoing conflict continue to increase the risk of sexual violence against women and girls. Regular focus group discussions conducted in Malakal PoC have revealed incidents of sexual violence against women and girls as they go out of the PoC site to fetch firewood and other supplies. In Jonglei, particularly in Pibor region, women and girls continue to experience GBV including sexual and physical violence during cattle raiding. The Murle – a Nilotic ethnic group inhabiting Pibor county and the Boma area in Jonglei State – are nomadic and associated with cattle raiding. Women fear being kidnapped by other Murle clans or other ethnic groups who wish to take them as their wives. The Murle also abduct children. This ethnic group therefore tends to live in hard-to-reach areas (deep remote rural areas), far away from towns, because they fear having their women and children kidnapped and/or fear having to give abductees back to those they have been kidnapped from.

Upper Nile and Unity states hosts 292,640 refugees (over 90 per cent) out of the total estimated refugee population of 333,673 in South Sudan. The refugees are from Sudan in both the case of Unity (South Korofan Refugees) and Upper Nile states (Blue Nile Refugees). The remaining 10 per cent of the population are spread in multiple locations in the Greater Equatorias and Jonglei. In Upper Nile, the refugees are concentrated in Maban, while in Unity state, the main concentration of refugees is in JamJang, Pariang county.

In Upper Nile, Maban county, the total refugee population is 176,372, constituting 35,070 households, while in the host community in Maban, the population is 91,980 (National Bureau of Statistics, 2022). More than half of the population is made up of refugees. About 67 per cent of the refugee population are women and children and, overall, the female population is 51 per cent. The refugee population is mainly in four locations: Kaya (27,325); Doro (73,072); Yusuf Batil (53,569); and Gendrassa (20,485). The high refugee population puts strain on the existing services and the host communities often feel overlooked by the support provided to refugees. In Maban, the pressure on existing services has been a source of tension, and has triggered numerous incidents in the past. Currently, Cordaid is supporting Maban hospital, the main referral facility in the area, but the funding from multiple donors is declining. UNICEF, with funding from WB, is supporting nine PHC facilities in Maban. It is also, with funding from other donors, running a Community Management of Malnutrition (CMAM) programme in Maban. Despite ongoing support, the needs

of the refugee community and the sharing of the health services with host community, are putting pressure on existing services. There is a need for stronger partnerships to support different components of health and the CMAM programme (i.e., severe acute malnutrition, moderate acute malnutrition), integration, acceleration and scaling-up of health and nutrition interventions for both host community and refugees in communities, PHC level and at hospital level. Given the current services delivery mode of operations by many of the partners in the county, health systems strengthening has been neglected. This is due to ownership and management of the service delivery in the county being, not in the hands of the State Ministry of Health (SMOH) and County Health Departments (CHDs), but in those of transient partners.

In the case of Unity's JamJang and Yida payams, the total refugee population is 125,404, constituting 24,840 households. The estimated population of Pariang county (which contains JamJang payam) is usually 144,575 (National Bureau of Statistics, 2022). About 84 per cent of the refugee population are women and children, and the overall female population in the area is 54 per cent. The population is mainly in three locations Yida (33,821), Ajuong Thok (46,024), and Pamir (45,423). The large population of refugees and the varying allocation of services between host and refugee populations has put strain on services and created tensions with the host communities. The population of refugees in JamJang and Yida payams (125,404) is close to the population in the entire county of Pariang (144,575). HPF is supporting delivery of integrated health services package in Pariang county including JamJang. UNICEF, with funding from other donors, is also running a CMAM programme in Pariang. Despite the ongoing support, the needs of the refugee community are outstripping the capacity of existing services.

In Maban and Pariang counties, a major shift to strengthening the capacities of the MoH, the SMOH and CHD, will address the need for the future sustainability of, not only these two counties, but in all supported states and counties in the country. To reset the delivery of services within a stronger health system and greater MoH and SMOH ownership in these two counties, there needs to be a specific assessment of the extent to which existing integrated health, nutrition and WASH service delivery approaches fulfill the needs of both the host communities and the refugee populations, while at the same time strengthening the MoH and SMOH structures.

4.3 Health sector overview

South Sudan's health-care system includes community, primary, secondary, and tertiary levels. Community health care is based at village level and is manned by community health teams. The health services should be free of charge, and accessible to the whole population at primary and secondary levels. In South Sudan's decentralized system, the national MoH provides policy guidance, leadership, funding, monitoring and evaluation, while at state level health-care delivery at other levels is overseen. The country has a partially functioning health management information system, because of the varied challenges resulting from the conflict.

South Sudan's health system faces enormous challenges, meaning that the country has some of the poorest health outcomes in the world. Under-five mortality is 91 per 1,000 live births; neonatal mortality is 39 per 1,000 births; and maternal mortality is estimated at 789 per 100,000 births. The country's health system is systemically underdeveloped. Seventy-one per cent of the population lives more than 5 km from a health facility. A significant disparity in health status across socio-demographic factors and geographical locations has been documented across numerous sectoral studies.

Core health service delivery indicators are lagging, for example, in WB-supported health project areas. As of 2018, only 23 per cent of mothers in Upper Nile state and 26 per cent of mothers in Jonglei state received at least one antenatal care visit by a skilled birth attendant during their last pregnancy. Similarly, only 17 per cent (Upper Nile) and 3 per cent (Jonglei) of children between 12 and 23 months received the diphtheria, tetanus and pertussis vaccine before their first birthday. These figures are based on vaccination records, however, this rises to 43 per cent in both states when relying on reports from parents. South Sudan lacks the basic PHC infrastructure to detect COVID-19 cases and contain the pandemic. As described by Kruk et al. (2015), PHC systems provide the backbone for responding to epidemics and other emergencies. South Sudan's PHC system is severely constrained, with major shortages of skilled human resources to respond to front-line health needs and serious infrastructure gaps. A 2019 Service and Availability Readiness Assessment conducted by WHO found that there were 1.42 facilities per 10,000 people, with only 20 per cent of health facilities occupying a permanent structure. Similarly, the Service and Availability Readiness Assessment found 6.3 health workers per 10,000 people (WHO guidance gives a target of 23 health workers per 10,000 people). Readiness to deliver basic services across facilities is only 37 per cent.

The states of Jonglei and Upper Nile have the highest percentage of non-functional facilities in the country. There were 345 functional health facilities in the two states, against the national total of 1,542 in 2020. Almost all facilities lack medical equipment, transport, referral mechanisms, communication, water, sanitation and power supplies. There are some positive trends; for example, the number of midwives with essential professional midwifery competencies has increased significantly since 2010, from eight in 2011 to over 600 (United Nations Population Fund, 2018). However, these are concentrated in specific areas. The health and nutrition indicators for Upper Nile and Jonglei remain the lowest nationally. Health-care workers are perceived as being 'imported' from other tribes. Sensitivity to the ethnicity of health workers is particularly high in Upper Nile and Jonglei states and GPAA. The poorly developed health infrastructure, limited access to health and nutrition services and the poor health outcomes could be a contributory factor to high level of resentment and hostility in communities against humanitarian and restoration programmes in the two states.

While government coordination capacity is weak, donor-financed health service delivery has become increasingly coordinated. The HPF – a consortium of financiers led by the United Kingdom's Foreign, Commonwealth and Development Office – finances health service delivery in eight of South Sudan's 10 states and two of the country's three administrative areas. WB finances health service delivery in the two remaining states and one administrative area (Pibor)

through the CERHSP. In most locations, health service delivery is managed by a contracting agency, Crown Agents in HPF areas and UNICEF and ICRC in WB-financed areas. The HPF and the current WB-supported CERHSP have aligned service delivery and monitoring approaches. While the consolidation of service delivery has helped to improve the consistency of delivery in the country, service delivery challenges remain, which include skilled health-care worker shortages, lack of infrastructure and nascent state-level governance structure.

Barriers to accessing health care among beneficiaries include lack of physical access, lack of good roads, lack of knowledge and information about the benefits of PHC, and lack of adequate community engagement when designing and implementing interventions. The poor state of roads quality/accessibility affects delivery of both personnel and drugs including vaccines. Several myths and misconceptions were noted, especially in Jonglei state. Some community members reported that vaccinations make women sterile, can lead to the early death of children, and are used by the United Nations and other agencies as a means of population control in South Sudan. Some Traditional Birth Attendants are seen as the ‘doctors’ in the community, despite a lack of knowledge. Traditional Birth Attendants therefore need to be informed and empowered to refer patients, especially emergency cases, in a timely manner. They also need to be empowered to combat myths and misconceptions (such as children needing to stay inside for 30 days after birth, which can be a barrier to babies receiving postnatal care).

South Sudan routinely experiences health emergencies. It also faces significant challenges in responding effectively, including ongoing conflict, flooding and many displaced people, combined with weak laboratory and fragile health service delivery systems, along with difficult terrain and poor infrastructure, which impede access and increase the costs of communication and surveillance efforts. With technical and financial support from development partners, the country has been expanding its capacity and infrastructure to respond to health emergencies. Currently, eight hospitals, 58 PHCCs and 125 PHC units (PHCUs) are supported under CERHSP. With AF, new health and nutrition facilities will be added to the existing facilities.

According to the Implementation Completion and Result Report (ICRR) for the PEHS project February 2019- February 2021, and its mid-term review, there were outstanding primary environmental safeguards issues related to occupational health and safety (including infection prevention and control, or IPC), on-site access to water and sanitation for health service delivery, and medical waste management. Out of the 190 health facilities assessed in 2019, 83% did not have medical waste management facilities, 41% had no toilets, and 88% had no sufficient water storage. At PEHSP completion reporting in 2022, the medical waste management capacities had improved with all facilities having good practices in place within the low-capacity environment including good COVID-19 IPC compliance. There were little improvements in water and sanitation situation.

As of October 2021 (quarter 7 Independent Monitoring of CERHSP), health infrastructure and service delivery units were assessed based on: the availability of outpatient departments, with distinct rooms for different services and age groups of clients; maternal child health, with distinct rooms for different services; outpatient treatment programme space, with distinct rooms for different services; maternity, with distinct rooms for different services; sterilization units, with distinct rooms for different processes; observation wards or rooms that provide services for 24

hours a day, seven days a week; latrines (for patients and staff), handwashing facilities at latrines and reliable power supply.

The quarter 7 assessment established minimal improvement due to inadequate investment in infrastructure, especially at the lower levels (PHCCs and PHCUs). This is because PHCU infrastructure is mostly funded by local authorities and communities, leaving the PHCUs with structures that are not safe for staff and clients/patients. Future projects should consider investment in infrastructure including at the PHCUs. Waste management and cleanliness were assessed in terms of the availability of facilities for waste disposal and cleanliness of the environment. Hospitals have continued to improve, with an 87.5 per cent score in terms of quality, compared with the baseline score of 58.3 per cent. The quality of waste management services at PHCCs is unstable at 65.3 per cent, while PHCUs scored 61.1 per cent.

4.4 COVID-19 pandemic

Since the first case of COVID-19 was reported in March 2020, reported cases and deaths are believed to be severely underreported, and data on COVID-19 deaths are limited. However, while efforts have been made to strengthen testing capacity, which is now decentralized, South Sudan's ability to detect COVID-19 cases is critically impacted by fundamental weaknesses in the country's health system capacity. As of 17 February 2022, over 90 per cent of COVID-19 cases were detected in the capital, Juba, Central Equatoria state (59 per cent) and in Ruweng Administrative Area (33 per cent). Most of the COVID-19 cases were found to be travellers, as they are systematically tested. The COVID-19 testing challenges are further amplified by the emergence of new variants of the virus and the reintroduction of global travel restrictions. As of 13 April 2023, over 4 million people had been vaccinated (66 per cent of people 18 years and above or 30 per cent of population). The full vaccination includes 83 per cent of the health worker, 25 per cent of refugee population and, 42 per cent of people with comorbidities. The procurement of 3.9 million additional doses vaccine using financing from the African Vaccine Acquisition Fund will stabilize the supply of the vaccine and allow for long-term planning and deployment.

5. ENVIRONMENTAL, SOCIAL AND SECURITY RISKS

This section summarizes key environmental and social risks, in line with the UNICEF-supported CERHSP AF1 & AF2 components and subcomponents, and guided by the harmonized application of the WB ESF, ESS and UNICEF ESS.

According to the Implementation Completion and Result Report (ICRR) for the PEHS project February 2019- February 2021, and its mid-term review, there were outstanding primary environmental safeguards issues related to occupational health and safety (including infection prevention and control, or IPC), on-site access to water and sanitation for health service delivery, and medical waste management. Out of the 190 health facilities assessed in 2019, 83% did not have medical waste management facilities, 41% had no toilets, and 88% had no sufficient water storage. At PEHSP completion reporting in 2022, the medical waste management capacities had improved with all facilities having good practices in place within the low-capacity environment including good COVID-19 IPC compliance. There were little improvements in water and

sanitation situation. The outstanding issues will be addressed under CERHSP project and its additional financing (AF1 & AF 2).

5.1 Environmental risks

Potential adverse environmental impacts are expected to be limited, site-specific, and reversible. The activities associated with the AF project will complement the positive impacts of the parent project by facilitating: COVID-19 containment; reducing COVID-19-related hospital admissions; vaccine procurement, deployment, and administration. The COVID-19-related actions are addressed under mitigation measures based on current guidance on integration of COVID-19 vaccinations into health-care systems, rather than as an exception to the systems.

The predicted environmental risks associated with the AF project include:

- The generation of additional COVID-19 related health-care waste in the form of sharps, swabs, and PPE.
- Infectious diseases risks including exposure to COVID-19 within health services platforms.
- OHS risks linked to health-care workers involved in handling and administering vaccines, those working in the health-care waste stream and logistical workers involved in the cold storage chain
- Risks and impacts from loss or spoiled vaccines due to a mismanaged vaccine cold chain and poor vaccine handling and transportation practices and vaccine expiries for various reasons.
- Community health and safety risks from the handling, transport, and disposal of vaccine-associated health-care waste
- Risks to a successful countrywide vaccination programme due to low demand related to COVID-19 vaccine hesitancy, or a refusal to receive the COVID-19 vaccine because of religious beliefs, traditions, or negative online influences.
- Infrastructure and equipment design and safety including Improvements to the design of health and nutrition facilities based on the assessment of the impact of flooding and other climate-related events.
- Emergency preparedness and response

The current plan is to increase the capacity of vaccine-related infrastructure (i.e., vaccine centres, additional storage) either by construction or renovation of existing facilities, or to increase cold storage capacity by procuring refrigeration units or refurbishing equipment.

Improved health-care waste management under the former PEHSP and the subsequent CERHSP supports segregation, storage, transportation, and safe disposal of health-care waste generated by COVID-19 laboratory and medical activities. The additional health-care waste generated by the

CERHSP includes sharps, vials, expired vaccines, swabs, and PPE. These are managed under the MWMP.

Relevant risks identified and managed under the parent project include health-care workers' exposure to COVID-19, testing and handling of supplies, health-care waste management and community health and safety issues related to the handling, transportation and disposal of health-care waste and procurement and use of substandard PPE. There are many risks inherent within the cold chain, including poorly maintained refrigeration equipment, theft, lack of security or law enforcement availability, mishandling, unavailability of climate control vehicles, technical failures in temperature and coolant, human error, road infrastructure and accessibility to rural areas, vaccine accountability and tracking of deliveries and shipments, etc. The risks to cold chain logistical workers are from transportation risks (vehicle licensing, training, accidents) and contact with ultra-low temperatures.

All health workers involved in the implementation of COVID-19 vaccines should possess adequate knowledge and skills to ensure safe and efficient vaccination administration. There are OHS risks with using untrained vaccine administrators because of wasted vials, breakages, a lack of needles and no dedicated vaccine storage or poorly maintained refrigeration equipment, and a lack of vaccine administration areas at health-care facilities.

The CERHSP objective to scale up use of solar power in health facilities and other service delivery areas beyond the cold chain system, and in the absence of grid electricity supply, means that there is also a need for backup fossil fuel-powered generators. Battery-dependent power storage systems will increase the number of batteries needing appropriate disposal after expiry. A lack of proper disposal may expose the environment to heavy metals, plastics and other contaminants found in batteries. The impact of using the backup generators and disposal of the solar batteries will need planned mitigation measures.

The unprecedented flooding in South Sudan in 2021 caused multiple risks to the environment and to people's livelihoods. As a result of the flooding, health and nutrition services have been disrupted. Minor rehabilitation will only occur within the existing footprint of public health facilities and will be limited to works critical to the functioning of the centre (e.g., plastering and retiling; replacement of doors, windows, locks; repair of electrical wiring, water pipe inflow and outflows; climate-proofing to reduce the impact of seasonal flooding, etc.). There is to be no new construction of health facilities; any small-scale building is expected to be for latrines, water storage, medical waste management sites, solar panel installation, flooding-related drainage, and will be confined within the existing health facility footprint.

The environmental risk rating is assessed as substantial, due to the baseline capacity of health-care facilities to manage medical waste. This baseline capacity will continue to be improved through UNICEF supervision, capacity-building and continued investment in minor physical upgrades and materials within the footprints of health-care facilities.

5.2 Social risks

Social risks are, above all, the result of the fragility, conflict, and violence context in the project area. The severe flooding in 2021 caused risks to the environment and livelihoods. It displaced thousands of people, many of whom have taken refuge on higher ground within their county, with many sheltering in churches, schools and public spaces. Floods have destroyed farmland and crops, affecting seasonal harvest, placing at risk the next planting season, and killing many livestock. People in some affected areas have reportedly no access to safe water, increasing the risk of waterborne diseases. Residents of Jonglei were hit hardest by floods, with 305,000 people affected, followed by Upper Nile, with 141,000 affected through displacement, disrupted access to health services, WASH, nutrition and loss of livelihoods. The affected population, including children and elderly people, are living in open areas and under trees, exposed to harsh weather conditions, with hot days and very cold nights. According to ad hoc reports, affected populations are also exposed to dangerous animals, including snakes. Women and girls lack private and safe spaces, as people are gathered in open areas. Children's educations have been halted due to the risks associated with flooding; and Friendly Centres for children, women and girls have ceased activity.

In addition to the social risks associated with flooding, such as disruption to health services, other social risks include: (1) intracommunal tensions over implementation issues; and (2) assets and staff becoming targets of violent groups. Violence (political, criminal, ethnic, etc.) and SGBV are two areas of concern, because of escalating social risks. Further risks include equity issues as well as elite capture, ethnicity of project staff, exclusion of nomadic pastoralists, and grievances from people related to beneficiaries, especially pertaining to medical procedures going wrong and challenges on referral to secondary treatment.

Social risks related to COVID-19 vaccine roll-out support include:

- The implementation of a fair, equitable and inclusive policy for in-country vaccine access and allocation
- Voluntary consent for vaccination and no forced vaccination
- Increased risk of COVID-19 transmission and adverse events following immunization
- Addressing capacity constraints in national systems to monitor, investigate and respond to adverse events following immunization.
- Security and safety of services and beneficiaries including mitigation against GBV and Sexual Exploitation and Abuse (SEA)
- Emergency preparedness and response

As such, the social risk is considered high. The SGBV risk has also been rated high.

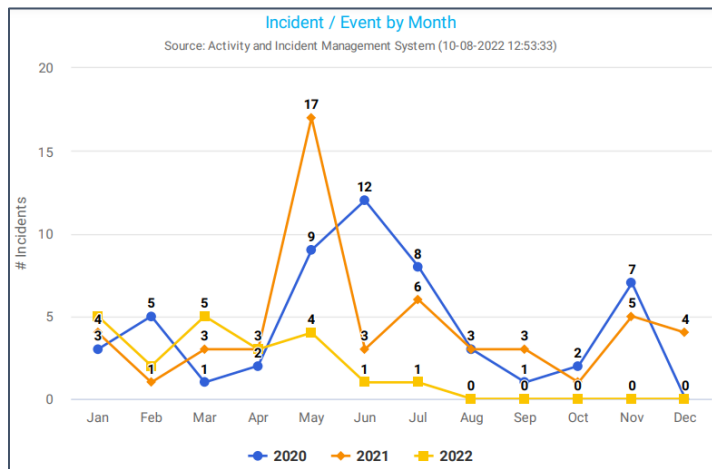
5.3 Security risks

The security situation in South Sudan is currently impacted by the economic downturn from oil and COVID-19, as well as the impacts of climate change, political dynamics and ethnic divides, which continue to ignite armed conflict, intercommunal violence, and criminality. These issues do have an impact on the geographic areas where the CERHSP operates. Each state has its own unique dynamics, which have the potential to impact project implementation to varying degrees. While

these security risks may have an impact, UNICEF and its Ips are still able to operate and deliver the programmes and activities of the CERHSP.

Jonglei has witnessed a large degree of ethnic clashes on a seasonal basis. In March 2021, despite local and national conflict resolution efforts, Murle raids on neighbouring communities continued, including Duk, Twic, Ayod and Uror counties. For example, in April 2021, suspected Murle youth attacked a cattle camp near Pieri town, Uror county, which resulted in a significant number of cattle being stolen and an unconfirmed number of casualties. Subsequently, it was reported that, in retaliation, Gawaar Nuer youth mobilized to attack the Murle in the GPAA. However, through intervention, the attack was prevented.

This conflict continued throughout the year in certain parts of Jonglei and GPAA. For example, in Akobo and Pibor, various attacks against ethnic groups regularly took place. In early November 2021, an attack in Dengjok took place, resulting in 10 fatalities and four injured. In many cases, a high degree of negotiation has taken place to reduce grievances between ethnic groups, with varying degrees of success. In some cases, these negotiations between communities, authorities and humanitarian organizations have resulted in agreement and commitment to resume programmatic activities. More extreme ultimatums have been issued. For example, in December 2021, because of tensions between Murle and the Lou Nuer youth, the County Commissioner ordered the Murle to leave Akobo County. They were given two weeks to vacate the county, which coincided with peace talks between parties from Jonglei and the GPAA. The temporary halt to this project’s activities due to ethnic divides, and subsequent kinetic activity, is a risk that will continue in the foreseeable future.



An added dimension to the security environment in Jonglei and GPAA is the increasing impact of the formation of the Kitwang faction of the Sudan People's Liberation Movement-in-Opposition, which formed earlier in 2021. In mid-October 2021, the group announced that 102 members of the Cieng-Makiir Lou Nuer subclan had joined the movement. Further disagreements between Gatwech, the leader of the Kitwang Faction, and Vice-President Machar may lead to further fracturing of the Nuer and

additional alliance changes are expected in Lou Nuer areas. In 2022, this dimension has continued, with restrictions of movement on the humanitarian community in Nyirol and Uror Counties being recently imposed.

There have been 127 security incidents and events in Jonglei and GPAA since 2020, impacting UNICEF and all its IPs.

In Upper Nile, security risks to the CERHSP include, but are not limited to, suspension of activities due to communities demanding humanitarian organizations to recruit from local communities, ethnic clashes, looting of medicines, solar panels, nutrition supplies, and divides between different political groups. In early 2021, the suspension of humanitarian activities in Renk continued. This impasse was not resolved until November 2021, when negotiations between humanitarian organizations, local authorities and communities resulted in agreed resumption of activities and safety guarantees.

Armed clashes were reported in Upper Nile on a regular basis, impacting the humanitarian community, and to a limited extent, the CERHSP. In early 2021, armed clashes throughout Maban resulted in loss of life, and to the United Nations elevating the security status from GREEN (normal activities) to GREY (restriction of movement) in the county. The cause of this downturn was due to both the political ramifications of the county being allocated to the SPLA-iO, as well as ethnic divides.

Ethnic divides impact the security dynamics in Upper Nile, particularly in the south, where Nuer subclans were engaged in three different conflict cycles, which had escalated since late May 2021. These are linked shared causes of discontent and fragmentation occurring along the Sobat river, as communities and structures are adapting to the political and security realities of the Revitalised Agreement on the Resolution of the Conflict in the Republic of South Sudan. Fighting between clans broke out on the east and west banks of the Sobat river in Ulang county, while in Nasir county, fighting took place between subclans of Mandeng, leading to casualties on both sides. To complicate the situation, in Nasir county, skirmishes between SPLA-iO and South Sudan People's Defence Forces (SSPDF) elements took place outside of Nassir town, triggered by Lou Nuer elements raiding a joint SPLA-iO/SSPDF checkpoint. In retaliation, local sources indicated that SSPDF allegedly attacked and burned down a SPLA-iO garrison. In certain instances, clashes along ethnic divides have displaced communities, which has further exacerbated the security situation as these communities fear further reprisals from host communities.

The Kitgwang Declaration and intra-iO split in August 2021 triggered fighting at In Opposition (IO) locations in Upper Nile with pro-Kitgwang forces fighting against pro-Machar forces, further increasing the number of displaced communities throughout the state. In Tonga, for example, barges carrying supplies and soldiers were reportedly seized by pro-Gatwech SPLA-iO forces. Tonga is a pro-Gatwech SPLA-iO stronghold, and any action by pro-Machar has been met with substantial resistance. Defections between these groups have also caused security uncertainty, which has triggered violence. In 2022, divides within the Kitgwang group were reported, resulting in armed clashes between forces loyal to one commander, and the White Army (Nuer) in areas south of Tonga. Further community displacements were reported due the fighting from the west of Panyinkang county to Sudan.

In Unity state, inter-ethnic attacks are commonplace, which may have an impact on the CERHSP. Longstanding tensions between certain ethnic groups continue, resulting in violent clashes that have the ability, for a temporary period, for humanitarian action to take place in certain areas of the state. The rivalry between the Lou community of Tonj North and Luanyjang community of

Tonj East, is one such example, where attacks between the two groups have been regularly occurring.

Another area of concern to humanitarian activities is Mayom. In the latter half of 2021, there was a reported increase in incidents between Mayom and Abiemnom, and between Guit and Pariang, raising concerns about the situation between the Ruweng Administrative Area and neighbouring areas. The issue of general insecurity along the Mayom-Ajakuach Road was also of concern. Reports indicated the continued presence of criminal elements operating along the Guit-Pariang border, an axis previously prone to incidents resulting in high levels of fatalities. Outside of seasonal cattle raiding, intercommunal pressures and competition for jobs at the oil fields in Manga, Pariang had also contributed to youth grievances. In November 2021, attacks by armed actors in Mayom led to revenge violence involving Bul Nuer groups in the area and the ability for local authorities to deploy and contain the situation were hampered by flooding in Rubkona preventing the SSPDF to move from Bentiu to Mayom. This situation continued into 2022 and, in mid-July 2022, clashes between SSPDF and SSPM/SSPA in Mayom, where the County Commissioner was killed, further demonstrating the difficult working environment. The SSPM/SSPA commander, though a prominent figure among the Bul Nuer, has deep-seeded grievances with additional political elites from the Bul Nuer community. He formed SSPM/SSPA in May 2021 to fight a “fundamental regime change”. Reports of further attacks by the SSPM/SSPA have since occurred, which may have far reaching geographic implications if other groups are incentivized to act. Other clashes were reportedly in neighbouring Warrap state, between officials and this group.

Investment and support to service providers, not only in health but in other sectors as well, might heighten the risk of providers becoming targets of attacks, pillaging and violence by armed groups. Cases of health facilities and hospitals being raided have been documented in South Sudan, as well as other fragility, conflict, and violence contexts in the region. UNICEF recognizes that both its personnel and its partners are involved in security incidents/events and understands that there is an ever-increasing need to provide support to these organizations to ensure that both the UNICEF mandate is delivered, and that IPs can operate as safely as possible.

The project aims to improve the availability and quality of health services in targeted facilities and aims to provide support that is aligned with other engagements of health partners in the country, whether they be emergency-related or giving basic service delivery support. This includes the provision of financial (performance payments, hazard pay, salary top-ups, etc.) and non-financial (provision of drugs, equipment, rehabilitation) support. As such, it is acknowledged that the project may lead to service providers becoming targets of criminal acts, including those that maybe violent in nature.

6. ENVIRONMENTAL, SOCIAL AND SECURITY MITIGATION MEASURES

The activities associated with CERHSP AF1 & AF2 will complement the positive impacts of the parent project, PEHSP, and the subsequent CERHSP, by facilitating COVID-19 containment,

reducing COVID-19-related hospital admissions, vaccine procurement, deployment, and administration. AF strengthens the integration of the health and nutrition package of services and the extension of the packages to refugees and host communities in Upper Nile and Unity states.

The Environmental and Social Risk Classification of CERHSP AF1 & AF2 is high, due to risks resulting from:

Environmental risks

- Increased risk of COVID-19 transmission and adverse events following immunization
- Health facility conversion to solar power and risks associated with backup generators for uninterrupted power supply.
- Flooding-related environmental risks including rehabilitation works risks
- The generation of additional COVID-19 related health-care waste in the form of sharps, swabs, and PPE.
- OHS risks linked to health-care workers involved in handling and administering vaccines, those working in the health-care waste stream and logistical workers involved in the cold storage chain.
- Community health and safety risks from the handling, transport, and disposal of vaccine-associated health-care waste.
- Emergency response - Contingent Emergency Response- related risks.

Social risks

- Flooding-related social risks including increased exposure of women and children to violence and disease)
- Security and safety of services and beneficiaries including mitigation against GBV and Sexual Exploitation and Abuse (SEA).
- Assets and staff becoming targets of violent groups; violence (political, criminal, ethnic, etc.) and GBV are two areas of concern because of escalating social risks.
- Equity and grievances issues, as well as elite capture, ethnicity of project staff, exclusion of nomadic pastoralists, and grievances from people related to beneficiaries, especially pertaining to medical procedures going wrong and challenges on referral to secondary treatment
- Intracommunal tensions over implementation issues
- The implementation of a fair, equitable and inclusive policy for in-country vaccine access and allocation.
- Adverse events following immunization.
- Low demand related to COVID-19 vaccine hesitancy, or a refusal to receive the COVID-19 vaccine because of religious beliefs, traditions, or negative online influences.

The overall setting for the mitigation measures is established by updating risks in line with ESS1: Assessment and management of environmental and social risks and impacts. The assessment will take the form of an audit, referencing the previous findings from 2020 with any new emerging significant risks.

6.1 Environmental mitigation measures

Where potential risks and impacts are anticipated, the project will comply with the UNICEF ESS and the WB ESS. In this case, the project will take measures that are commensurate with the risks in order to avoid, minimize, mitigate, manage, or compensate for adverse environmental impacts (*see Table 1*). Measures to ensure the safe and environmentally sound management of health-care wastes are necessary to prevent adverse impacts on health and the environment. The project will also enhance positive impacts in project selection, location, planning, design, implementation, and management.

With respect to COVID-19 vaccination-related risks, the MWMP will be updated to address aspects such as regulatory framework, planning issues, waste minimization and recycling, handling, storage and transportation, treatment and disposal options, and training. In the absence of appropriate national medical waste management regulations, guidelines, and monitoring tools, the CERSHP AF MWMP are based on WHO global guidance documents on health-care waste management.⁷ The MWMP anticipates increased volumes of COVID-19 vaccination-related waste, given the procurement of substantial quantities of vaccines using the AF. In anticipation of the risk of overwhelming the health system, UNICEF and partners will undertake evidence-based forecasting for COVID-19 vaccine procurement and adopt phased procurement and shipment schedules. At the same time, they will support capacity-building of the vaccination programme to handle the increased volumes of both solid and medical waste linked to the COVID-19 vaccinations. UNICEF and partners will ensure enhanced effective vaccine management practices are followed, minimizing vaccine waste, while also increasing capacity for safe disposal of vaccines.

Additional mitigation measures to ensure the safety of COVID-19 vaccination, include building the capacity of IPs to comply with the ESS and mitigation measures. The environmental requirement below will be included in the programme contracting documents with IPs, in line with WB EHSR for rehabilitation works and for health-care facilities.

“The IP/contractor will avoid the generation of hazardous and non-hazardous waste materials. Where waste generation cannot be avoided, the IP will reduce the generation of waste, and recover and reuse waste in a manner that is safe for human health and the environment. Where waste cannot be recovered or reused, it will be treated, destroyed, or disposed of in an environmentally sound manner that includes the appropriate control of emissions and residues resulting from the handling and processing of the waste material. If the generated waste is considered hazardous, reasonable alternatives for its environmentally sound disposal will be adopted. The IP/contractor will avoid or minimize the potential for community exposure to

⁷ WHO, Safe management of wastes from health-care activities, second edition, http://apps.who.int/iris/bitstream/10665/85349/1/9789241548564_eng.pdf

hazardous materials and substances that may be released. Where there is a potential for the public to be exposed to hazards, the IP will exercise special care to avoid or minimize their exposure by modifying, substituting, or eliminating the condition or material causing the potential hazards.”

UNICEF will continue to advocate, advise and support other fund managers to implement similar ESS clauses and to have this costed and included in operational plans for the national roll-out of COVID-19 vaccinations.

UNICEF will monitor and supervise health facilities, using detailed tools and checklists that cover OHS and other service delivery aspects. Gaps identified through the supervision and monitoring processes will be used as basis for developing training and capacity-building modules for IPs and health workers at health facility level, including all environmental management and worker OHS risks and measures.

The project will support investments in solar power for some facilities in Upper Nile and Jonglei, based on the assessment. The assessment considers environmental preservation and standards and guides the specification of equipment. In addition, the use of contractors in the installation of cold chain systems and solar power installations will require implementation of the LMP. To mitigate against the risks associated with disposal of used solar batteries, the project will support the MoH and local health authorities to establish a protocol on safe-keeping and disposal of batteries, including recycling, where possible and preference for long lasting batteries. In case of backup generators, mitigation measures will be put in place to minimize leakage of effluents from the generators to the environment including having designated generator housing that is well ventilated.

Given the need for rehabilitation works for the restoration of health and nutrition facilities that have been damaged by flooding, the works will be conducted in line with the WB EHSR for rehabilitation. Adherence will be enforced by incorporating the requirements of the ESCP, ESMF and other environmental and social (E&S) instruments into UNICEF's standard agreements with contractors/IPs. Such requirements will be extended by UNICEF's contractors/IPs.

Specific technical guidance for projects or works with potential exposure to COVID-19 can be found in the following Annexes:

- A. Screening tool for E&S risks
- B. Infection prevention control protocol
- C. Health and safety guidelines for retrofitting/rehabilitation of medical facilities
- D. ESHS risks and mitigation measures for small civil works at health-care facilities
- E. Communication guidance

In addition, further information can be found in the following:

- Guidance on Management of Solid Health-care Waste at Primary Health-care Centres⁸

⁸http://www.who.int/water_sanitation_health/publications/manhcwm.pdf

- Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings⁹
- WBG guidelines for Health Care Facilities¹⁰
- Standard Operating Procedures (SOPs) for autoclaves, incinerators, ventilation and filtration systems, and positive pressure equipment (these should be supplied with the equipment, along with the necessary training).

UNICEF and IPs will ensure use of paper-free and/or recyclable, environment friendly and biodegradable communication materials, and that there is appropriate removal and disposal of information education and communication materials, including leaflets, posters, flyers, and banners. These measures are informed by ESS3: Resource efficiency and pollution prevention and management.

The CERHSP AF1 & AF2 includes a CERC. The following section is intended to guide the environmental and social risk management activities of the emergency response component in response to the COVID-19 pandemic and form the CERC-ESMF, which is part of the operations manual for CERC.

Prior to, or at the time of activation of the CERC, a rapid update of the ESF assessment in line with ESS1 will be conducted, to inform action to address any anticipated EHS risks. If small civil works are required under CERC, the project will ensure adherence to the WB-EHSG for rehabilitations. The provision will be built into agreements with Ips or contractors.

6.2 Social mitigation measures

In terms of social risks, the project activities will generate considerable social benefits to the communities in the project areas. The study has also established a number of social consequences that the project activities are likely to induce, albeit on a small and localized scale. Social mitigation measures encompass, among others, awareness campaigns, transparent disclosure of project activities, analysis of risks throughout the project lifecycle, meaningful consultations, and participatory approach towards project activities on the ground, codes of conduct, integration of women into BHI committees, and constant enhancing of the GRM. The project also includes iterative social/conflict monitoring in line with the security management plan throughout the project period, to see how the support for local facilities interacts with local social dynamics, so that the project activities/approach are adjusted in real time (*see Table 1*).

COVID-19 vaccination protocol will follow global approaches to vaccine allocation based on a risk and needs basis, in other words, following an inclusive framework. The project will also establish logistical structures to ensure reaching targeted beneficiaries, such as the elderly, who not able to come to health centres, homeless people, people without documentation, such as urban migrants without IDs, etc. Respective planning will be included in the specific COVID-19 vaccination roll-out plans.

⁹<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>

¹⁰https://www.ifc.org/wps/wcm/connect/topics_ext_content/ifc_external_corporate_site/sustainability-at-ifc/policies-standards/ehs-guidelines

The implementation of the GBV/SEA action plan will be strengthened among communities displaced by floods and intercommunal violence as well as in services to the normal population as a mitigation measure. As part of the broader stakeholder's engagement, communities and local authorities, youth and women groups will be engaged for greater ownership of the services and as a mitigation measure against targeting of assets and staff in the health services points. The training of Adverse Events Following Immunization (AEFI) focal points and establishment of a referral mechanism will be used to mitigate against AEFI and to take prompt action if happens and as a reassurance to the communities. The intensification community engagement efforts, communication, and social mobilization using different community platforms will be used to increased demand for the COVID-19 vaccination services.

6.3 Security mitigation measures

In terms of security risks, the project addresses the risks of project beneficiaries and staff becoming targets in several ways including:

- To assist in the development of interventions and risk mitigation measures based on best-practices and proven strategies of both development partners as well as humanitarian organizations and close consultations undertaken with the health cluster in South Sudan
- To support enhanced access to areas and populations that were previously difficult to reach, due to the neutrality and impartiality of partner organizations mobilized
- To engage community leaders and provide oversight, which has been identified as a way to reduce the risk of pillaging by local populations
- Where possible, cash payments will be avoided and any financial payments to service providers will be direct payments to facility accounts at commercial banks or certified credit unions.
- Implementation of Implementing partner specific Security Management Plan (SMP)

Finally, the risk of GBV remains extremely high throughout the country. The project includes several interventions to address this, including a significant expansion of training for health workers and provision of services, including mental health and psychosocial support, for victims of GBV. UNICEF will train health workers in the facilities they support to provide services to GBV victims, both in terms of medical services (provision of post-exposure prophylaxis) and mental health and psychosocial support.

The security risks and mitigation measures are identified and updated on a continuous basis through the United Nations, inter-agency, and Implementing Partners Security and Significant Event Management Framework (SSEMF). The SSEMF is in line with the **ESS1: Assessment and management of environmental and social risks and impacts**. For the purposes of both security management and significant event management, the CERHSP project SSEMF considers both UNICEF and IP personnel, premises and assets. The SSEMF considers all project personnel, defined as UNICEF personnel (staff and consultants) and IP personnel (staff and consultants) whose salaries are supported by CERHSP, as well as MoH and health-care workers or community volunteers who receive incentives from CERHSP funding.

As part of the main mitigation measures, advisories are shared with the personnel falling under the SSEMF as new findings are established and, in some cases, specific actions – such as evacuations and restricted movements – are taken to safeguard staff safety.

Security and significant event management

Security and Significant Event Management is covered by ESS2: Labour and working conditions, and ESS10: Stakeholder engagement and information disclosure. A security and significant event management framework for the project will cover both UNICEF and IP personnel, premises and assets. The framework comprises four components:

1. United Nations Security Management System (UNSMS);
2. Inter-Agency Standing Committee Saving Lives Together Framework (SLT);
3. Significant Event Reporting; and
4. Implementing Partners (IP) Security Management Approach.

Incidents and accidents with significant adverse effects on the environment, the affected communities, the public or workers, project personnel, UNICEF and IPs' premises and assets falls within the scope of the CERHSP SSEMF. Project personnel are defined as UNICEF personnel (staff and consultants), IP personnel (staff and consultants) whose salaries are supported by CERHSP project.

Security management under the SSEMF comprises two workstreams:

- Security management related to UNICEF personnel, compounds and assets in accordance with the UNSMS
- Security management related to IP personnel, compounds and assets supported by the CERHSP, in accordance with SLT and further detailed in the IP Security Management Approach.

UNICEF will provide support to IPs to manage their security responsibilities under the SLT. The SLT is a series of recommendations aimed at enhancing security collaboration between the United Nations, international NGOs and international organizations (known as “SLT partner organizations”). The objective of SLT “is to enhance the ability of partner organizations to make informed decisions, manage risk and implement effective security arrangements to enable delivery of assistance and improve the safety and security of personnel and operations.” While the SLT is limited to international NGOs and does not extend to national NGOs, UNICEF will require those same SLT principles of all IPs delivering services under CERHSP project, whether they are national or international NGOs.

It is important to note that SLT partner organizations have different approaches to how they perceive and evaluate risks and how they assess vulnerabilities, accept different levels of risks they face, and implement security arrangements which they consider suitable for their organization and operational conditions. With regards to accountability, SLT partners accept that they remain fully accountable for the security of their personnel in accordance with their duty of care obligations as

employing organizations. Accordingly, organizations that wish to cooperate under the SLT are required to maintain internal security risk management procedures, contingency planning, and adequate and reliable arrangements to respond to security incidents and crises.

There are two levels of collaboration within the SLT: “regular” and “enhanced”. UNICEF’s implementation of the SLT will follow the “enhanced” level of collaboration with regards to security plans and information management to bolster security coordination arrangements, information sharing and operational/logistics arrangements. UNICEF and each IP will determine the security context(s) in which the IP will be operating (as part of the CERHSP project), including, but not limited to, intercommunal violence, crime, cattle raids, population displacement and hazards. To complement the SLT, UNICEF will implement and require IPs to act in accordance with an IP Security Management Approach, as well as a Significant Event Reporting¹¹ protocol.

¹¹ Significant Event is defined term in the Financing Agreement between UNICEF and the World Bank.

Table 1: Environmental Risks/ Impact, Mitigation, and Monitoring Plan

Project Activities	Risks/Impact	Mitigation Measures	Responsibility	Monitoring Indicators
Evidence generation on environmental and social risks facing project	Inadequate and/or outdated evidence, data, and information on environmental and social risks facing the project	<ul style="list-style-type: none"> • Biannual updating of information on the risks • Updating of the information on risks prior or during activation of the CERC 	UNICEF	ES assessment reports updated (Y/N)
Procurement Supply Chain Management of Medical Products including Medical Waste Management	<ul style="list-style-type: none"> ▪ Substandard quality of medical goods procured (drugs, supplies, equipment) ▪ Expiration of goods ▪ Inefficacy of goods ▪ Unnecessary and/or improper disposal of goods ▪ Hazardous medical and non-medical waste generated from service delivery points e.g. needles and other sharp objects ▪ Waste polluting the environment-unpleasant sights to the area, obstruction, foul smells, and attract insects and rodents, smoke from burning the waste, contamination of water masses 	<ul style="list-style-type: none"> ▪ Forecasting, planning, and phased procurement and shipping of COVID-19 vaccines ▪ Strengthening integration of COVID-19 vaccination into routine immunization system ▪ Build capacity on MWM at all levels and enforce adherence through contracts and agreements ▪ Establish a GRM mechanism for reporting grievances ▪ Ensure critical elements of the plan are appropriately reflected in the quality-of-care standards and related tools and regularly monitored as part of facility monitoring and supervision activities ▪ Allocations for the MWMP activities ▪ Capacity-building of SMOH and CHD, and health workers on implementation of the MWMP 	<ul style="list-style-type: none"> ▪ UNICEF ▪ Implementing partners 	<ul style="list-style-type: none"> ▪ Inventory management protocol in use at all levels (Y/N) ▪ Number of incident reports of all losses resulting from looting and vandalism submitted to the WB in line with UNICEF’s incident reporting mechanism ▪ Number of serious grievances such as fraud or sexual abuse or exploitation reported.

Project Activities	Risks/Impact	Mitigation Measures	Responsibility	Monitoring Indicators
Occupational Health and Safety(OHS)	<ul style="list-style-type: none"> ▪ Staff handling and use of dangerous substances and wastes and inhaling fumes will expose the workers to occupational health risks ▪ Medical personnel and waste handlers are exposed to dangerous and infectious health-care waste [HCW] as they collect and transport HCW ▪ COVID-19 Infection risks for health facility staff ▪ Staff incur on-the-job injuries due to improper clinical techniques, use of equipment, etc. ▪ Poor Water Sanitation and Hygiene (WASH) in health services delivery points 	<ul style="list-style-type: none"> ▪ Ensure critical elements of OHS in line with WB EHSG for health facility are included in the quality-of-care standards and related tools and monitored regularly ▪ Ensure the OHS standards are available in the facilities and staff have the right capacity and knowledge on their use ▪ Routine OHS pep (short) sessions in the facility. ▪ Workers should be equipped with appropriate PPE ▪ There should be always a first aid kit on each site ▪ Clear markings and signage should be used in all areas of the site ▪ All waste storage and disposal sites should be adequately condoned off from the public ▪ Staff on-boarding should include orientation/training on how to prevent most common occupational accidents ▪ Ensure minimum WASH standards as per health facility type ▪ Record and monitor all OHS incidents including near misses 	<ul style="list-style-type: none"> ▪ UNICEF ▪ Implementing partners 	<ul style="list-style-type: none"> ▪ OHS standards available in all service delivery points (Y/N) ▪ Grievances Redress Mechanism in all service delivery points (Y/N) ▪ Information on availability of GRM displayed (Y/N) ▪ PPE in use in all service delivery points (Y/N) ▪ Proportion of health facilities that meet minimum WASH standards
Community Health and Safety(CHS) including minor facility repairs and rehabilitation	<ul style="list-style-type: none"> ▪ Lapse of confidentiality ▪ Assault by medical staff ▪ Unrealistic expectation of level of care and/or recovery 	<ul style="list-style-type: none"> ▪ Interpersonal Communication (IPC) training for health staff (1) what essential services are offered at the health-care facility; (2) explanation of procedures and concurrent risks; (3) follow-up care instructions; and 	Implementing Partners	<ul style="list-style-type: none"> ▪ Number of staff trained on IP Communication ▪ Grievances Redress Mechanism in all service delivery points (Y/N)

Project Activities	Risks/Impact	Mitigation Measures	Responsibility	Monitoring Indicators
	<ul style="list-style-type: none"> ▪ Health facility rehabilitation works increasing dust and noise levels ▪ Worker first-aid ▪ Community (neighbour) health and safety ▪ Repair equipment handling ▪ Debris management ▪ Poor quality construction leading to harm to workers and/or patients ▪ Air pollution could also occur from using diesel-powered backup generator sets. ▪ Inadequate emergency preparedness and response at all service delivery points 	<p>(4) referrals to other health-care providers if services not offered or available</p> <ul style="list-style-type: none"> ▪ Medical staff code of conduct ▪ Complaints and feedback mechanism ▪ Regular daily cleaning promotion of WASH including hand hygiene at the health facility ▪ Ensure critical elements of Community Health and Safety in line with WB EHSR for rehabilitations are included in the contractual agreements with IPs, contractors; such requirements will be extended by UNICEF’s IPs and contractors to all subcontractors¹² ▪ Access to and use of PPE ▪ Cordon off and provide signage for areas undergoing minor repairs ▪ Store repair equipment to limit access to anyone other than designated operators ▪ Consultation and agreement with community for repair-related debris disposal ▪ On-site supervision of construction ▪ Develop site specific emergency preparedness and response plan ▪ Emergency prepositioning of supplies 		<ul style="list-style-type: none"> ▪ Information on availability of GRM displayed (Y/N) ▪ Emergency preparedness and response plan available in all service delivery points (Y/N)

¹² Note: standard UNICEF contracting language will not be amended, but EHSR requirements will be referenced in Project Documents or Contracting Documents (e.g., through terms of reference).

Project Activities	Risks/Impact	Mitigation Measures	Responsibility	Monitoring Indicators
Security of Project Personnel	<ul style="list-style-type: none"> ▪ Essential health services are disrupted. ▪ Injury or loss of life of Project Personnel due to targeted or non-targeted security incidents. ▪ Inadequate emergency preparedness and response at all service delivery points 	<ul style="list-style-type: none"> ▪ Develop well-detailed security management plan (SMP) for IPs as per the SSEMF ▪ Implement of the SSEMF ▪ UNICEF will monitor the implementation of security plans as part of regular PD performance monitoring processes, including field monitoring and reporting. ▪ Ongoing security information sharing via SLT, INSO and NGO Forum Security cells to inform preparedness actions. 	<ul style="list-style-type: none"> ▪ UNICEF ▪ Implementing Partners 	<ul style="list-style-type: none"> ▪ IP specific SMP in place (Y/N) ▪ Number of incident reports shared ▪ Emergency preparedness and response plan available in all service delivery points (Y/N)

Table 2: Social Risks/ Impact, Mitigation Measures, and Monitoring Plan

Project activities	Risks/ Impact	Proposed mitigation measures	Responsible party	Monitoring indicator
<p>Health service delivery via facilities or community outreach</p>	<ul style="list-style-type: none"> • Inequitable availability and access to service delivery, exclusion of nomadic communities • Social disruption due to perceived introduction of inequitable health services • Elite capture of services by individuals with connections or senior social status • Social ills, like sexual exploitation and abuse, selling medicine to vulnerable groups instead of providing them free 	<ol style="list-style-type: none"> 1. Mapping of functional health facilities and selection of those to be supported, considering local administrative boundaries, government and non-government (IO) controlled areas, population size, cultural characteristics of the population, and conflict dynamics 2. Ensure distribution of health facility sites in consultation with communities, that will enable all populations to safely and securely access them, given their cultural background, specific vulnerabilities, the areas of control of different parties to conflict, and trends in any hostilities 3. Strengthen dialogue with local stakeholders to effectively negotiate people’s access to services including for nomadic communities and cattle camps 4. Communicate with local leaders to inform communities about the health-care services to come in the community 5. Coordination with other partners and local health actors to mitigate duplication and reduce gaps in service delivery 6. Support the formation and strengthening of health local groups (e.g. BHI) for self-monitoring 7. Develop a GRM as part of UNICEF’s Accountability for Affected Populations strategy 8. Enforce and monitor IP compliance with UNICEF’s policy and measures on PSEA 9. Programme monitoring and supervision that includes consultations with community members 10. Strict monitoring by UNICEF and third-party audit institutions (programme visits, spot checks, audits) in accordance with the HACT framework 	<p>UNICEF</p> <p>UNICEF</p> <p>UNICEF and IPs</p> <p>UNICEF</p>	<ul style="list-style-type: none"> • Mapping of areas and the health facilities to be supported within each lot • Number of health facilities and communities supported • Number and type of grievances reported and addressed • Number of active local health committees • Number of programme monitoring visits • Number and type of people consulted (e.g., males/females) • Number of state coordination meetings • Number of IP staff trained on GBV and PSEA

Project activities	Risks/ Impact	Proposed mitigation measures	Responsible party	Monitoring indicator
			UNICEF, IPS, CHD officials	
	<ul style="list-style-type: none"> • Increase in medical waste in areas of operation • Poor hygiene, water and sanitation in health facilities negatively impacts safe delivery of health care services 	<ol style="list-style-type: none"> 1. Develop WASH in health facility guidelines (covering hygiene, sanitation, safe water and waste management) for circulation to IPs 2. Engage and train health workers on medical waste management 3. Monitor implementation during programme monitoring and supervision 	<p>UNICEF</p> <p>IPs</p> <p>UNICEF, IPs, CHD officials</p>	<ul style="list-style-type: none"> • Number of health workers trained • Development of guidelines • Number of programme monitoring visits • Tracking of corrective actions
	<ul style="list-style-type: none"> • IPs are not prepared nor equipped to respond to emergencies, including disease outbreaks 	<ol style="list-style-type: none"> 1. Train IPs in emergency preparedness and response, including infectious disease surveillance and response (IDSR) 2. Pre-position supplies (especially during the dry season), including emergency contingency supplies (e.g., cholera kits) 3. Provide technical assistance to IPs to develop emergency contingency plans 4. Collaborate with emergency responders/humanitarian actors 	<p>UNICEF (with WHO)</p> <p>UNICEF and IPs</p> <p>UNICEF</p>	<ul style="list-style-type: none"> • Number of health workers trained in emergency preparedness and response • Availability of pre-positioned supplies
	<ul style="list-style-type: none"> • Ghost workers and ghost health facilities included in the project fraudulently consuming budgetary resources through inflated staffing and facility costs • Shortage of suitably qualified staff or presence of lowly skilled medical staff resulting in poor-quality critical life-saving services • Salaries meant for health workers not being remitted to staff resulting in absence of 	<ol style="list-style-type: none"> 1. Physical verification and mapping of health facilities by community mobilizers as well as an auditing firm 2. Regular monitoring of IPs and health facilities, including audits and spot checks in accordance with HACT framework 3. Transparent recruitment of qualified health care workers, with preference provided to local residents (as less likely to have high turnover) and with attention to gender and conflict sensitivity 4. Support IPs with in-service training, monitoring and supervision of facility and community-based health care workers for quality improvement of services 	<p>UNICEF</p> <p>UNICEF, IPs, local health officials, third-party monitor</p> <p>IPs</p>	<ul style="list-style-type: none"> • Status of mapping of health facilities • Number of programme monitoring visits, spot checks, audits • Number of health-care workers trained (by type of training, by gender) • Standardised Package of Performance-based incentives available

Project activities	Risks/ Impact	Proposed mitigation measures	Responsible party	Monitoring indicator
	health personnel at facilities and disruption of services	<ol style="list-style-type: none"> 5. Provision of technical assistance to strengthen the capacity of CHDs, IPs and NGOs in delivering programme results 6. Nominated IPs will pay standardized performance incentives of PHCC/PHCU workers 7. Provide on-time compensation to staff 		
	<ul style="list-style-type: none"> • Community activities seen as not acceptable according to local traditions or not affordable, thereby generating hostility to the healthcare system and resulting in a lack of buy-in of community health services by community leadership and stakeholders 	<ol style="list-style-type: none"> 1. Involve key local stakeholders in Boma Health Team / Community Health Worker (BHT/CHW) selection and implementation processes to ensure buy-in, recognition, and acceptability from the community 2. Strengthen the ability of community health leaders and structures (particularly Boma Health Committees) to enable accountability, monitor community health initiatives and support CHWs 3. Adapt BCC messaging to address local myths and misconceptions and to encourage care seeking from CHWs 4. Ensure recruitment of female CHWs (minimum 30%) to reduce gender barriers to services 	UNICEF and IPs	<ul style="list-style-type: none"> • Number of Community Health Workers (males/females) recruited and trained • Number and type of community engagement activities • Number of people reached
	<ul style="list-style-type: none"> • Low capacity of CHWs and supervisors, poor linkages between CHWs and health facilities, limited equipment, and a lack of data, impede the quality of community health services 	<ol style="list-style-type: none"> 1. Ensure sufficient human resources at adjacent health facilities to carry out CHW supervision 2. Establish referral and counter-referral networks between CHWs and health facilities to improve the continuum of care 3. Conduct CHW training and supervision to ensure compliance with standard operating procedures and reporting guidelines 4. Provide on-time compensation to CHW (e.g., performance-based incentives linked to reporting) 5. Development and distribution of community data collection tools linked to the HMIS 	UNICEF and IPs UNICEF and MoH	<ul style="list-style-type: none"> • Number of Community Health Workers (males/females) recruited and trained • Community data collection tools developed and disseminated among CHW

Project activities	Risks/ Impact	Proposed mitigation measures	Responsible party	Monitoring indicator
		<p>with IPs to gauge and stock adequate quantities per period</p> <p>5. Health kits and supplies are prepositioned nearby in secure locations for emergency response/replenishment</p> <p>6. Circulate to partners the SOP for immediate reporting of loss and looting incidents</p>		
Security of project personnel embedded in the communities	<ul style="list-style-type: none"> • Shortage of suitably qualified staff or presence of lowly skilled medical staff • Inequitable availability and access to service delivery in areas that are not highly vulnerable • Essential health services are disrupted • Injury or loss of life of Project Personnel due to targeted or non-targeted security incidents 	<ol style="list-style-type: none"> 1. UNICEF will continue to work closely with UNMISS and OCHA to utilize their channels for lobbying for access in conflict areas to allow programmatic assessments and interventions, monitoring and vital distribution of life saving drugs by UNICEF and its partner' access 2. Bolster security in hospitals, PHCCs, PHCUs through manned guarding of facilities, and securing of points of entry. UNICEF shall support partners with relevant financial resources from the Project funding to strengthen security at facilities 3. Strengthen regular and ongoing community engagement and dialogue to reduce targeting of health institutions when conflict occurs 4. Strengthen support to IPs via the SSEMF, including financial support from the Project funding to strengthen security management capacity of the IPs 5. Improve security related Significant Event reporting to enhance information sharing and ability to inform decisions around project personnel security and service provision 	UNICEF and IPs	<ul style="list-style-type: none"> • Number and type of incidents reported • Number and type of community engagement activities

7. STAKEHOLDER ENGAGEMENT AND INFORMATION DISCLOSURE

A detailed outline of the stakeholder engagement and information disclosure is contained in the SEP. The SEP includes a description of the UNICEF-supported components and subcomponents and the specific stakeholder's engagement needed for effective and efficient implementation of the project. The CERHSP has a new component 1, with subcomponents on strengthening cold chain infrastructure, COVID-19 vaccinations, and demand generation for COVID-19 vaccination. The CERHSP also includes component 3 on strengthening of MoH capacity. These new subcomponents are national and require stakeholder engagement and disclosure at national level. Components 2 and 4 in the CERHSP are a continuation from the old PEHSP. The previously applied stakeholder's engagement procedures will be updated and harmonized with the new approaches in CERHSP.

The SEP includes a stakeholder's identification and corresponding supportive activities for the three categories of key stakeholders. The three categories include the parties directly affected/impacted by the project; other interested parties; and identified vulnerable groups. To reach and engage with these key stakeholders, specific strategies will be applied as detailed in the SEP following stakeholder analysis and identification of a primary method of engagement. The identified strategies include advocacy, capacity building, mass and social media, social mobilization, and specific crisis communication plan for COVID-19 vaccination. Additional details on stakeholder engagement are contained in the SEP, as a separate attachment.

The final CERHSP AF2 ESCP was disclosed on Tuesday, February 28, 2023. The ESMF and outstanding set of E&S plans and instruments will be taken through a process of consultation and disclosure as soon as it is finalized. As previously agreed, and documented in the ESCP, the ESMF for PEHSP and related E&S plans remain in force till finalization and disclosure of the CERHSP project ESMF and E&S plans.

8. ESMF IMPLEMENTATION

8.1 General management structure and responsibilities

The general management structure and responsibilities outlined below are complemented in further detail in the LMP in Annex 2.

World Bank

The CERHSP is financed by funds entrusted to WB. A WB task team has been established to oversee, support and make decisions about remedies in connection with the project managed by UNICEF. In particular, the task team's functions/responsibilities consist of: (1) reviewing periodic financial progress and results reports measured by targets and benchmarks agreed at the time of project approval; (2) applying the agreed process for dealing with serious issues, including significant social and environmental issues; (3) reviewing progress reports on actions taken to address a serious situation and results obtained, including details of any recovery of funds or write-off of losses; and (4) exercising remedies of suspension and termination in accordance with the provision of the legal agreement, if necessary. In addition, the WB task team will provide additional technical support in knowledge management and evidence generation, organization of technical and strategic round table engagements and discussions with UNICEF. The WB E&S team has provided specific technical support in the development of the ESMF and related E&S plans and tools and will continue to provide support throughout the project implementation.

WB is also engaged in the Biannual Technical Supervision Missions. UNICEF, WB and other project stakeholders, including MoH, will meet biannually to review progress, opportunities and constraints, strategic direction and oversight, review implementation progress and financial status.

UNICEF

UNICEF will be responsible for overseeing the implementation and compliance with the ESMF and will be responsible for the revision or updates of this document during the project, in consultation with WB. The 'project assurance' function of UNICEF is to carry out objective and independent project oversight and monitoring functions. This role ensures appropriate project management milestones are managed and completed. UNICEF provides quality assurance for the project, ensures compliance with UNICEF SESSPs, WB ESF and implementation of the requirements of this ESMF. UNICEF is responsible for the procurement, contracting and monitoring/supervision of IPs and service providers/contractors that are responsible for implementing the different UNICEF-led components/subcomponents. Some of the duties of the contractors include:

- Organization and implementation of training, where necessary, following a cascaded model
- Organization of information to be passed from management to workers
- Provision and implementation of social management measures and occupational health and safety measures
- Review of the circumstances and causes of social risks to advise to their senior management and UNICEF on preventive measures.

On a monthly and quarterly basis, UNICEF, together with its IPs and County Health Departments (CHDs), will continuously monitor the above provisions during the planning and implementation phases of the intervention. UNICEF staff and third-party monitors at central and field level will be in charge of monitoring and bolstering safeguard compliance, as guided by the ESMF. The IPs' progress reports will provide ongoing information about key environmental and social impacts of the project, effectiveness of mitigation measures, and any outstanding issues to be remedied. These will additionally be addressed during quarterly performance review and coordination meetings.

The international health specialists in UNICEF South Sudan's Health Section (Chief of Section, Health Manager, Project Manager, and Immunization Manager) will have strategic oversight of the ESMF and ensure engagement with other relevant sections (e.g. Field Operations and WASH) and actors (e.g. WHO). As such, they will provide quality assurance, technical support and oversight to the development and monitoring of the NGO partnership agreements, which will include ESMF components. They will also support field office staff and partners with programme implementation and monitoring and identify corrective actions to any bottlenecks identified at national and field level. The positions also participate in strategic monitoring activities and reviews, especially at the central MOH, to assess programme performance and report on required action/interventions at the higher level of management to help ensure that results are achieved.

Field health and WASH national staff (in Jonglei and Upper Nile) will do the following: Whilst contributing to strategic discussions on the project and scope/content of the project at local level, the staff provide ongoing technical support to CHD and IPs on the ground. They will directly support state and county level coordination, monitoring the scope and quality of activities being implemented, working closely and collaboratively with internal and external colleagues and partners in the field to discuss ESMF related operational and implementation issues, provide solutions, recommendations and/or alert appropriate officials and stakeholders for higher-level intervention and/or decision. As such, they will regularly participate in monitoring activities and reviews to assess programmes and report on required action/interventions to help ensure that results are achieved by IPs and verified at County and State level. Health facilities will be regularly visited (a minimum of 30 per cent of the total number every 6 months) in government and non-government (IO) controlled areas to assist County Health Officials and IPs to strengthen project-related planning, monitoring and implementation capacity through appropriate training measures, provision of technical

capacity and coaching. This includes performing frequent supervision visits to IPs, health facilities and communities targeted by the project as per agreed planning and using a modified version of the MOH's 2011 quantitative supervisory checklist (QSC), which includes waste management, infection prevention and control and site inspections. These visits will bolster reporting on the availability of and any misuse of pharmaceuticals, essential drugs and medical supplies observed during supervision visits.

International and national Juba and field-based Security Advisors will have oversight of the security related matters. In this role they will provide technical advice and support to PEHSP IPs and undertake the lead role in UNICEF's implementation of the enhanced SLT.

UNICEF's Implementing Partners

Implementing partners (national and international NGOs) will constitute the primary implementation modality for the delivery of health services. As is the case in all sectors in South Sudan, and as experience shows from PESHP, implementing partners have different levels of capacity. Therefore, UNICEF will provide close support and supervision. Capacity building of partners forms a key activity of UNICEF staff. The selection of implementing partners under PESHP followed a stringent transparent process. Throughout the implementation of PESHP, UNICEF made adjustments to implementing partners when performance issues could not be remediated. This will continue under the Project. Implementing partners also interact with MoH health care workers and community health care workers (BHI teams) to provide supervision, support and payment of incentives (in most cases).

Through their contracts and scope of work, Implementing Partners will be responsible for the following within the ESMF:

- Identifying needs for improved medical waste management and IPC procedures in health facilities, and providing the means to improve infrastructure and practices through the provision of supplies and operating costs to health facilities, as appropriate
- Implement / comply with all relevant environmental and social requirements as defined in the contracting documents
- Monitor the implementation of the ESMF in health facilities and by sub-contractors (if relevant)
- Implement and manage a GRM
- Report on implementation of the implemented components of the ESMF including grievances, accidents, and incidents

Third Party Monitoring Organization

The Third-Party Monitoring Organization (TPMO) is contracted by and reports directly to UNICEF. The Health Monitoring and Evaluation Specialist will work closely with the TPMO, providing technical guidance and monitoring performance as manager for this contract. The TPMO supports the UNICEF and World Bank with better means for learning from field experience, improving service delivery to beneficiaries, planning and

allocating resources, and demonstrating results. The [World Bank's ESF Good Practice Note on Third Party Monitoring](#) has been taken into account in the management of TPMO activities.

Other UNICEF Service Providers

Under the Project, UNICEF will contract services from private sector organizations. These services will primarily be for logistics, printing and telecommunications. Almost all procurement of goods under the Project will be procured from offshore private sector vendors vetted throughout global supply contracts by UNICEF Supply Division in Copenhagen.

Technical Working Committees UNICEF will coordinate with the numerous MoH Technical Working Committees established on various health programming aspects relevant to the Project. UNICEF is already a standing member of all relevant technical committees. These national committees act as a forum to receive consultations from state level MOH and leaders. These technical committees also include Risk Communications and Community Engagement Committee which often acts as a consolidator of community feedback and consultation of various health topics.

8.2 Monitoring and Reporting

Key objectives of the monitoring plan include:

- Enabling UNICEF and the World Bank to evaluate the success of mitigation as part of project supervision; and
- Allowing corrective actions to be taken whenever needed.

On a monthly and quarterly basis, UNICEF, together with its IPs and CHDs, will continuously monitor the above provisions during the planning and implementation phases of the intervention. UNICEF staff and third parties at central and field level will oversee monitoring and bolstering of safeguard compliance, as guided by the ESMF. The IPs' progress reports will provide ongoing information about key environmental and social impacts of the project, effectiveness of mitigation measures, and any outstanding issues to be remedied. These will additionally be addressed during quarterly performance reviews and coordination meetings.

UNICEF will include a section on safeguards compliance in each progress report that will be submitted to WB, with input from IPs. The IP feedback will be provided in a standard template based on the WB ESF and the relevant ESSs and UNICEF SESSP. In the case of the CERHSP, in the annual or six-monthly monitoring reports additional reporting may be requested on the extent to which the following safeguard objectives. Both UNICEF and TPMOs will monitor compliance with environmental mitigation measures will also be monitored at each supervision visit. Monitoring and procedures will be set out in a way that conditions that necessitate mitigation and capacity development measures are detected early.

UNICEF shall prepare and submit to the International Development Association regular (every six months) monitoring reports on the ESHS performance of the project including, but not limited to, stakeholder engagement activities and grievance logging. UNICEF shall report incidents occurring in the project areas which could significantly affect project implementation using a preset procedure.

8.3 Capacity-building and training

UNICEF has the responsibility for ensuring systems are in place so that relevant employees, contractors and other workers are aware of the environmental and social requirements for project implementation, including the ESMF. The following capacity-building and training programmes will be in place:

- Capacity-building of UNICEF staff (led by UNICEF): to impart awareness of essential regulatory and other requirements and elements of the ESMF, to help understand the importance of social and environmental management from design stage through implementation.
- Training and awareness of service provider personnel (overseen by UNICEF): training on relevant health facility Environmental Health and Safety (EHS) requirements, including social, health and safety requirements, will be embedded in the training of all service provider personnel conducted prior to the start of each payment cycle.

The capacity-building activities for UNICEF, IP staff and health workers will highlight existing mechanisms through the quality-of-care tools for monitoring the EHS at facility level. The capacity-building exercise will be done on a continuous basis, promoting use of the data generated from the monitoring activities.

The design of training modules shall consider differing levels of responsibility, ability, language skills, literacy and risk exposure. UNICEF will ensure that contractual obligations and systems are in place so that IPs and service providers ensure that persons under their control performing tasks related to environmental and social risk management are competent, based on appropriate education, training or experience, and shall retain associated records.

ATTACHMENTS

1. Attachment 1. Labor Management Plan
(attached separately)
2. Attachment 2. Stakeholder Engagement Plan
(attached separately)
3. Attachment 3. GBV Assessment and Action Plan
(attached separately)
4. Annex 2: Generic Medical Waste Management Plan

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ANNEX 2: Infection Control and Waste Management Plan (ICWMP) Template for HCFs

1. Introduction

- 1.1. Describe the project context and components
- 1.2. Describe the targeted healthcare facility (HCF):
 - Type: State hospital, County Hospitals, Primary health care centers, medical laboratory, quarantine, or isolation centers.
 - Special type of HCF in response to COVID-19: E.g., existing assets may be acquired to hold yet-to-confirm cases for medical observation or isolation.
 - Functions and requirement for the level infection control, e.g., biosafety levels.
 - Location and associated facilities, including access, water supply, power supply.
 - Capacity: beds
 -
- 1.3. Describe the design requirements of the HCF, which may include specifications for general design and safety, separation of wards, ventilation, and air conditioning (HVAC), autoclave, and waste management facilities.

2. Infection Control and Waste Management

- 2.1. Overview of infection control and waste management in the HCF
 - Type, source, and volume of healthcare waste (HCW) generated in the HCF, including solid, liquid and air emissions (if significant)
 - Classify and quantify the HCW (infectious waste, pathological waste, sharps, liquid and nonhazardous) following WBG EHS Guidelines for Healthcare Facilities and pertaining GIIP.
 - Given the infectious nature of the novel coronavirus, some wastes that are traditionally classified as non-hazardous may be considered hazardous. It's likely the volume of waste will increase considerably given the number of admitted patients during COVID-19 outbreak. Special attention should be given to the identification, classification, and quantification of the healthcare wastes.
 - Describe the healthcare waste management system in the HCF, including material delivery, waste generation, handling, disinfection and sterilization, collection, storage, transport, and disposal and treatment works
 - Provide a flow chart of waste streams in the HCF if available
 - Describe applicable performance levels and/or standards
 - Describe institutional arrangement, roles, and responsibilities in the HCF for infection control and waste management.
- 2.2. Management Measures
 - Waste minimization, reuse, and recycling: HCF should consider practices and procedures to minimize waste generation, without sacrificing patient hygiene and safety considerations.
 - Delivery and storage of specimen, samples, reagents, pharmaceuticals, and medical supplies: HCF should adopt practices and procedures to minimize risks associated with delivering, receiving and storage of hazardous medical goods.
 - Waste segregation, packaging, color coding and labeling: HCF should strictly conduct waste segregation at the point of generation. Internationally adopted method for packaging, color coding and labeling the wastes should be followed.
 - Onsite collection and transport: HCF should adopt practices and procedures to timely remove properly packaged and labelled wastes using designated trolleys/carts and routes. Disinfection of pertaining tools and spaces should be routinely conducted. Hygiene and safety of involved supporting medical workers such as cleaners should be ensured.

- Waste storage: A HCF should have multiple waste storage areas designed for different types of wastes. Their functions and sizes are determined at design stage. Proper maintenance and disinfection of the storage areas should be carried out. Existing reports suggest that during the COVID-19 outbreak, infectious wastes should be removed from HCF's storage area for disposal within 24 hours.
- Onsite waste treatment and disposal (e.g., an incinerator): Many HCFs have their own waste incineration facilities installed onsite. Due diligence of an existing incinerator should be conducted to examine its technical adequacy, process capacity, performance record, and operator's capacity. In case any gaps are discovered, corrective measures should be recommended. For new HCF financed by the project, waste disposal facilities should be integrated into the overall design and ESIA developed. Good design, operational practices and internationally adopted emission standards for healthcare waste incinerators can be found in pertaining EHS Guidelines and GIIP.
- Transportation and disposal at offsite waste management facilities: Not all HCF has adequate or well performed incinerator onsite. Not all healthcare wastes are suitable for incineration. Onsite incinerator produces residuals after incineration. Hence offsite waste disposal facilities provided by local governments are probably needed. These offsite waste management facilities may include incinerators, hazardous wastes landfill. In the same vein, due diligence of such external waste management facilities should be conducted to examine its technical adequacy, process capacity, performance record, and operator's capacity. In case any gaps are discovered, corrective measures should be recommended and agreed with the government or the private sector operators.
- Wastewater treatment: HCF wastewater is related to hazardous waste management practices. Proper waste segregation and handling as discussed above should be conducted to minimize entry of solid waste into the wastewater stream. In case wastewater is discharged into municipal sewer sewerage system, the HCF should ensure that wastewater effluent comply with all applicable permits and standards, and the municipal wastewater treatment plant (WWTP) can handle the type of effluent discharged. In cases where municipal sewage system is not in place, HCF should build and properly operate on site primary and secondary wastewater treatment works, including disinfection. Residuals of the onsite wastewater treatment works, such as sludge, should be properly disposed of as well. There're also cases where HCF wastewater is transported by trucks to a municipal wastewater treatment plant for treatment. Requirements on safe transportation, due diligence of WWTP in terms of its capacity and performance should be conducted.

3. Emergency Preparedness and Response

- Emergency incidents occurring in a HCF may include
 - o spillage,
 - o occupational exposure to infectious materials or
 - o exposure to radiation,
 - o accidental releases of infectious or hazardous substances to the environment,
 - o medical equipment failure,
 - o failure of solid waste and wastewater treatment facilities,
 - o and fire.
- These emergency events are likely to seriously affect medical workers, communities, the HCF's operation and the environment.
- Thus, an Emergency Response Plan (ERP) that is commensurate with the risk levels is recommended to be developed. The key elements of an ERP are defined in ESS 4 Community Health and Safety (para. 21).

4. Institutional Arrangement and Capacity Building

A clearly defined institutional arrangement, roles and responsibilities should be included. A training plan with recurring training programs should be developed. The following aspects are recommended:

- Define roles and responsibilities along each link of the chain along the cradle-to-cradle infection control and waste management process.
- Ensure adequate and qualified staff are in place, including those in charge of infection control and biosafety and waste management facility operation.
- Stress the chief of a HCF takes overall responsibility for infection control and waste management.
- Involve all relevant departments in a HCF, and build an intra-departmental team to manage, coordinate and regularly review issues and performance.
- Establish an information management system to track and record the waste streams in HCF; and
- Capacity building and training should involve medical workers, waste management workers and cleaners. Third-party waste management service providers should be provided with relevant training as well.

5. Monitoring and Reporting

Many HCFs in developing countries face the challenge of inadequate monitoring and records of healthcare

waste streams. HCF should establish an information management system to track and record the waste

streams from the point of generation, segregation, packaging, temporary storage, transport carts/vehicles, to treatment facilities. The HCF is encouraged to develop an IT based information management system should their technical and financial capacity allow.

As discussed above, the HCF chief takes overall responsibility, leads an intra-departmental team and

regularly reviews issues and performance of the infection control and waste management practices in the

HCF. Internal reporting and filing systems should be in place.

Externally, reporting should be conducted as per government and World Bank requirements.

Activity	Potential E&S issues and risks	Proposed mitigation measures	Responsibilities	Timeline	Budget
General Health care facility operation - environment	General waste, wastewater, and air emissions				
General Health Care facility operation OHS issues	<ul style="list-style-type: none"> • Physical hazards • Electrical and explosive hazards • Fire • Chemicals use • Ergonomic hazards • Radioactive hazards 				
Health care facility operation- infection control and waste management					
Waste minimization, reuse, and recycling					
Delivery and storage of specimen, samples, reagents, pharmaceuticals, and medical supplies					
Waste segregation, packaging, color coding and labeling					
Onsite waste collection and transport					
Waste storage and handling of specimen					
Onsite waste treatment and disposal					
Waste transportation and disposal at offsite waste management facilities					
Wastewater treatment					

Activity	Potential E&S issues and risks	Proposed mitigation measures	Responsibilities	Timeline	Budget
Health facility operation – transboundary movement of specimen, samples, reagents and infectious materials					
Emergency events	<ul style="list-style-type: none"> ○ spillage, ○ occupational exposure to infectious materials or ○ exposure to radiation, ○ accidental releases of infectious or hazardous substances to the environment, ○ medical equipment failure, ○ failure of solid waste and wastewater treatment facilities, ○ and fire. 	Emergency response plan			

Appendix A. Screening Tool for E&S Risks

Screening Form for Potential Environmental and Social Issues

UNICEF will use this form to screen for the potential environmental and social risks and impacts of a proposed subproject. The form will allow UNICEF to: (i) identify the relevant Environmental and Social Standards (ESS); (ii) establishment an appropriate Environmental and Social risk for the subproject, and; (iii) specify the type of environmental and social assessment required, including specific instruments/plans.

The Screening Form is not a substitute for subproject-specific environmental and social assessments or specific mitigation plans.

Subproject name	
Subproject location	
Implementing Partner	
Estimated Investment	
Was the site visited beforehand	
Estimated Start/Completion Date	
Observations/Comments	
Signature of ESS Specialist	
Signature of Program Manager	

Question		Answer	Relevant ESS	Extent of Required Measures
Yes	No			
			ESS1	ESIA/ESMP, SEP
			ESS5	Resettlement Plan, SEP
			ESS3	ESIA/ESMP, SEP
			ESS1, ESS3	ESMP
			ESS2	LMP, SEP
			ESS2	LMP
			ESS10	SEP
			ESS4	ESIA/ESMP, SEP

healthcare facilities and related activities?				
Is the subproject located within or in the vicinity of any ecologically sensitive areas?			ESS6	ESIA/ESMP, SEP
Is the subproject located within or in the vicinity of any known cultural heritage sites?			ESS8	ESIA/ESMP, SEP
Does the project area present considerable gender-based violence and Sexual Exploitation and Abuse (SEA) risk?			ESS1	ESIA/ESMP, SEP

Conclusions of the screening:

1. **Indicate the proposed environmental and social risk ratings² (High, Substantial, Moderate or Low), and provide justifications.**
2. **Indicate the proposed environmental and social risk management instruments that must be prepared and how they will be implemented (responsibilities, resources, timeline).**

Appendix B. Infection and Prevention Control Protocol (IPCP)

The following information was adapted from the CDC Interim Infection Prevention and Control Recommendations for patients with confirmed COVID-19 or persons under investigation for COVID-19 in Healthcare Settings. The original reference should be consulted for any updates.

HEALTH CARE SETTINGS

1. Minimize Chance of Exposure (to staff, other patients and visitors)

- Upon arrival, make sure patients with symptoms of any respiratory infection arrive to a separate, isolated and well-ventilated section of the health care facility to wait, and issue a facemask
- During the visit, make sure all patients adhere to respiratory hygiene, cough etiquette, hand hygiene and isolation procedures. Provide oral instructions on registration and ongoing reminders with the use of simple signs with images in local languages
- Provide alcohol-based hand sanitizer (60-95% alcohol), tissues and facemasks in waiting rooms and patient rooms
- Isolate patients as much as possible. If separate rooms are not available, separate all patients by curtains. Only place together in the same room patients who are all definitively infected with COVID-19. No other patients can be placed in the same room.

2. Adhere to Standard Precautions

- Train all staff and volunteers to undertake standard precautions - assume everyone is potentially infected and behave accordingly
- Minimize contact between patients and other persons in the facility: health care professionals should be the only persons having contact with patients and this should be restricted to essential personnel only
- A decision to stop isolation precautions should be made on a case-by-case basis, in conjunction with local health authorities.

3. Training of Personnel

- Train all staff and volunteers in the symptoms of COVID-19, how it is spread and how to protect themselves. Train on correct use and disposal of personal protective equipment (PPE), including gloves, gowns, facemasks, eye protection and respirators (if available) and check that they understand
- Train cleaning staff on most effective process for cleaning the facility: use a high-alcohol based cleaner to wipe down all surfaces; wash instruments with soap and water and then wipe down with high-alcohol based cleaner; dispose of rubbish by burning etc.

4. Manage Visitor Access and Movement

- Establish procedures for managing, monitoring, and training visitors
- All visitors must follow respiratory hygiene precautions while in the common areas of the facility, otherwise they should be removed

- Restrict visitors from entering rooms of known or suspected cases of COVID-19 patients. Alternative communications should be encouraged, for example by use of mobile phones. Exceptions only for end-of-life situation and children requiring emotional care. At these times, PPE should be used by visitors.
- All visitors should be scheduled and controlled, and once inside the facility, instructed to limit their movement.
- Visitors should be asked to watch out for symptoms and report signs of acute illness for at least 14 days.

CONSTRUCTION SETTINGS IN AREAS OF CONFIRMED CASES OF COVID-19

1. Minimize Chance of Exposure

- Any worker showing symptoms of respiratory illness (fever + cold or cough) and has potentially been exposed to COVID-19 should be immediately removed from the site and tested for the virus at the nearest local hospital
- Close co-workers and those sharing accommodations with such a worker should also be removed from the site and tested
- Project management must identify the closest hospital that has testing facilities in place, refer workers, and pay for the test if it is not free
- Persons under investigation for COVID-19 should not return to work at the project site until cleared by test results. During this time, they should continue to be paid daily wages
- If a worker is found to have COVID-19, wages should continue to be paid during the worker's convalescence (whether at home or in a hospital)
- If project workers live at home, any worker with a family member who has a confirmed or suspected case of COVID-19 should be quarantined from the project site for 14 days, and continued to be paid daily wages, even if they have no symptoms.

2. Training of Staff and Precautions

- Train all staff in the signs and symptoms of COVID-19, how it is spread, how to protect themselves and the need to be tested if they have symptoms. Allow Q&A and dispel any myths.
- Use existing grievance procedures to encourage reporting of co-workers if they show outward symptoms, such as ongoing and severe coughing with fever, and do not voluntarily submit to testing
- Supply face masks and other relevant PPE to all project workers at the entrance to the project site. Any persons with signs of respiratory illness that is not accompanied by fever should be mandated to wear a face mask
- Provide handwash facilities, hand soap, alcohol-based hand sanitizer and mandate their use on entry and exit of the project site and during breaks, via the use of simple signs with images in local languages
- Train all workers in respiratory hygiene, cough etiquette and hand hygiene using demonstrations and participatory methods
- Train cleaning staff in effective cleaning procedures and disposal of rubbish.

3. Managing Access and Spread

- Should a case of COVID-19 be confirmed in a worker on the project site, visitors should be restricted from the site and worker groups should be isolated from each other as much as possible;
- Extensive cleaning procedures with high-alcohol content cleaners should be undertaken in the area of the site where the worker was present, prior to any further work being undertaken in that area.

Appendix C. Health and Safety Guidelines for Retrofitting/Rehabilitation of medical facilities

The following table lists the health and safety risks and impacts associated with small civil works financed by the Bank for retrofitting and rehabilitation of medical facilities (including isolation units and respiratory facilities) in response to the COVID-19 outbreak. Potential mitigation measures and references to sources of additional advice and information are provided as guidelines for the PIU to use in preparing the appropriate environmental instrument such as the Environmental and Social Management Plan (ESMP).

Activity	Risks and Impacts	Mitigation Measures
Design activity – hospitals, clinics	The focus on treatment and care is progressed disproportionately with the need for adequate medical waste infrastructure.	<p>Ensure that the designs for medical facilities also consider the collection, segregation and treatment of medical waste.</p> <p>The treatment of healthcare waste produced during the care of COVID-19 patients should be collected safely in designated containers and bags, treated and then safely disposed.</p> <p>Open burning and incineration of medical wastes can result in emission of dioxins, furans and particulate matter, and result in unacceptable cancer risks under medium (two hours per week) or higher usage. If small-scale incinerators are the only option available, the best practices possible should be used, to minimize operational impacts on the environment. Best practices in this context are:</p> <ul style="list-style-type: none"> ✓ effective waste reduction and segregation, ensuring only the smallest quantities of combustible waste types are incinerated. ✓ an engineered design with sufficient residence time and temperatures to minimize products of incomplete combustion. ✓ siting incinerators away from health-care buildings and residential areas or where food is grown. ✓ construction using detailed engineering plans and materials to minimize flaws that may lead to incomplete destruction of waste and premature failures of the incinerator. ✓ a clearly described method of operation to achieve the desired combustion conditions and emissions; for example, appropriate start-up and cool-down procedures, achievement and maintenance of a minimum temperature before waste is burned, use of appropriate loading/charging rates (both fuel and waste) to maintain appropriate temperatures, proper disposal of ash and equipment to safeguard workers.

		<ul style="list-style-type: none"> ✓ periodic maintenance to replace or repair defective components (including inspection, spare parts inventory and daily record keeping); and ✓ improved training and management, possibly promoted by certification and inspection programs for operators, the availability of an operating and maintenance manual, visible management oversight, and regular maintenance schedules. <p>Single-chamber, drum and brick incinerators do not meet the BAT requirements under Stockholm Convention.</p> <p>Small-scale incineration should be viewed as a transitional means of disposal for health-care waste.</p> <p>Alternative treatments should be designed into longer term projects, such as steam treatment methods. Steam treatment should preferably be on site, although once treated, sterile/non-infectious waste may be shredded and disposed of in suitable waste facilities.</p> <p>See WHO Safe management of wastes from health-care activities</p>
Construction activity – hospitals, clinics, mortuary	<p>Land taking for the construction of new and expansion of existing hospitals.</p> <p>Injury during the construction of new buildings or refurbishment of existing buildings.</p>	<p>Follow ESS5 and IPF Policy para 12 on E&S requirements in situations of urgent need of assistance.</p> <p>Apply ESHGs to implementation of projects.</p>
Design and operation of facilities, including triage, isolation (or quarantine) facilities	The design of the facility and the operating procedures will help prevent spread of infection	<p>For patients with possible or confirmed COVID-19, isolation rooms should be provided and used at medical facilities. Isolation rooms should:</p> <ul style="list-style-type: none"> ✓ be single rooms with attached bathrooms (or with a dedicated commode); ✓ ideally be under negative pressure (neutral pressure may be used, but positive pressure rooms should be avoided); ✓ be sited away from busy areas (areas used by many people) or close to vulnerable or high-risk patients, to minimize chances of infection spread.

		<ul style="list-style-type: none"> ✓ have dedicated equipment (for example blood pressure machine, peak flow meter and stethoscope), but should avoid excess equipment or soft furnishings. ✓ have signs on doors to control entry to the room, with the door kept closed. ✓ have an anteroom for staff to put on and take off PPE and to wash/decontaminate before and after providing treatment. <p>An operation manual should be prepared prior to the opening of isolation rooms to describe the working procedures to be taken by healthcare workers to protect themselves and prevent infection escape while providing treatment. The operational procedures should be of a standard to meet guidance from WHO and/or CDC on infection control:</p> <ul style="list-style-type: none"> ➤ WHO interim guidance on Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected; ➤ WHO technical brief water, sanitation, hygiene and waste management for COVID-19; ➤ WHO guidance on infection prevention and control at health care facilities (with a focus on settings with limited resources); ➤ WHO interim practical manual for improving infection prevention and control at the health facility; ➤ CDC Guidelines for isolation precautions: preventing transmissions of infectious agents in healthcare settings; and ➤ CDC guidelines for environmental infection control in healthcare facilities.
<p>Improve access to support and treatment for disadvantaged vulnerable groups</p>	<p>Some vulnerable groups (especially the elderly or those with pre-existing medical conditions) may be severely affected by COVID-19 and may need additional support to access treatment.</p>	<p>Projects should develop and commit to specific actions to ensure disadvantaged and vulnerable groups have effective treatment, whether in medical facilities or in the community.</p> <p>Similarly, where IP communities are involved, need to follow ESS7 and IPF policy Para 12 on emergency provision.</p>
<p>Employment of workers</p>	<p>Workers do not receive the care</p>	<p>Contractors should ensure that contracted workers have medical insurance, covering treatment of COVID-19.</p>

	needed if infected with COVID-19.	
Transient and expat workforce	Workers that are mobilized from abroad or returning from abroad become vectors for transmission of disease to construction projects. Workers that travel from other regions may also provide a vector for passing infection onto work sites.	<p>Expats or transient workers should adhere to national requirements and guidelines with respect to COVID-19.</p> <p>Expats or transient workers coming from countries/regions with cases of the virus:</p> <ul style="list-style-type: none"> • Should not return if displaying symptoms • Should self-isolate for 14 days following their return <p>For self-isolation, workers should be provided with a single room that is well-ventilated (i.e., with open windows and an open door). If a single room is not available for each worker, adequate space should be provided to maintain a distance of at least 1 m between workers sharing a room. Workers in isolation should limit their movements in shared space, for example through timed use of shared spaces (such as kitchens and bathrooms) with cleaning prior to and after use of the facilities. Visitors should not be allowed until the worker has shown no signs and symptoms for 14 days, and the number of staff involved in caring for those in isolation should be kept to a minimum.</p> <p>Healthcare professionals and cleaners should visit each day (wearing the appropriate PPE and observing hygiene requirements and make appropriate arrangements for supplying food and water to the kitchens for the workers in isolation. Further information is provided by WHO in Home care for patients with suspected novel coronavirus (COVID-19).</p>
Labor camps	Close working and living conditions of workforce may create conditions for the easy transmission of COVID-19 and the infection of large numbers of people.	<p>Develop contingency plans with arrangements for accommodation, care and treatment for:</p> <ul style="list-style-type: none"> • Workers self-isolating • Workers displaying symptoms • Getting adequate supplies of water, food and supplies <p>Contingency plans also should consider arrangements for the storage and disposal arrangements for medical waste, which may increase in volume and which can remain infectious for several days (depending upon the material).</p>

		<p>Ensure medical facilities are stocked with adequate supplies of medical PPE, as a minimum:</p> <ul style="list-style-type: none"> ✓ Gowns, aprons ✓ Medical masks and some respirators (N95 or FFP2) ✓ Gloves (medical, and heavy duty for cleaners) ✓ Eye protection (goggles or face screens) ✓ <p>Medical staff at the facilities should be trained and be kept up to date on WHO advice and recommendations on the specifics of COVID19.</p> <p>The medical staff/management should run awareness campaigns and posters on site advising workers:</p> <ul style="list-style-type: none"> • how to avoid disease spread (cough/sneeze in crook of elbow; keep 1m or more away, sneeze/cough in tissue and immediately throw tissue away, avoid spitting, observe good hygiene) • the need to regularly wash hands with soap and water – many times per day • to self-isolate if they think they may have come in contact with the virus • to self-isolate if they start to display any symptoms, but alert and seek medical advice <p>Wash stations should be provided regularly throughout site, with a supply of clean water, liquid soap and paper towels (for hand drying), with a waste bin (for used paper towels) that is regularly emptied.</p> <p>Wash stations should be provided wherever there is a toilet, canteen/food and drinking water, or sleeping accommodation, at waste stations, at stores and at communal facilities. Where wash stations cannot be provided (for example at remote locations), alcohol-based hand rub should be provided.</p> <p>Enhanced cleaning arrangements should be put in place, to include regular and deep cleaning using disinfectant of catering facilities/canteens/food/drink facilities, latrines/toilets/showers,</p>
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		<p>communal areas, including door handles, floors and all surfaces that are touched regularly (ensure cleaning staff have adequate PPE when cleaning consultation rooms and facilities used to treat infected patients)</p> <p>Worker accommodation that meets or exceeds IFC/EBRD worker accommodation requirements (e.g. in terms of floor type, proximity/no of workers, no ‘hot bedding’, drinking water, washing, bathroom facilities etc.) will be in good state for keeping clean and hygienic, and for cleaning to minimize spread of infection.</p> <p>To minimize pressure on PPE resources: WHO advice on the effectiveness and use of PPE by general public should be followed to ensure that the supplies are not exhausted through ineffective use – this is equally important on construction sites.</p> <p>Other measures (such as working water sprinkling systems at crushers and stock piles, covered wagons, water suppression or surfacing of haul roads etc.) should be used for dust suppression on site before relying upon the use of dust masks (which could unnecessarily reduce the availability of N95/FFP2 masks for use by medical staff performing some duties)</p>
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References and sources of further information

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>

<https://www.cdc.gov/coronavirus/2019-ncov/lab/lab-biosafety-guidelines.html>

<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>

<https://www.gov.uk/government/collections/coronavirus-covid-19-list-of-guidance#guidance-for-health-professionals>

<https://worldbankgroup.sharepoint.com/sites/wbsites/coronavirus/Pages/index.aspx>

Appendix D. Environmental, Social, Health and Safety (ESHS) Risks and Mitigation Measures for small civil works at health care facilities where COVID-19 may be present

The paragraphs below describe the ESHS risks at each of the stages or phases of small civil works projects where COVID-19 may be of concern. The subsequent matrix describes the associated mitigation measures. The discussion and matrix can be modified to create an Environmental and Social Management Plan (ESMP) for these types of small works under the CERC.

- Phase 1 - Design and Deployment.** The selection of a site must take into account land ownership and community safety. Given that the CERC objective is to support immediate priority activities, the activities or subprojects with resettlement issues will be avoided. Once a site is being prepared, there must be attention paid to avoid impacts such as controlling runoff, flood-prone, areas of shallow water tables and other climate change related risks prone areas, having safe areas for waste storage bins or receptacle storages, and adequate facilities for the collection, storage and eventual treatment of sanitary wastewater. Standard measures to avoid impacts from traffic safety, dust, and noise must be observed, as well as those dealing with occupational health and safety for site workers. Areas with diesel generators may also be used for power or emergency back-up, requiring adequate ventilation, fuel storage, and safety measures. As well, construction waste and debris will need to be disposed of properly.
- Phase 2 - Operations.** Once operational, facilities will have biomedical waste which will need proper treatment and disposal. The health and safety of health care workers could be affected by poor waste management practices. Operation of an autoclave or incinerator is also a source of risk if not properly done. Thermal injuries, or chemical burns could also arise in the context of disinfection, sterilization or waste treatment activities. Infection control procedures are also of critical importance during the operations phase.
- Phase 3 - Decommissioning.** After the facility is finished operating as an active isolation the facility must be adequately sanitized, waste materials removed and disposed of, and supplies and equipment must be safely stored and maintained for future use.

Phase 1 - Design and Deployment

Aspect	Potential Impacts	Proposed Mitigation
Site selection for construction/assembly area	<ul style="list-style-type: none"> There may be anxiety and complaints from those living in or using nearby areas about potential impacts of COVID -19 	<ul style="list-style-type: none"> Conduct community outreach once site has been finalized. Follow the level of outbreak guidance on Risk Communication and Community engagement (RCCE) readiness and response to the 2019 novel coronavirus (2019-nCoV) published by the WHO.

Aspect	Potential Impacts	Proposed Mitigation
Hazardous materials handling, storage, use and transportation	<ul style="list-style-type: none"> • The risk of accidental discharge of hazardous products, leakage of hydrocarbons, oils or grease from construction machinery 	<ul style="list-style-type: none"> • Avoid the storage of hazardous substances around water bodies • Ensure that storage containers of hazardous substances are always in good condition and tightly closed • Ensure that storage facilities are provided impervious surfaces and bunds to control spill in case of accidental spillage • Develop spill response plan as part of the construction ESMP • Secondary containment for fuels to avoid spill contamination and inspection during operation • Some training in fuel and waste handling should be part of the orientation for workers • Maintain the MSDS Sheets for hazardous materials onsite
Construction Wastes and Debris	<ul style="list-style-type: none"> • Improper storage and/or disposal of materials • Dispersion of materials in nearby canals, ditches, rivers, streets and adjacent properties 	<ul style="list-style-type: none"> • The contractor shall handle construction materials and waste in accordance with approved procedures. • The contractor should only dispose of materials in areas approved by the Municipality or relevant authority • The contractor shall contain excavated materials in the vicinity of the worksite within berms to prevent dispersion and sedimentation of drains, creeks, streets and adjacent properties • In case of accidental waste dispersion, the environmental authority shall be informed, and restoration measures shall be applied.
Dust and noise from construction activity	<ul style="list-style-type: none"> • Impaired Air quality due to emissions from vehicles and dust generated • Respiratory impacts on site workers, nearby residents and pedestrians • Noise generation from the use of machines and construction equipment with its impact on workers and neighborhoods 	<ul style="list-style-type: none"> • Dust suppression methods such as wetting materials or slowing work should be employed as needed to avoid visible dust • Gas masks / respirators when working in closed areas such as access manholes, etc. (according to approved procedures) • Document requirements and standards in the Contract • Hearing protection for working around machinery where the noise exceeds 85 dB (according to approved procedures) • The location of noisy machinery (including generators) can be positioned away from sensitive sites such as schools' hospitals, residential areas etc. • Maintain vehicles and Contractor's machinery according to maintenance requirements.
Community Health and Safety	<ul style="list-style-type: none"> • Movement of heavy trucks and equipment may cause traffic problems and create unsafe situations for local motorists. • Unauthorized entry of local persons may place them in jeopardy if they are on work locations. 	<ul style="list-style-type: none"> • Ensure that a Traffic Management Plan is in place where this might be an issue. • Ensure that sites are properly barricaded during construction and temporary pedestrian walkways are provided when required • Restrict hospital staff and public from going to the construction site during and outside working hours by placing posters, reflecting tapes and erecting barriers. • Contractor must develop a Community Health and Safety Plan (CHSP).
Worker health and safety	Accidents to workers on the construction site	<ul style="list-style-type: none"> • Train workers on prevention of accidents and managing incidents. • Workers must wear protective gear. • Provide first aid kit and emergency plan for accidents or incidents • Proper supervision of the construction workforce.

Aspect	Potential Impacts	Proposed Mitigation
Worker health and Safety – COVID -19 Risks	Exposure and spread of infection	<ul style="list-style-type: none"> • For COVID -19 management on the construction site follow the infection control protocol in Annex B of this CERC Addendum.
Water pollution from runoff or infiltration of wastes on different sites where facilities or equipment may be deployed	<p>Clogging of ditches or drains with sediment or silt</p> <p>Fouling of waterways with pollutants of any kind</p>	<ul style="list-style-type: none"> • Prepare the ground where the facility or equipment will be placed by compacting, lining, coating, and otherwise ensuring it is impervious to water infiltration or percolation. • Sensitize the workers to appropriately manage construction materials and wastes • Use berms, silt traps or silt fences, pits or other measures to ensure that any runoff from the site is controlled
Medical Waste Management	Improper handling of medical waste could expose nearby communities or workers to infection	<ul style="list-style-type: none"> • A Medical Waste Management Plan for handling any items during the site preparation

Phase 2 - Operations

Aspect	Potential Impacts	Proposed Mitigation
Community Health and Safety	Exposure of visitors	<ul style="list-style-type: none"> • Control and restrict access to the facility following COVID-19 protocol and guidance from the WHO for health facility, and the COVID-19 risk communication package for healthcare facilities. • Implement the Infection control protocol in the annexes of this CERC-ESMF.
Occupational Health and Safety	<p>Injury to healthcare workers</p> <p>Infection of health care workers</p>	<ul style="list-style-type: none"> • Train staff on how to use PPE and ensure there is adequate supply • Regularly monitor performance and conduct maintenance of equipment • Train staff in infection control and SOPs for equipment. • Use the checklist tool from WHO “Risk assessment and management of exposure of health care workers in the context of COVID-19 for any instances where facility staff are exposed to a confirmed COVID 19 persons. • Determine how illness among isolation facility staff will be managed in terms of required reporting, self-isolation, and workers compensation. Share this approach to all facility staff.
Medical Waste Management	<p>Exposure of nearby communities</p> <p>Exposure of workers</p>	<ul style="list-style-type: none"> • Use procedures from the WHO, CDC, CARPHA, and national plans to properly classify, segregate, label, store, handle, and dispose of wastes • Provide training on waste management and infectious disease management training and surveillance programs
Air emissions from incinerator	Air pollution from inadequate incineration of waste	<ul style="list-style-type: none"> • Ensure the SOPs from the incinerator supplier are followed and that training is received from supplier • Sensitize and train staff to adequately segregate, store, and transport the waste to the incinerator and/or autoclave • Adequately budget for fuel for the incinerator and/or autoclave • Provide appropriate breathing masks to incinerator operators and other staff that work near the incinerator • Regularly monitor and maintain the incinerators to ensure they are working properly in accordance with SOPs

Aspect	Potential Impacts	Proposed Mitigation
Air emissions from isolation unit filtration systems	Spread of airborne particles or aerosols	<ul style="list-style-type: none"> • Control airflow and provide filtration for intake/exhaust • Manage air filters as medical waste • Regularly monitor and maintain the filtration system to ensure they are working properly in accordance with SOPs
Hazardous liquid waste management	<p>Spread of infection</p> <p>Contamination of streams or groundwater</p>	<ul style="list-style-type: none"> • Liquid wastes to be stored, neutralized, and disposed of so that it is not infectious • Sensitize staff to avoid spillage of waste water on the ground surface • Sensitize staff and users of the facility to appropriately use the wastewater collection and disposal facilities
Non-hazardous liquid and solid waste	Unintended mixing of wastes, vector control, waste and debris accumulation	<ul style="list-style-type: none"> • Segregate liquid and solid wastes where possible • Construct the septic tank and soak-pit according to the design specifications • The latrines or septic tank and soak pit site should be regularly monitored and serviced to prevent problems or overflow • Ensure that wastewater disposal is adequately budgeted for maintenance
Traffic Management and Access Control	Unauthorized entry to facility of vehicles or persons	<ul style="list-style-type: none"> • Control visitor access and movement into and out of the facility and surrounding areas • Establish dedicated loading and unloading areas for supply vehicles and emergency vehicles.
Community Concerns on COVID-19	Misinformation about the spread of the disease may result in the public not taking the appropriate preventative measures, which may result in the isolation facility being overwhelmed with cases.	<ul style="list-style-type: none"> • Develop and implement a communication plan for all media types with key messages on prevention for facility visitors, local community, and national level following the tool from the WHO “Risk Communication and Community Engagement (RCCE) Action Plan Guidance COVID-19 Preparedness and Response” • The plan will target the general population as well as specify messages for key vulnerable populations groups such as the elderly and their caregivers. The plan will take guidance from WHO COVID-19 guidance for preventing and addressing stigma and WHO COVID-19 risk communication package for healthcare facilities

Phase 3 - Decommissioning

Aspect	Potential Impacts	Proposed Mitigation
Site clean-up	Risk of infection from contaminated runoff, dust, or soil	<ul style="list-style-type: none"> • Incinerate or bury contaminated solid waste and dispose ash in approved sites • Remove or seal and encapsulate any wastewater system elements

Aspect	Potential Impacts	Proposed Mitigation
Contaminated equipment	Risk of infection from contaminated equipment	<ul style="list-style-type: none">• Provide appropriate PPE for staff for cleaning equipment used in all areas used• Clean all equipment used following standards provided by WHO

Appendix E. Communications Protocol

Under conditions of a disease outbreak a common approach to stakeholder engagement where large gathering of the public is encouraged will need to change. There are numerous alternatives, but they key criteria for stakeholder engagement remains the same, and that is meaningful dialogue with project-affected people with attention given to the most vulnerable. Every alternative must still include what feedback and suggestions were provided by stakeholders. Some suggestions for community engagement during a COVID-19 outbreak are listed below.

- Avoid public gatherings (taking into account national restrictions), including public hearings, workshops and community meetings.
- If smaller meetings are permitted, conduct consultations in small-group sessions of no more than 10 people, such as focus group meetings in an outside area with chairs placed 6 feet apart.
- If in-person meetings are not permitted, make efforts to conduct meetings through online channels, including webex, zoom and skype.
- Try social media and online channels to share activity information. Where possible and appropriate, create dedicated online platforms and chatgroups appropriate for the purpose.
- Employ traditional channels of communications (TV, newspaper, radio, dedicated phone-lines, and mail) if a stakeholder does not have access to online channels or does not use them frequently.
- Where direct engagement with project affected people or beneficiaries is necessary, identify channels for direct communication with each affected household via a combination of email messages, mail, online platforms, dedicated phone lines with knowledgeable operators, or direct calling by the project team.

Communication and engagement activities under this CERC will also follow the publication from the WHO “Risk communication and community engagement (RCCE) readiness and response to the 2019 novel coronavirus (2019-nCoV)” which will guide messaging about the COVID -19 preparedness and response measures under the CERC and gives broader guidance and checklists for national level communication during different phases of a disease outbreak.

Appendix F: Results from WB GBV Assessment for Additional Financing.

97. Summary. Social risks are largely the result of the FCV context in the targeted areas. This includes risks resulting from (i) intra-communal tensions, including between refugees and host communities, over implementation issues and (ii) assets and staff becoming targets of violent groups. Violence (political, criminal, ethnic, etc.) and gender-based violence are two forms of concern as result of escalating social risks. The GBV risk has been rated High. Both environmental and social risks are rated as High. Based on this assessment, the overall environmental and risk level is considered High. Experience from the parent and previous project (P176480, P168926) has shown the capacity of the implementing agencies to develop and improve environmental and social risk management structures. Functional grievance redress mechanism (GRM) has been developed and integrated with community outreach. Security incident prevention and management have consistently improved, including on the provision of resources to strengthen local project implementors as well as monitoring and reporting. That said, high residual risks remain due to the contextual situation. Respective risk management instruments are available and can cover the limited expansion in scope resulting from project design changes outlined above.

98. GBV: Pervasive incidences of GBV in South Sudan are a significant contextual challenge. Assessment of AF related sexual exploitation and abuse/GBV has been conducted during AF preparation. Given the context of also pervasive insecurity, the AF adopts a robust approach to address potential GBV risks, including site-specific assessments of the availability of referral systems and its establishment if insufficient. Relevant mitigation measures to address these risks (e.g., integrating Codes of Conduct with sexual exploitation and abuse/GBV-related protections into community consultations and mapping activities to identify service providers, and establishment of a GRM with procedures and channels to enable safe, confidential, and ethical reporting of GBV incidents) are articulated in the Environmental and Social Management Framework (ESMF). The AF also includes capacity building and training of relevant stakeholders with a focus on primary health facilities; risks will be monitored throughout project implementation through regular re-assessment with the risk screening tool, particularly as new project locations are determined, and through regular monitoring engagement. A GBV Action Plan has been prepared and its implementation is a requirement in the Environmental and Social Commitment Plan (ESCP).

104. Risk Management Instruments. The ESMF includes in line with the ESF the (i) overall project-wide Environmental and Social Risks assessment in line with ESS1-ESS10; (ii) generic management and mitigation procedures for handling environmental and social risks resulting from the project in the South Sudanese context; (iii) a social assessment including risks of discrimination, community tensions, and violence and respective measures in a social management plan; (iv) a GBV Action Plan; (v) Labor-Management Procedures including a worker's GRM; (vi) the SEP25 including a community GRM; (vii) organizational structure and resource planning; and the (viii) monitoring and reporting system. It also includes a summary of the Security Management Plan, which has been developed separately. Commitments with binding timelines have been agreed on together with the implementing partners and will be included in the ESCP. The parent project ESCP is fully implemented, as noted in the February 2022 ISR.

Gender Dimensions and Targeting Vulnerable Groups

105. Particularly in emergency situations and pandemics, gender inequalities and norms influence access to critical health services, as well as risk of exposure to disease. While men do worse clinically once infected, women face a higher-than-average risk of COVID-19 infection, death, loss of livelihood, and gender-based violence. They have also been impacted by discontinuity of essential reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) services, including for maternal and sexual and reproductive health, and GBV. These gender dimensions intersect with other inequalities, particularly for populations that are poor, with limited access to formal education, living in hard-to-reach areas, temporary or informal settlements, or areas affected by conflict, or living with disabilities. Women refugees also face vulnerabilities to health challenges and GBV. The project, through actions detailed below, including targeted communications and complementary promotion of essential maternal health services, will seek to address women challenges in accessing health care. Antenatal visits will be tracked as a proxy for restoration of these essential services.

106. In addition, there is a risk that vaccine deployment plans could leave women and other vulnerable groups behind. Through monitoring and implementing activities outlined in the ESCP, ESMF, and SEP will help ensure appropriate stakeholder engagement, proper awareness raising and timely information dissemination. This will help: (i) avoid conflicts resulting from false rumors; (ii) ensure equitable access to services for all who need it; and (iii) address issues resulting from people being kept in quarantine. These will be guided by standards set out by WHO as well as other international good practices including social inclusion and prevention of sexual exploitation and abuse and sexual harassment. Mechanisms to engage citizens, and target beneficiaries more specifically, in providing ideas and feedback on program delivery will help identify gaps at the point of service delivery (information availability, access to testing and vaccination, access to relevant care, equal treatment etc.), build community knowledge and confidence, establish trust, ensure governments respond to community needs (including vulnerable groups), and thus to optimize the impact of the COVID-19 emergency response.

107. The project components all also address gender dimensions with targeted interventions including: (i) integration of gender-responsive approaches in communications strategies with the public, including use of multiple accessible mediums in local languages; (ii) use of targeted messaging, and the creation of responsive platforms for registry of inquiries and grievances, through a variety of mediums to target women and different vulnerable groups; (iii) inclusion of interventions to support demand creation/restoration of essential RMNCAH-N services together with COVID-19 vaccinations, critical to averting increases in excess mortality and mobility for women and girls and improving access to sexual and reproductive health and rights; and (iv) support for promotion of awareness and use of GBV services, including the expanded network of Integrated Service Centers at health facilities that offer medical, legal, psychosocial support and referrals. These interventions will be monitored and measured through the projects' results framework, and through ESF instruments. The PDO indicators and intermediate ones are both disaggregated to capture the gender aspect of the project activities.