

**Environmental and Social Management Framework for
The Provision of Essential Health Services Project (PEHSP)
in the states of Jonglei and Upper Nile, South Sudan**

UNICEF South Sudan

25 September 2020

Table of Contents

LIST OF ABBREVIATIONS	3
EXECUTIVE SUMMARY	4
1 INTRODUCTION	5
1.1 PROJECT BACKGROUND	5
1.2 PROJECT OBJECTIVES	6
1.3 PROJECT DESCRIPTION	6
1.4 OBJECTIVES AND METHODOLOGY OF THE ENVIRONMENTAL AND SOCIAL MANAGEMENT FRAMEWORK (ESMF)	9
2. LEGAL AND INSTITUTIONAL FRAMEWORK	9
2.1 ENVIRONMENT POLICY OF SOUTH SUDAN.....	9
2.2 SOUTH SUDAN’S TRANSITIONAL CONSTITUTION, 2011	10
2.3 ENVIRONMENTAL PROTECTION ACT, 2001.....	10
2.4 ENVIRONMENT HEALTH ACT, 1975.....	11
2.5 PUBLIC HEALTH ACT, 2008.....	11
2.6 WORLD BANK SAFEGUARD POLICIES AND REQUIREMENTS	12
2.7 UNICEF SAFEGUARDING POLICIES AND REQUIREMENTS.....	12
3. ENVIRONMENTAL, SOCIAL, AND SECURITY IMPACTS	17
3.1 SOCIAL IMPACTS	17
3.2 ENVIRONMENTAL IMPACTS	18
3.3 SECURITY RISKS.....	21
4. MITIGATION MEASURES	21
4.1 MITIGATION MEASURES.....	22
4.2 MONITORING PLAN	29
4.3 IMPLEMENTATION ARRANGEMENTS	29
5. PUBLIC CONSULTATION AND DISCLOSURE	30
5.1 REVIEW OF PUBLIC CONSULTATIONS.....	30
5.2 GRIEVANCE REDRESS MECHANISM	32
6. CONCLUSIONS	33
REFERENCES	34
ANNEX 1: SOCIAL DEVELOPMENT AND MONITORING PLAN.....	35
ANNEX 2: GENERIC MEDICAL WASTE MANAGEMENT PLAN.....	42

LIST OF ABBREVIATIONS

AAP	Accountability to Affected Populations
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
BHT	Boma Health Team
BPHNS	Basic Package of Health and Nutrition Services
CHD	County health department
CHW	Community health worker
CSOs	Civil society organizations
ENAP	Every Newborn Action Plan
FCV	Fragility Conflict & Violence
GAM	Global acute malnutrition
GBV	Gender-based violence
HIV	Human immunodeficiency virus
HMIS	Healthcare management information system
IEC	Informational, educational and communications
IDP	Internally Displaced Person
IP	Implementing partner
IPC	Integrated food security phase classification
LQAS	Lot quality assurance sampling
M&E	Monitoring and evaluation
MOH	Ministry of Health
NGOs	Non-governmental organizations
NHP	National Health Policy
OCHA	Office for the Coordination of Humanitarian Affairs
OP	Operational Policy
OTP	Outpatient therapeutic programme
PEHSP	Provisions of Essential Health Services Project
PHC	Primary health care
PHCC	Primary health care centre
PHCU	Primary health care unit
PoC	Protection of Civilians
PSEA	Protection from sexual exploitation and abuse
RMNCAH	Reproductive, Maternal, Newborn and Child Health
RRC	Relief and Rehabilitation Commission
RRHP	Rapid Results Health Project
SA	Social Assessment
SPLA	Sudanese People's Liberation Army
SPLA-iO	Sudanese People's Liberation Army in Opposition
SSDP	South Sudan Development Plan
SSEMF	Security and Significant Event Management Framework
TBA	Traditional birth attendant
UNICEF	United Nations Children's Fund
UNMISS	United Nations Mission in South Sudan
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

In 2011, South Sudan, one of the world's most politically volatile countries, gained independence after several decades of civil conflict with Sudan. In 2013, civil war broke out in South Sudan and continues to ravage the nascent nation: the war and its drivers have culminated in an appalling humanitarian crisis. Subjected to widespread violence, coupled with enduring underdevelopment and poverty, thousands of the country's people have since died, with millions more forced into refuge, both internally and externally. Food insecurity has heightened, the economy weakened, and inflation has risen to an all-time high, consequently threatening the livelihoods of over half the country's population. Instability has severely hampered South Sudan's capacity to adequately administer urgently needed basic services, consequently weakening its health system. As a result, South Sudan's infant, under-five, child, and maternal mortality rates are among the highest in the world. The health situation is even more dire in the long-standing conflict-affected region of Greater Upper Nile, particularly the states of Upper Nile and Jonglei.

Against this backdrop this Environmental and Social Management Framework (ESMF) is intended to ensure that activities implemented by the United Nations Children's Fund (UNICEF) with support from the World Bank under the Provision of Essential Health Services Project (PEHSP) are compliant with the relevant requirements of national policies, regulations and legislations, as well as the World Bank's Safeguards Policies and Procedures. The report suggests that the PEHSP offers considerable benefits that include: increased access to health services and health facilities for women, internally displaced persons (IDPs), and other vulnerable groups; quality improvement in health services; and increased access to pharmaceutical supplies. Realizing these benefits will result in improved health status for women and children, evidenced by appreciable reductions in morbidity and mortality rates. The report also identifies several social and environmental consequences that the project activities are likely to induce, albeit on a small and localized scale. Social negative risks and impacts could include elite capture of health services resulting in social disruption and conflict: this will need to be mitigated by equitable delivery of health services. The document, in line with the Social Assessment, also outlines security risks resulting from the project context towards communities and project workers as well as respective mitigation measures.

In summary, the project is likely to have limited and reversible environmental impacts, that can readily be mitigated, with the main risks resulting from the project's Fragility Conflict & Violence (FCV) context. There are no significant and/or irreversible adverse environmental issues anticipated from the activities to be financed under the PEHSP. The main environmental risks will result from inadequate medical waste management and, to a lesser extent, risks associated with minor health facility repair. Where potential risks and impacts are anticipated, the project will implement alternative measures to avoid, minimize and mitigate adverse environmental impacts, ensuring the project complies with local laws and regulations and the World Bank's safeguard policy on Environmental Assessment (OP/BP 4.01).

1 INTRODUCTION

This document outlines the ESMF for the PEHSP that will be implemented by UNICEF, with support from the World Bank, in the states of Jonglei and Upper Nile. These states are historically amongst the most conflict-affected states in South Sudan with the least investment in infrastructure, and most difficult to access physically.

This project will complement existing activities carried out by the Government of South Sudan and development and humanitarian partners. Like any other area in South Sudan the entire region faces the challenges of prevalent medical conditions, such as malaria, acute respiratory infections and diarrhoea, which are among the major causes of death for the growing number of internally displaced persons, who face inadequate access to basic services, limited economic opportunities, poor infrastructure and food insecurity.

1.1 Project Background

At the time when PEHSP began implementation, it was about five years since the national conflict broke out in South Sudan, largely between Government forces of the Sudan People's Liberation Army (SPLA), and forces aligned with the SPLA in Opposition (SPLA-IO). At the beginning of the project, the fighting between the Government and SPLA-IO was continuing in Upper Nile and Jonglei. In Upper Nile, the Shilluk – who lay ancestral claim to the west bank of the Nile, parts of the east Bank and, crucially, Malakal town – were aligned with the opposition, and their fight with the Government was likely to drag out for a long time; while Akobo county in Jonglei remained one of the SPLA-IO strongholds and, as such, when the road conditions allow, were vulnerable to Government advancement.

Since the start of the project, following the formulation of the Revitalised Transitional Government of National Unity (R-TGoNU) in February 2020, the civil conflict has abated in most of the country; however, there are some areas where fighting of armed groups continues, and sub-national violence persists.

While civil conflict has primarily ceased in Upper Nile and Jonglei, there are also two other levels of conflict: intercommunal conflict, such as between the Dinka Bor and the Murle, which involve cattle raids in Jonglei, or among the Shilluk and Dinka Padang in Upper Nile; and intra-communal conflict, including frequent clashes between sub-sections of the Dinka communities, or different age sets, such as within the Murle community. The various levels of conflict are interconnected, with intercommunal and intra-communal conflict increasingly politicized. Some estimates have shown that, in some locations, loss of life has been higher from intra- and inter-communal conflicts than the national conflict.

The causes and drivers of conflict in Jonglei and Upper Nile include: chronic food insecurity; widespread inequity; inadequate coverage of basic services; competition for resources including cattle, land and water; easy availability of small arms; the manipulation of ethnic and clan identities by elites to mobilize groups around political and violent objectives; lack of strong and effective governance at local level; lack of security; and absence of rule of law. All the above factors make the crisis in Upper Nile and Jonglei complex and multidimensional. As such, it is anticipated that even with the signing of the peace agreement at the national level, widespread intra- and inter-communal conflict will continue to be witnessed in these states.

Access to health care in Jonglei and Upper Nile remains extremely challenging due to insecurity and closure of health facilities. Many hospitals and health clinics have shut down, have been looted or attacked or health personnel have fled or no longer fully function due to lack of public funds (Protection Cluster, 2017). Ongoing displacement of health workers, non-functionality of health facilities due to insecurity, inaccessibility widespread looting and vandalization continue to increase the risk of multiple outbreaks to the fleeing population with limited access to healthcare services including surveillance and health alerts (Health Cluster, 2017). Meanwhile, lack of infrastructure makes large areas of the country

unreachable during the six-month-long heavy rainy season. In addition, inflation rates are high due to overreliance on imported consumer goods, and lower foreign exchange reserves. In the short term, it seems highly unlikely that viable options will create sufficient fiscal space for primary health care programmes and procurement of basic pharmaceuticals.

Consequently, in relation to health service delivery, the states of Jonglei and Upper Nile remain extremely challenging due to widespread insecurity and looting of health supplies and assets, including the closure of health facilities. Access to primary health care has been difficult for a large proportion of the vulnerable populations situated there, including internally displaced persons and host community populations. For instance, according to available 2016 Health Management Information System (HMIS) data, consultation utilization rates for all ages were lowest in Jonglei state (0.2). Similarly, antenatal care (ANC) first visit coverage was the lowest in Upper Nile (14.8 per cent) and Jonglei (21.5 per cent). When it comes to coverage of pregnant women with at least four antenatal care visits (ANC4+), the lowest coverage was reported in Upper Nile (7.8 per cent) and Jonglei (9.5 per cent). For deliveries by a skilled birth attendant, Upper Nile and Jonglei recorded the lowest rates with only 2.2 per cent and 2.3 per cent, respectively. Immunization coverage is especially poor in conflict-affected regions, with Penta3 coverage of only 13 per cent in Jonglei and 20 per cent in Upper Nile. This situation is further complicated by looting of cold chain equipment. In 2017, of 116 units of cold chain equipment installed, about 14 per cent were vandalized and looted, mostly in Upper Nile and Jonglei (6 per cent in each: Ministry of Health (MOH), 2017). The resulting gap in immunity puts children at high risk of malnutrition and vaccine-preventable disease.

Against this backdrop, the PEHSP will play a crucial role towards achieving the Health Sector Development Plan's overall objective of "increasing the utilization and quality of health services, with emphasis on maternal and child health and with attention to effectiveness, efficiency, and equity" (MOH, 2016).

1.2 Project Objectives

The objective of this project is to deliver low-cost, high-impact essential health services to about 1.8 million people living in the Upper Nile and Jonglei states.¹ This includes about 85,000 pregnant women; 82,000 children under one; and 382,000 children under five (National Bureau of Statistics, 2015).² The main strategy is to deliver a package of essential health care services from existing functional health facilities, which are not supported by other donors/partners. This will be complemented by community-based approaches to increase and expand equitable coverage and access, particularly for mobile or hard-to-reach populations in areas with intermittent periods of stability and access. In close coordination with local health authorities and other stakeholders, UNICEF will partner with national and international non-governmental organizations (NGOs) to deliver the essential package of primary health services, which will be complemented by the procurement and distribution of essential medicines and supplies.

1.3 Project Description

The areas of health care to be covered in the PEHSP include the following:

- (i) Child health services;
- (ii) Maternal and neonatal health services;
- (iii) Basic and comprehensive emergency obstetric and newborn care at primary health care centre and hospital level;
- (iv) Basic curative services;
- (v) Procurement and distribution of essential medicines and supplies;
- (vi) Emergency preparedness and response;

¹ This equates to about 50 per cent of the 3,631,202 persons estimated by the National Bureau of Statistics to be living in the two former states

² Physical verification and mapping was completed to ensure no overlap with other donor-supported health facilities.

- (vii) Disease surveillance and outbreak response;
- (viii) Quality improvement and supervision; and
- (ix) Minor repair of health care facilities.

Minor repair of health care facilities includes the following: painting of interior walls; repairing of holes in the roof; repairing of floor tiles; repairing of cupboard doors and hinges; repairing of doors and locks and door hinges; repairing of pit toilets (slabs and covers) and other existing waste management facilities, and replacement of faucets/taps and pipes.

The PEHSP will support an agile mix of static primary health care services that is complemented by regular outreach (especially during the dry season) to increase and expand equitable coverage and access, particularly for mobile or hard-to-reach populations with intermittent periods of stability and access.

In close collaboration with central and state MOHs, UNICEF will work in partnership with NGOs (which are still to be selected) to ensure continuity of services, and also directly contract suppliers and service providers.

Through contracted NGOs, UNICEF will support a subset of the MoH's 2011 Basic Package of Healthcare and Nutrition Services (BPHNS). A minimum set of low-cost, high impact essential services (from the comprehensive MOH package) has been distilled taking into account:

- The package of essential primary health care services supported by the previous World Bank-supported Rapid Results Health Project (with IMA) 2012-2018;
- Consultations with stakeholders, especially with a view to alignment with HPF3 (a health pooled fund covering the other eight states);
- Support that will be provided from other partners (including OFDA, ICRC, UNFPA and WHO);
- The resources available;
- The intrinsic capacity of human resources for health available in South Sudan to deliver the services; and
- Prioritization of services with the greatest impact, especially for women and children.

The draft list of essential medicines and supplies to be procured and kept in stock. These drugs will be procured via UNICEF's Supply Division (SD) in Copenhagen, its headquarters division that procures medicines and supplies globally for UNICEF and/or partners. The SD procures drugs at economies of scale from WHO-prequalified suppliers via competitive procurement processes. For more information about this, please see https://www.unicef.org/supply/index_about.html

UNICEF maintains a protocol about how it is keeping its pharmaceutical stock once it has arrived in South Sudan, recording who is keeping the inventory (UNICEF warehouse managers and logistics specialists) and how, and who is reviewing storage and how (UNICEF supply specialists and warehouse managers). It is available at https://www.unicef.org/supply/index_39627.html Variances are reported, if drugs go missing, if drugs expire or if drugs go out of temperature control. Reports of all losses resulting from looting and vandalism are compiled in UNICEF's Country Office in Juba and reported to our regional office and concerned donors. This is in line with UNICEF's incident reporting mechanism.

A link for Feedback and Complaints concerning UNICEF supplies can be found at: https://www.unicef.org/supply/index_66223.html. More information can be found at https://www.unicef.org/supply/index_about.html

One of the major criteria that will be used to select NGO implementing partners (IPs) for the project will be the NGO's capacity to securely transport, store and distribute medicines and supplies from the point of collection from UNICEF to those health facilities under their purview. Supplies transferred to IPs from UNICEF will be used exclusively for project implementation. Moreover, the IP is expected to exercise the

highest standard of care when using and administering supplies and equipment, which should include the placement of UNICEF markings on the assets, along with careful detailed inventory and record keeping and appropriate and secure storage conditions in line with their own procedures as well as WHO global, given the lack of up-to-date national MOH guidance. Specifically, at the health facility, medicines and supplies are expected to be stored appropriately in locked cupboard/stores in dry, clean, well-ventilated areas (not exceeding 30°C). Medication should also be correctly labelled with records of requests and arrivals of medication along with monthly stock verification. Expired medicines will be separated for appropriate disposal. Cold chain equipment will be provided (if not already available) for the storage of vaccines. Using a modified version of the 2011 supervision checklist developed by the MOH, the IP will monitor the condition of pharmaceutical supplies at health facilities at least monthly and UNICEF staff will monitor a sub-set of these (at least 30 percent) on a regular basis throughout the project.

All activities in a project document, including budget available for minor repair, require prior approval. Only medium- to large-scale construction requires approval from Headquarters. This project does not anticipate minor repairs exceeding \$2,500 each, which is the threshold required for UNICEF South Sudan Country Office approval. If procurement for repair work should exceed this amount (which is not anticipated), IPs will undergo a procurement assessment (as part of their micro-assessment) covering the following:

- Does the IP have written procurement policies and procedures?
- Does the IP require written or system authorizations for purchases with adequate access controls and segregation of duties between entering purchase orders, approval and receiving of goods?
- Does the IP follow a well-defined process for sourcing suppliers and prequalifying suppliers, or do formal procurement methods include wide broadcasting of procurement opportunities?
- Does the IP follow a well-defined process to ensure a secure and transparent bid and evaluation process?
- When a formal invitation to bid has been issued, does the IP award the contract on a pre-defined basis set out in the solicitation documentation taking into account technical responsiveness and price?

If the assessment results in significant or high risk, UNICEF will procure the goods / services directly. If not, then procurement will be factored into the NGO partnership agreement.

In the event of construction, which is not anticipated, there is a construction assessment for construction activities over \$100,000. This assessment is standardized with the criteria established by our dedicated Construction Unit in Copenhagen.

On arrival of the supplies in Juba, the supplies will be positioned in UNICEF warehouses in Juba, Malakal (Upper Nile) and Bor (Jonglei). From these, supplies will be distributed directly to the IPs. In addition to regular programme supplies, these warehouses are used to preposition emergency relief commodities. This also means that UNICEF has the capacity to immediately respond to the health, nutrition, WASH and other urgent needs of 20,000 people at all times. Medicines, medical supplies and vaccines meet WHO prequalification standards and are distributed throughout the country by road and by air. UNICEF has Long Term Agreements (LTAs) in place with logistics service providers to transport and distribute its supplies by air and surface at global and South Sudan levels. Prepositioning of stock is top priority during the dry season when the roads are open, river levels stable and counties unaffected by perennial flooding. More information about UNICEF's supply chain process can be found at https://www.unicef.org/supply/index_54257.html.

The project will include some very minor repair of health centres (such as repair of leaking roofs, broken taps or toilets). The contracted NGO partners will undertake this in line with agreed UNICEF-partner procedures (following small scale procurement procedures as each activity is not expected to exceed

\$2,500). There will be no direct contractual relationship between UNICEF and contractors. However, UNICEF has a construction engineer who provides technical support in the case of any material repair activities.

These front-line interventions will be supported in some areas with community-based health services (including integrated community case management), to bolster community resilience and basic services provision even while communities are exposed to shocks and cannot be accessed. This, combined with emergency preparedness and response, will help ensure service continuity. Additional efforts also will be made to address the plight of women and child survivors and extend life-saving services to improve accessibility. UNICEF's Health and Child Protection programmes will work closely to ensure an integrated approach to improve the well-being and safety of women and children through the administration of clinical management of rape services, and access to and provision of confidential and sensitive health services to survivors of all forms of gender-based violence (GBV).

In summary, the three main strategies will be:

- (1) Directly supporting essential service delivery;
- (2) Routine outreach to areas that are intermittently stable and accessible; and
- (3) Training and operational support for community health workers on integrated community case management, disease surveillance and the reporting of service delivery data and vital statistics (Boma Health Initiative).

1.4 Objectives and Methodology of the Environmental and Social Management Framework (ESMF)

This ESMF maps general policies, guidelines, codes of practice, and procedures applicable for the project, scheduled to be implemented by UNICEF and supported by the World Bank. The document defines the processes and procedures, assessment, monitoring, and management of the environmentally and socially related issues. In addition, the ESMF analyses environmental policies and legal regime in South Sudan as well as safeguard policies of the World Bank and UNICEF, and describes the principles, objectives, approaches and site-specific environmental and social mitigation measures that will be followed. The ESMF was prepared mainly through a desk review, based on existing documents and reports, as well as analysis of relevant national legislation, policies, and guidelines, including the World Bank Operational and Safeguards Policies related to this project. Additionally, UNICEF conducted a Social Assessment in October 2018 and updated in September 2020, elements of which have been incorporated into this ESMF, with detailed outlined there.

2. LEGAL AND INSTITUTIONAL FRAMEWORK

During its brief history, the Republic of South Sudan has enacted a range of laws and introduced a number of policies. These laws and regulations guide government planning and project implementation. As such, this section provides an overview of pertinent laws and regulations as a framework for interpreting potential environmental and social impacts of the PEHSP.³

2.1 Environment Policy of South Sudan

In 2010, South Sudan enacted an environmental policy. A revised version of this policy covers the 2015-2025 period. More generally, this policy sets the stage for managing environmental shocks, assisting political leaders and policymakers to allocate resources wisely to promote development programmes that

³ Ministry of Health, 2012. Development of a Medical Waste Management Plan for South Sudan. This document mentions a Draft Policy on National Medical Waste Management which cannot be located.
<http://documents.worldbank.org/curated/en/473271468000911143/pdf/E41280EA0P132101300SS0MW0Final0Re p.pdf>

are economically efficient, socially equitable, and environmentally friendly to ensure attain 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 attendant population and future generations. More specifically, the objectives of the South Sudan's environmental policy are to:

- a. Improve livelihoods of South Sudanese through sustainable management of the environment and utilization of natural resources;
- b. Build capacity of the government at all levels of governance and other stakeholders for better management of the environment;
- c. Integrate environmental considerations into the development policies, plans, and programmes at the community, government and private sector levels; and
- d. Promote effective, widespread, and public participation in the conservation and management of the environment.

This policy is relevant to, and in line with, the PEHSP given it is one of the prevailing general guidelines and principles stipulating environmental management when designing and executing development projects. Its emphasis on pollution is particularly crucial for the health project.

2.2 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 the basis for policies related to the environment, including the following provisions: (1) the people of South Sudan shall have a right to a clean and healthy environment; (2) every person shall have the obligation to protect the environment for the benefit of present and future generations; (3) every person shall have the right to have the 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 so as to protect the biodiversity of South Sudan. Finally, the Constitution promotes local engagement in matters related to environment. In particular, 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.

2.3 Environmental Protection Act, 2001

The Environmental Protection Act of 2001 has the following objectives: i) to protect the environment in its holistic definition for the realization of sustainable development; ii) to improve the environment and the sustainable exploitation of natural resources; and iii) to create a link between environmental and developmental issues, and to empower concerned national authorities and organs 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.

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 (HCENR). The study should contain the following information:

- a. The anticipated impact of the project on the environment;
- b. The negative impacts that could be mitigated during implementation of the project;

- c. Alternative options for the proposed project;
- d. A clear undertaking that the short-term utilization of natural resources and the environment will not jeopardize their long-term sustainability; and
- e. The precautionary measures to be taken to mitigate the negative impacts of the project.

Moreover, Article 18 details the duties of the competent authority tasked with overseeing the general environmental policies and directives. These duties are as follows:

- a. To lay down quality control standards for the protection of the environment;
- b. To preserve water sources from pollution;
- c. To protect air, food, soil and vegetation cover from pollution and degradation;
- d. To preserve the flora and fauna from extinction as a result of illegal hunting or any other human threat;
- e. To protect food from contamination or pollution by chemicals or any other factor;
- f. To protect the air from pollution caused by physical operations or chemicals; and
- g. To preserve the soil from any pollution resulting from harmful industrial and other types of waste.

The EIA regulation also provides for Environmental Audits for all projects for which EIA has been undertaken. Thus, an individual/institution who/which wants to undertake a project ought to ensure that predictions made in the EIA are complied with.

2.4 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 wastes and other activities that may pollute the environment, including medical wastes.

2.5 Public Health Act, 2008

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

Pollution of Water and Air

i) Measures to prevent pollution of water for consumption. ii) Measures destined to prevent pollution of potable water. iii) Anyone who offers the public water to drink or for human food, including frozen food, should ensure that the water conforms to the potability regulations; iv) Management and disposal of hazardous wastes; and v) Storage of wastes on the premises of waste generators.

Atmospheric pollution

i) Enforce regulations and measures necessary to combat all elements of pollution and protect the natural level of the environment and public health; ii) Measures to prevent and fight against noise and other alternative nuisances have to be observed at the local premises, environment premises and main agglomerations; iii) Allowable toilet systems and excreta disposal methods; iv) Rearing and straying of animals and pets; v) The activities and behaviour of individuals and institutions, which cause or are likely to cause environmental pollution or vector breeding; vi) Individual and communal recycling of wastes; and vii) Any other matters that demand local regulation to achieve and maintain a clean and healthy environment.

2.6 World Bank Safeguard Policies and Requirements

In addition to the above South Sudanese laws and regulations, the PEHSP should comply with the safeguards policies and procedures of the World Bank, specifically OP/BP 4.01 on Environmental Assessment and OP/BP 4.10 on Indigenous People, which are the only triggered safeguards policies.

For the PEHSP, OP 4.01 is applicable due to the potential negative environmental impacts of some project activities, including (i) provision, storage, handling, and disposal of essential drugs, supplies and equipment; (ii) delivery of basic health services; (iii) basic facility repair and the anticipated increase in medical waste due to improved coverage and quality health services across the country. The project is a Category B - Partial Assessment for Environmental Assessment (EA) purposes. Through the ESMF, the project also considers the World Bank Group's Environmental, Health, and Safety Guidelines for Health Care Facilities, in so far as they are relevant for rural primary health care centres in conflict settings (see <https://www.ifc.org/wps/wcm/connect/bc554d80488658b6b6e6f66a6515bb18/Final%2B-%2BHealth%2BCare%2BFacilities.pdf?MOD=AJPERES&id=1323161961169>). Finally, the project's FCV context has been assessed, both, in this ESMF as well as the related Social Assessment. Security risks and mitigation measures have been developed and will be implemented in a proportionate and feasible manner. A summary can be found below. Accordingly, contextual security risks are considered high for the project.

No impacts related to the World Bank's Operational Policy on Involuntary Resettlement (OP 4.12) are anticipated under any of the project activities proposed for implementation. Moreover, with respect to OP 4.12, minor repair of health clinics will not involve structural rehabilitation (roofs or walls) and will not involve new construction or extension (i.e. major environmental impacts in this regard). Rather, all repair activities will be implemented within existing facilities.

Meanwhile OP 4.10 on Indigenous People has been triggered. Because Indigenous People are indeed the overwhelming majority in the project area, elements of an Indigenous Plan have been integrated into project design. For example, IPs will be made aware of any sensitivity concerning the deployment of health care workers from ethnic groups coming from outside of the community to certain facilities, especially to those health facilities that serve a predominant tribe (UNICEF Mapping, 2018). These cultural characteristics and issues will be critically examined, identified and factored into local planning during the start of the project. More generally, Benefits and the approach by which they will be provided will be culturally appropriate and adapted to the respective needs and structures of the vulnerable groups involved.

2.7 UNICEF Safeguarding Policies and Requirements

UNICEF's standard procedures include aspects of safeguarding against sexual exploitation and abuse, fraud, use of child labour, disease outbreaks and emergencies. The following outlines the responsibilities of UNICEF and our IPs for some extraordinary incidents. After internal assurance and approval, donors (e.g. the World Bank) are duly informed.

Child Labour

UNICEF projects with IPs will avoid 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.

Gender-Based Violence Strategy for UNICEF and NGO Implementing Partners

UNICEF's Health and Child Protection programmes will work closely to ensure an integrated approach to improving the wellbeing 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 GBV.

Aside from improving essential maternal and newborn care, including basic emergency and obstetric newborn care (BEmONC), at primary healthcare facility and community levels, women's and adolescent girls' safety will be enhanced and deaths further reduced with improved and timely referral, coupled with effective pre-referral measures. The focus will be on preventing mother-to-child transmission of HIV as well as post-rape care interventions and their better integration into maternal and newborn health (MNH) services. To address social norms that perpetuate inappropriate behaviours/practices and inequitable decision-making power, activities will also be supported to address demand-side barriers, paired with community mobilization and engagement.

The theory of change states that

- **if** government-led mechanisms review and update key Standard Operating Procedures (SOPs), implementation guidelines and tools for essential MNH services delivery at facility and community level, and
- **if** frontline and community workers are equipped with essential commodities and the capacity to deliver essential quality MNH (including PMTCT and CMR) services to vulnerable populations in targeted emergency and non-emergency settings, and
- **if** referral systems are established for survivors of gender-based violence as well as for emergency obstetric and newborn complications.

then this output would be achieved and at least 3,000 frontline health and community workers would have improved capacity to provide quality, essential maternal and neonatal care (including PMTCT and CMR) to pregnant women/girls and babies in emergency and non-emergency settings.

In addition to implementing essential, lifesaving interventions, this will entail building the capacity of frontline health and community workers and local partners to deliver appropriate maternal and neonatal care messages, 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 exploitation

Under their partnership agreements, IPs must ensure that all their employees and personnel comply with the provisions of ST/SGB/2003/13 entitled "Special Measures for Protection from Sexual Exploitation and Sexual Abuse", which is available at <http://www.un.org/Docs/journal/asp/ws.asp?m=ST/SGB/2003/13>. The IP should further ensure that none of its employees and personnel exposes any intended beneficiary, including children, to any form of discrimination, abuse or exploitation and that each of the IP's employees and personnel complies with the provisions of other UNICEF policies relating to protection of children as advised by UNICEF from time to time.

The Secretary-General reaffirmed his commitment to PSEA and launched a new approach to PSEA in his report on special measures for protection from sexual exploitation and sexual abuse (2016). Following this, in August 2017, UNICEF's Eastern and Southern Africa Regional Office issued its step-by-step guide to Country Offices to prevent and respond to sexual abuse at country level. A diagram of the process is reproduced below⁴:

⁴ Since the time of the original report, UNICEF has significantly scaled efforts at the global, regional and country level related to PSEA systems. However, the scope of the partial September 2020 revision of the Social Assessment Report and EMSF document did not include a complete revision of content.

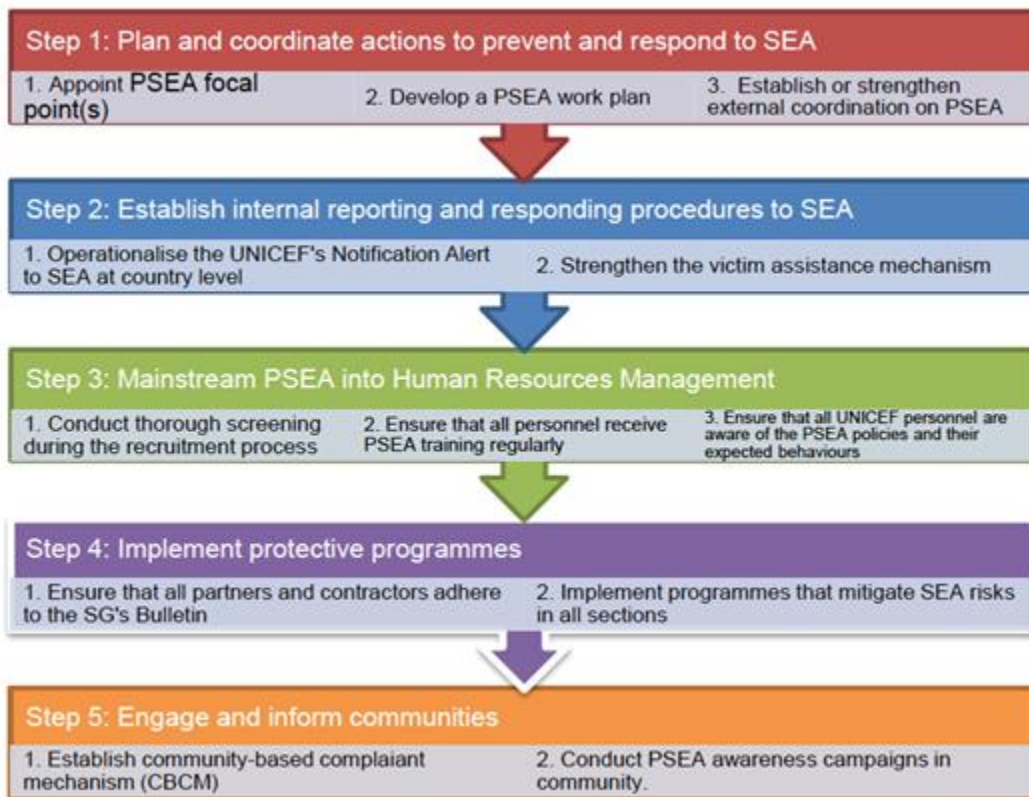


Figure 3: Five steps to respond to SEA at country level, UNICEF ESARO, August 2017

In line with the attached regional protocol and Country Office Standard Operating Procedures (SOP 2018.21), UNICEF South Sudan:

- ***Ensures that all UNICEF personnel in UNICEF South Sudan are aware of the PSEA policies and their expected behaviours.*** Country offices 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, provided to all staff members as part of their induction. This is also displayed throughout the Country Office in each section.
- ***Ensures that all partners and contractors adhere to the Secretary General's Bulletin Organizations and entities in a contractual relationship with UNICEF are expected to abide by the Secretary General's Bulletin.***⁵ Given the critical role that UNICEF's partners and contractors play in program implementation, UNICEF invests in building capacity of those partners that do not have adequate capacity on PSEA. UNICEF's standard Program Cooperation Agreement (PCA) with IPs includes prohibitions of SEA by vendor personnel (Clause 19). 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 UN Secretariat offices (UNICEF supply contract Annex A clause 7.7). These provisions will apply to corporate or institutional contractors (individual contractors and consultants are addressed in the "recruitment procedures").

⁵ Secretary-General's bulletin ST/SGB/2008/5: Prohibition of discrimination, harassment, including sexual harassment, and abuse of authority

- **Has developed and implemented a Country Office protocol that includes the following community-based complaint mechanism.** All complaints should be reported verbally or in writing to:
 - a. Designated PSEA focal persons
 - b. Chiefs of field offices
 - c. Country Representative
 - d. Via phone:
 - i. +211 920 111 333 (English)
 - ii. +211 920 111 888 (Arabic)
 - f. Via email: SSD_PSEAinfo@unicef.org

- This information will be posted by the selected IPs at all health facilities, with the understanding that reporting is not optional and failure to report is a violation of the Secretary General's Bulletin.

Environmental Sustainability for Children

UNICEF issued 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: (i) strengthen UNICEF policy and guidance on environmental sustainability as a cross-cutting issue; (ii) strengthen the inclusion of environmental sustainability in UNICEF programming; (iii) advocate for the full recognition and inclusion of children in the policy discourse on environmental sustainability; (iv) strengthen opportunities for children's development and well-being to benefit from environmental sustainability related public and private finance; and (v) incorporate environmental sustainability management in the organization. The Strategic Framework is currently being updated.

UNICEF does not presently have anything specifically called a social risk management framework as it is part of the organization's overall programming approach, for which more information can be found at <https://agora.unicef.org/course/info.php?id=6825>.

Emergency Preparedness

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 accidental and emergency situations in a manner appropriate to prevent and mitigate 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. 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 Population framework⁶.

Security and Significant Event Management

A Security and Significant Event Management Framework (SSEMF) for the project will cover both UNICEF and IP personnel, premises and assets. The SSEMF is comprised of four components:

1. United Nations Security Management System (UNSMS);

⁶ Details of the UNICEF approach to Accountability to Affected Population can be found in the project Social Assessment Report.

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

For purposes of both security management and Significant Event management, the PEHSP SSEM takes into account both UNICEF and IP personnel, premises and assets. The SSEM takes into account all Project Personnel which are defined to be UNICEF personnel (staff and consultants), IP personnel (staff and consultants) whose salaries are supported by PESHP as well as Ministry of Health (MOH) healthcare workers or community volunteers who receive incentives from PESHP funding.

Security management under the SSEM is comprised of two workstreams:

- a) Security management related to UNICEF personnel, compounds and assets in accordance with the UNSMS; and
- b) Security management related to IP personnel, compounds and assets supported by the PESHP in accordance with SLT and further detailed in the Implementing Partner Security Management Approach.

UNICEF will provide support to IPs related to their management of their security responsibilities under the SLT. The SLT is a series of recommendations aimed at enhancing security collaboration between the United Nations (UN), 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 PEHSP 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.” The UNICEF 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 PEHSP), including, but not limited to, intercommunal violence (ICV), 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 Reporting⁷ Protocol.

⁷ Significant Event is defined term in the Financing Agreement between UNICEF and the World Bank.

3. ENVIRONMENTAL, SOCIAL, AND SECURITY IMPACTS

The objective of this project is to deliver essential health services to an estimated 3,631,202 people, including vulnerable and conflict-affected populations, living in the Upper Nile and Jonglei States. The project interventions aim to improve the provision of high-impact low costs health services, which will result in positive and negative potential impacts as discussed in this chapter. Potential environmental and social impacts can be adequately managed by integrating environmental and social due diligence into the project cycle. The ESMF will guide handling of project environmental and social aspects during implementation, specifically the identification of potential projects impacts.

3.1 Social Impacts

Social benefits

There are several potential positive impacts of the project and associated works. The most obvious positive impact is improved access to health services, and reduced vulnerability to disease.⁸

The project aims at improving access to health services – and thereby improving health status – through provision of maternal, neonatal and child health services; provision of basic curative services and basic and comprehensive emergency obstetric and newborn care; procurement and distribution of essential medicines and supplies; strengthening systems for emergency preparedness and response and diseases surveillance and outbreak response; and quality improvement and supervision. The project is expected to improve access to low-cost, high-impact health services by communities (including internally displaced persons) in Jonglei and Upper Nile states and thereby to reduce child mortality, maternal mortality and the spread of infectious diseases and generally improve the health and well-being of the population in the two states. This will in turn improve productivity and social cohesion along the life course, including intergenerational benefits.

Social risks

Generally, improvement of health care services should result in greater individual as well as community wellbeing. This in turn may lead to greater social cohesion and stabilization during the 18-month project period. On the other hand, if service delivery is perceived to be inequitable and services captured by individuals with connections or senior social status, this could contribute to heightened conflict and social disruption.

To ensure compliance of the project with the requirements of OP 4.10, the implementation process will ensure that the delivery of health services under the PEHSP through static and outreach activities will ensure the participation of all sections of the community, and that delivery of essential health services benefits all communities in the project area. Given the nature of the project and its demographic context whereby Indigenous People are the overwhelming majority of the project beneficiaries, no separate Indigenous Peoples Plan is required for the project. An assessment of social risks resulting from specific characteristics of the social environment has been prepared in line with OP 4.10 The Social Assessment includes also a comprehensive Social and Development Monitoring Plan, which has been reproduced here in Annex 1. This includes also a discussion of the FCV context with related risks for grievances, community and workers security, elite capture, etc. as well as respective mitigation measures, including regular security risk assessments, resources for security measures, and close cooperation with all stakeholders along the SLT.

Related human resource issues will be considered, including options to ensure adequate social safeguards and citizen engagement. Capacity-building activities will be conducted to strengthen feedback

⁸ Refer to social assessment for a detailed analysis of social positive impacts and risks

mechanisms at the local level. Potential grievances will be collected at community level through village/Boma health committees and monitored closely by Country Health Departments at the local level (see mitigation plan in the social assessment).

3.2 Environmental Impacts

Environmental Benefits

The project delivers important gains, particularly with respect to environmental health and sanitation. Overall, the environmental benefits expected include: a less polluted environment due to improved medical waste management practices; and improved access to health services and improved hygiene and sanitation practices at household level resulting from the strengthened awareness and community mobilization part of the project.

Environmental risks: Risks associated with basic facility repair

The PEHSP will likely involve minor repair of existing health infrastructure facilities. Repair at selected health facilities presents risks typical for small civil works, such as: occupational health and safety; heavy equipment and increased traffic; dust and noise; storm water runoff from disturbed areas or concrete mixing areas; inadequate debris disposal; poor sanitary facilities; and others.

Project activities should also ensure that existing facilities, with minor repairs if necessary, are able to manage their wastewater effectively. Diesel generators may also be used for emergency power back up, requiring adequate ventilation, fuel storage, and safety measures. During operations, these systems must be maintained adequately to minimize potential releases to the environment.

Repair at selected health facilities could create sources of medical waste, equipment or supplies needing proper management and disposal. Other hazardous materials may also be discovered during demolition, repairs, or refurbishment.

Risks arising from medical waste

The main environmental risks for the project, though considered low to moderate given the scale of the activities, relate to the handling and disposal of medical waste, such as waste generated during the provision of health care, other medical products and medical laboratory substances.

According to the WHO, 15 per cent of the total amount of waste generated by health care activities is considered hazardous material that may be infectious, toxic or radioactive. Needles and syringes used for the administration of injection can be inadequately disposed of. Open burning and incineration of health care wastes can, under some circumstances, result in the emission of dioxins, furans, and particulate matter. Medical risk exposure may affect all persons who are in contact with hazardous medical waste and who may potentially be exposed to the various risks it entails: persons inside the establishment generating the waste, those who handle it, and persons outside the facility who may be in contact with hazardous wastes or their by-products, if there is no medical waste management or if that management is inadequate.

The following groups of persons may be potentially exposed:

- Inside the health facility (hospital, primary health care centre (PHCC), primary health care unit (PHCU)): health and medical personnel (doctors, nursing staff, midwives, auxiliaries, pharmacists, laboratory technicians); logistics personnel (cleaners, laundry staff, waste managers, carriers, maintenance personnel); and patients, families and visitors.
- Outside the health facility (hospital, PHCC, PHCU): off-site transport personnel, personnel employed at disposal infrastructures and the general population, including adults or children scavenging at waste disposal sites. These practices are common in many regions of the world,

especially in low- and middle-income countries. People who scavenge waste are at immediate risk of needle-stick injuries and exposure to toxic or infectious materials.

The following list compiled by WHO classifies the different types of hazardous medical waste that will most likely arise during project implementation:

- *Infectious waste*: waste contaminated with blood and other bodily fluids (e.g. from discarded diagnostic samples), cultures and stocks of infectious agents from laboratory work (e.g. waste from autopsies and infected animals from laboratories), or waste from patients with infections (e.g. swabs, bandages and disposable medical devices);
- *Pathological waste*: human tissues, organs or fluids, body parts and contaminated animal carcasses;
- *Sharps waste*: syringes, needles, disposable scalpels and blades, etc.;
- *Chemical waste*: for example, solvents and reagents used for laboratory preparations, disinfectants, sterilization and heavy metals contained in medical devices (e.g. mercury in broken thermometers) and batteries; and
- *Pharmaceutical waste*: expired, unused and contaminated drugs and vaccines.

Adverse health risks associated with health care waste and by-products include:

- Infection risks: health-care waste contains potentially harmful microorganisms that can infect patients, health workers and the general public. Other potential hazards may include drug-resistant microorganisms which spread from health facilities into the environment;
- Sharps-inflicted injuries;
- Toxic exposure to pharmaceutical products, in particular, antibiotics and cytotoxic drugs released into the surrounding environment, and to substances such as mercury or dioxins, during the handling or incineration of health care wastes;
- Chemical burns arising in the context of disinfection, sterilization or waste treatment activities;
- Air pollution arising as a result of the release of particulate matter during medical waste incineration; and
- Thermal injuries occurring in conjunction with open burning and the operation of medical waste incinerators.

Potential environmental impacts associated with health care waste and by-products include:

- Disposal of untreated health care wastes in landfills can lead to the contamination of drinking, surface, and ground waters if those landfills are not properly constructed; and
- The treatment of health care wastes with chemical disinfectants can result in the release of chemical substances into the environment if those substances are not handled, stored and disposed in an environmentally sound manner.

Incineration of waste has been widely practised in South Sudan, but inadequate incineration, or the incineration of unsuitable materials, results in the release of pollutants into the air and the generation of ash residue. Incinerated materials containing or treated with chlorine can generate dioxins and furans, which are human carcinogens and have been associated with a range of adverse health effects. Incineration of heavy metals or materials with high metal content (in particular lead, mercury and cadmium) can lead to the spread of toxic metals in the environment. Only modern incinerators operating at 850-1100 °C and fitted with special gas-cleaning equipment are able to comply with the international emission standards for dioxins and furans.

A MOH service availability readiness assessment (SARA), with support from WHO, is expected to be concluded by the end of the year⁹. This includes a waste management component. No prior assessment of this nature has been done in South Sudan's eight-year history. The SARA will provide a baseline for the health facilities that will be supported by UNICEF and will form the basis for policy and procedural

⁹ Since the beginning of the project, the SARA has been completed.

development to establish appropriate health waste management arrangements in low-resource settings, using low-resource technologies.

Risks arising from medical supplies

Storage of medical equipment will be careful to avoid wastage and loss. Specifically, at the health facility, medicines and supplies are expected to be stored appropriately in locked cupboard/stores in dry, clean, well-ventilated areas (not exceeding 30°C). Medication should also be correctly labelled with records of requests and arrivals of medication along with monthly stock verification. Expired medicines will be separated for appropriate disposal. Cold chain equipment will be provided (if not already available) for the storage of vaccines.

There is no specific MOH protocol on procedures for health workers in the event of needle stick injuries. However, IP policies and procedures are in place for staff working in health facilities that they manage. These will be complemented with WHO guidance and circulated by UNICEF. Staff training on universal precautions will be key, along with providing appropriate safety boxes and tools.

Risks of spread of disease

For Ebola virus disease (EVD) specifically, SOPs for screening, surveillance, case management and infection prevention and control are presently being drafted and should be available by the end of November. Meanwhile, the MOH EVD contingency plan launched in July 2018 is attached for more information.

In the absence of government guidelines, UNICEF will work with its IPs to ensure that local staff employed by the IPs and the government carry out the following activities to ensure appropriate infection control and prevention practices:

- Develop or adapt a standard operation procedure for waste management, infection prevention and control practices;
- Provide training on universal safety precaution and hazardous and non-hazardous waste management to health workers (including separation and disposal);
- Regular monitor and report the waste management practice in the facility; and
- Ensure appropriate infection prevention and control practices are in place in all facilities.

IPs will be contracted to oversee health care service delivery in the health facilities assigned to them for management and implementation. As such, they will recruit and manage front line health care workers for this purpose. These staff will be subject to the IPs policies and procedures, which in turn will be subject to national protocol. UNICEF will conduct regular spot checks and program visits to ensure that staff are aware of these policies and procedures, including compensatory mechanisms for which they are entitled.

UNICEF will work with IPs to minimize the potential for community exposure to water-borne, water-based, water-related, and vector-borne diseases, and communicable diseases (e.g. HIV, TB and malaria) that could result from project activities, taking into consideration the differentiated exposure to and higher sensitivity of marginalized groups.

Steps to foster community health and safety considerations will also include:

- Community orientation on their rights, entitlements and commitments made by IPs;
- Gathering information on existing communication channels/information sources and people's communication preferences;
- Based on needs assessments, working with existing community structures (village committees, Boma health committees) to establish accountability mechanisms that can be adapted in the event of a disaster;
- Supporting training for staff, partners and volunteers;

- Agreeing with communities the information sharing mechanisms and complaints mechanisms and a clear complaints-handling process;
- Establishing linkages with other actors for advocacy work and to share community concerns; and
- Scheduling regular reviews and information sharing

3.3 Security Risks

Security risks are defined separate from social and environmental impacts as they span both types of benefits and risks.

Civilians have borne the brunt of the conflict as it evolved to include different ethnic, political, and resource drivers. Attacks against civilians have not been limited to direct attacks on their lives but importantly has also included the systematic looting and burning of villages, destroying people’s sense of security and ability to support and care for themselves. As a result, millions of citizens have been displaced, resulting in untold deaths from starvation, thirst, exposure, and lack of access to medical care.

Sexual and gender-based violence remain acutely prevalent throughout the country. In the February 2018 report, the UN Commission documented many accounts of rape, gang rape, forced stripping or nudity, forced sexual acts, castration and mutilation of genitalia. Some of the survivors the Commission spoke to had been subjected to sexual violence multiple times. The Commission also met with men and boys who were victims or witnesses of sexual violence perpetrated during detention, or as punishment during military attacks on civilians.

Large-scale abuses have been documented in the specific zones to be supported by the proposed project. The UN report found reasonable grounds to believe that arms-carriers engaged in killings of civilians, rape and other forms of CRSV, theft or pillage, and destruction of civilian and humanitarian objects, generating mass force displacement of populations.

The conflict has had a significant impact on children, with profound human rights abuses conducted on them. The Commission paid special attention to violations and crimes against children and documented all the six grave violations against children referred to in the Secretary-General’s reports on children and armed conflict: killing and maiming; recruitment or use of child soldiers; attacks against schools or hospitals; abduction; rape and other forms of sexual violence and denial of humanitarian access.

Investments and support to service providers, not only in health but other sectors as well, might heighten the risks 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 FCV contexts in the region. The fact that the project aims to improve the availability and quality of health services inherently means the project seeks to improve facility infrastructure, availability of essential equipment and commodities, and human resources in targeted facilities. The proposed project aims to provide support that is aligned with other engagements of health partners in the country, whether they be emergency-related or basic service delivery support. This includes the provision of support that is both financial (performance payments, hazard pay, salary top-ups, etc.) and non-financial (provision of drugs, equipment, rehabilitation). As such, it is acknowledged that the project may lead to service providers becoming targets of acts of violence.

4. MITIGATION MEASURES

4.1 Mitigation Measures

This project is Environmental Category “B” in accordance with the World Bank Operational Policy 4.01 “Environmental Assessment”. The project is likely to have small and limited-scale potential impacts and risks despite limited capacity and difficult country context. There are no significant and/or irreversible adverse environmental issues anticipated from the activities to be financed under the PEHSP. Where potential risks and impacts are anticipated, the project will comply with the World Bank’s safeguard policy on Environmental Assessment (OP/BP 4.01). In this case, the project will take measures commensurate to the risks to avoid, minimize, mitigate, manage or compensate for adverse environmental impacts (see Table 1 below). Measures to ensure the safe and environmentally sound management of health care wastes are necessary to prevent adverse health and environmental impacts from such waste. Additionally, the project will enhance positive impacts in project selection, location, planning, design, implementation and management

In terms of social impacts and 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 localised scale. These negative impacts can be mitigated as long as the recommendations given in the Social Development and Monitoring Plan are implemented through the planned activities and regular checks and monitoring. This is in line with the efforts of the Government to improve on health care of the rural population.

In terms of security risks, the project addresses the risks of project beneficiaries becoming targets in several ways. First, the proposed interventions and risk mitigation measures are based on best-practices and proven strategies of both development partners (UN agencies, HPF, bilaterals) as well as humanitarian organizations such as ICRC and Doctors Without Borders. Close consultations were undertaken with the health cluster in South Sudan to ensure the proposed project design captures these measures. Second, the selection of ICRC and UNICEF as The World Bank Provision of Essential Health Services Project (P168926) direct Recipients of IDA will result in greater flexibility and responsiveness than previous implementation arrangements. It will also lead to enhanced access to areas and populations that were previously difficult to reach, due to the neutrality and impartiality of partner organizations mobilized. Third, service delivery support will be primarily in-kind and will be delivered with the engagement of community leaders and their oversight, which has been identified as a way to reduce risks of pillaging by local populations. Fourth, 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. And fifth, while the banking system remains undeveloped in rural parts of the country, so does the market for essential commodities for which payments would be used to procure. As such, the risk of transporting cash remains low.

Finally, risks related to SGBV remain acutely prevalent throughout the country. The project has included several interventions to address this, including a significant expansion of training for health workers and provision of services, including mental health and psycho-social support, for victims of SGBV. For example, ICRC and UNICEF will be training health workers in the health facilities they support to provide services to SGBV victims, both in terms of medical services (provision of post-exposure prophylaxis) and mental health and psycho-social support. Currently only a few health facilities offer these services, with the numbers being significantly scaled up through the proposed project. In the case of ICRC, for example, the number will increase from five primary care facilities (PHC) to all 25-30 PHC facilities and the two secondary hospitals to be operational in the project area.

Next to those project-induced risks, contextual risks resulting from the FCV context will pose a challenge for project implementation. Such risks relate equally to communities as well as project workers. While largely not under the control of the project, it will ensure via ongoing risk assessments and security risk management measures to enhance safety as much as possible under the given context. Constant

coordination between UNICEF, IPs, local communities and government, the wider UN system in the country, and the World Bank is thereby essential.

The O.P 4.01 environmental safeguard implications identified require the integration of medical waste management into PEHSP implementation to address aspects such as regulatory framework, planning issues, waste minimization and recycling, handling, storage and transportation, treatment and disposal options, and training. Because South Sudan lacks appropriate medical waste management regulations, guidelines and monitoring tools, the EHSP will plan waste management measures based on WHO global guidance documents on health care waste management.¹⁰ The following steps will be taken to mitigate environmental impact:

- During the process of selecting IPs and assessing their capacity to implement sub-projects, criteria will be used to measure awareness of and compliance with environment and social standards (drawn from UNICEF’s 2016 Draft Social and Environmental Standards and Procedures (SES)¹¹ as described in section 4.2 below);
- Include a standard environmental clause in partnership and cooperation agreements based on UNICEF’s Draft Social and Environmental Standards that will be appended to or incorporated into contracts for small repair works;

“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 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.”

- IPs and UNICEF will monitor health facilities using a Medical Waste Management Monitoring checklist, based on the WHO protocol (Annex 2).
- Integrate the monitoring of adequate medical waste management through the use of the medical waste management monitoring checklist in each supervision visit to health facilities; and
- Train IPs and health workers at health facility level on good practices in hygiene, cleanliness and healthcare waste management (Social Development and Monitoring Plan in Annex 1).

¹⁰ WHO, Safe management of wastes from health-care activities, second edition, http://apps.who.int/iris/bitstream/10665/85349/1/9789241548564_eng.pdf

¹¹ pp.13-18

Table 1: Impact, Mitigation, Monitoring and Reporting Table

S/N	ENVIRONMENTAL / SOCIAL IMPACT	DESCRIPTIONS	MITIGATION MEASURES	MONITORING AND REPORTING ROLES AND CONTENT TO ASSURE COMPLIANCE
1	<p>POOR MANAGEMENT OF MEDICAL GOODS PROCURED</p>	<ul style="list-style-type: none"> ▪ Sub-par quality of medical goods procured (drugs, supplies, equipment) ▪ Expiration of goods ▪ Inefficacy of goods ▪ Unnecessary and/or improper disposal of goods 	<ul style="list-style-type: none"> ▪ Procurement system ▪ Cold chain / storage and transport management system ▪ Computerized or manual inventory system 	<ul style="list-style-type: none"> ▪ UNICEF to maintain protocol of how it is keeping its pharmaceutical stock, who is keeping the inventory and how, and who is reviewing storage and how. ▪ Reports of all losses resulting from looting and vandalism compiled in UNICEF’s Country Office in Juba and reported to Regional Office and World Bank, in line with UNICEF’s incident reporting mechanism. ▪ IP to provide careful detailed inventory and record keeping and appropriate and secure storage conditions. IP to monitor the condition of pharmaceutical supplies at health facilities at least monthly and UNICEF staff to monitor a sub-set of these on a regular basis. ▪ Communities will also be advised how to contact the nearest UNICEF Field office directly, especially in the event of reporting serious grievances such as fraud or sexual abuse or exploitation (by phone, email).
2	<p>OCCUPATIONAL HEALTH AND SAFETY</p>	<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 HCW (health care waste) as they collect and transport HCW ▪ Staff incur on-the-job injuries due to improper clinical 	<ul style="list-style-type: none"> ▪ Workers should be equipped with appropriate Protective Personal Equipment (PPE) ▪ There should be a first aid kit at all times 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 	<ul style="list-style-type: none"> ▪ Local IPs to ensure compliance of health facility staff and contractors with the mitigation measures and to report any violations to UNICEF ▪ In addition, local structures to be used to enable workers to voice grievances and complaints, and on field visits and spot checks UNICEF staff to routinely and systematically consult affected persons to give them opportunities to air their concerns.

		techniques, use of equipment, etc.	<ul style="list-style-type: none"> ▪ Staff on-boarding should include training on how to prevent most common occupational accidents 	
3	COMMUNITY HEALTH AND SAFETY	<ul style="list-style-type: none"> ▪ Lapse of confidentiality ▪ Assault by medical staff worker ▪ Unrealistic expectation of level of care and/or recovery 	<ul style="list-style-type: none"> ▪ Medical staff training on communication to clients on (i) what essential services are offered at the HCF at intake; (ii) explanation of procedures and concurrent risks; (iii) follow-up care instructions; and (iv) referrals to other health care providers if services not offered or available ▪ Medical staff Code of Conduct ▪ Complaints and feedback mechanism ▪ Regular daily cleaning at the health facility 	<ul style="list-style-type: none"> ▪ Local IPs to ensure compliance of health facility staff with mitigation measures and to report any violations to UNICEF ▪ Local structures to be used to enable contractors and others affected by construction to voice grievances and complaints. UNICEF staff to routinely and systematically consult affected persons to give them opportunities to air their concerns. ▪ Communities to be advised how to contact nearest UNICEF Field office directly, especially when reporting serious grievances such as fraud or sexual abuse or exploitation (by phone, email). These will be reporting as per the SSEMF.
4	MINOR FACILITY REPAIRS	<ul style="list-style-type: none"> ▪ Worker first-aid ▪ Community (neighbour) health and safety ▪ Repair equipment handling ▪ Debris management ▪ Poor quality construction leading to harm to workers and/or patients 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ Local IPs to ensure compliance of contractors with the mitigation measures and to report any violations in their quarterly progress reports to UNICEF under the Partnership Cooperation Agreement (PCA) ▪ In addition, community structures will be mapped and used to enable contractors and others affected by construction to voice grievances and complaints. Furthermore, during field visits UNICEF staff will routinely and systematically consult affected persons to give them opportunities to air their concerns.

			community for repair-related debris disposal <ul style="list-style-type: none"> ▪ On-site supervision of construction 	
--	--	--	--	--

Table 1: Impact, Mitigation, Monitoring and Reporting Table

S/N	ENVIRONMENTAL / SOCIAL IMPACT	DESCRIPTIONS	MITIGATION MEASURES	MONITORING AND REPORTING ROLES AND CONTENT TO ASSURE COMPLIANCE
5	MEDICAL WASTE MANAGEMENT	<ul style="list-style-type: none"> ▪ There is an expected increase in waste generated from health centres. If not managed properly, could be harmful to the public and in extreme cases hazardous waste could lead to disease outbreak ▪ Public access to HCW could pose hazards to the public as such areas could possess needles and other sharp objects ▪ Waste generated on site if not managed properly could accumulate and become unpleasant sights to the area. ▪ Waste dumped outside may cause vehicular hold ups and accidents. ▪ Increase in generation wastes such as expired vaccines and hazardous health waste generated by health care facilities if not managed properly could accumulate, produce foul smells, and attract insects and rodents that inevitably would have health implications for the general public. 	<ul style="list-style-type: none"> ▪ A well detailed medical waste management plan (MWMP) for each HCF should be put in place. See Annex 2 for details. 	<ul style="list-style-type: none"> ▪ Local IPs to ensure compliance of health facility staff and contractors with the mitigation measures and to report any violations in their quarterly progress reports to UNICEF under the PCA and, if applicable, the SSEM ▪ In addition, local structures will be mapped and used to enable contractors and others affected by construction to voice grievances and complaints. Furthermore, during field monitoring visits and spot checks conducted by UNICEF staff, affected persons will be

		<ul style="list-style-type: none"> ▪ There are also risks associated with these HCWs if not handled properly and kept away from the public. Such risk could come from open burning of HCW. ▪ Improper waste management could lead to leachate produced flowing into surface waters and contamination could occurs ▪ Infiltration of wastes such as contaminated swabs, expired vaccines, can find their way into surface water drainages causing contamination. ▪ Air pollution may arise from the indiscriminate open air burning of woods, plastics and other wastes generated during and from the repair works. ▪ Air pollution could also occur from using diesel powered generator sets and vehicles with poor or high emission rates. All these activities would negatively affect air quality. 		<p>routinely and systematically consulted in order to give them opportunities to air their concerns.</p>
6	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. 	<p>A well detailed security management plan (SMP) for IPs as per the SSEMF</p>	<ul style="list-style-type: none"> ▪ UNICEF to implement and ensure that IPs act in accordance with the SSEMF, including Implementing Partner Security Management Approach and the Significant Event Report protocol ▪ UNICEF to ensure implementation and support IPs in development of SMPs. ▪ IPs to ensure compliance with project area SMPs and Significant Event reporting requirements as outlined in their PCA programme

				<p>documents. Deviations or challenges to be reported in regular quarterly reports from partners.</p> <ul style="list-style-type: none">▪ 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.▪ Timely reporting of Significant Events to inform support from UNICEF, if required, and any decisions on changes in service provision required.
--	--	--	--	---

4.2 Monitoring Plan

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 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.

UNICEF will include a section on safeguards compliance in each progress report that will be submitted to the World Bank, with input from IPs. The IP feedback will be provided in a standard template set out by UNICEF in their global procedure applicable to all country offices. The template allows for additional questions to be asked in addition to the standard questions. In the case of the PEHSP, in the annual or six-monthly monitoring reports additional reporting will be requested on the extent to which the following safeguard objectives, as set out in UNICEF's 2016 Draft Social and Environmental Standards and Procedures (SES),¹² have been achieved and any challenges to meeting these objectives.

- SES 1: Labour and working conditions
 - C2: *Promotion of decent work*
 - C4: *Provision of information on rights*
 - C5: *Articulation of principles*
 - C6: *Prevention of exploitation*
 - C7: *Provision of safe working environment*
- SES 2: Resource efficiency and pollution prevention
 - C3: *Treatment of wastes*
 - C6: *Avoiding public exposure*
- SES 3: Community health, safety and security
 - C1: *Community health and safety*
 - C2: *Community exposure to disease*
 - C3: *Emergency preparedness*

Both UNICEF and Third-Party Monitors 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 particular mitigation and capacity development measures are detected early.

4.3 Implementation Arrangements

The international health specialists in UNICEF South Sudan's Health Section (Chief of Section, Health 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.

¹² pp.13-18

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. On a monthly basis, they will also assist with the collection and analysis of relevant data and information to gauge the progress of achievement of results under the ESMF framework and wider project. 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 of the SSEMF.. 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 .

The IPs will support the day to day delivery of the PEHSP through the provision of appropriate services at Community Level (Boma Health Initiative activities) and through different levels of Health Facilities namely; PHCUs, PHCCs, and selected County/State hospitals (with a focus on CEmONC and emergency referral). This will be done in collaboration with the relevant County/State Health Departments that are clustered in 10 or 11 geographically specific lots. The IP will be required to establish working relationships aimed at empowering the CHD, state health departments and other health managers at various levels from the onset of the project, that promotes ownership, continuity, and improved and sustainable MoH capacity to provide stewardship to the health sector.

5. PUBLIC CONSULTATION AND DISCLOSURE

5.1 Review of Public Consultations

Consultative meetings were held with relevant stakeholders and regulatory institutions, as well as the local communities in the respective counties as part of a MOH-led Social Assessment conducted in 2017 and updated in March 2018 to facilitate public participation in social and environmental aspects of project activities and operations within the context of national laws, regulations and policies and World Bank social safeguard policies. The consultation process was conducted to ensure stakeholder awareness of the operations and activities of the PEHSP.

Stakeholders to consult were chosen based on their direct roles, technical expertise and responsibility in ensuring that the project operations in their areas of jurisdiction comply with State development plans and meet the regulatory instruments and procedures of the country at large. Salient issues raised, and remarks made during the consultations reported in secondary data are summarized as follows.

Challenge	Recommended Action
<ul style="list-style-type: none"> • Ethnic conflicts among tribes such as the Murle, Dinka, Nuer etc. against each other. The conflict is characterized by child abductions, cattle raiding, fighting leading to loss of life, property and displacement of people. 	<ul style="list-style-type: none"> • Appealing to the government and stakeholders to create peace and sensitize communities involved in conflicts to make peace with one another. • Provide security to the affected community, especially women and girls.
<ul style="list-style-type: none"> • Limited accessibility to some areas in need of health services as a result of ethnic conflicts, political instability, and flooding. 	<ul style="list-style-type: none"> • Appealing to the government and other stakeholders to create peace and sensitize communities involved in conflicts to make peace with one another.
<ul style="list-style-type: none"> • High costs of delivering food into hard to reach areas. In hard to reach areas, airdrops are used (WFP), and these are very expensive. 	<ul style="list-style-type: none"> • Rehabilitation of roads and creating security and political stability.
<ul style="list-style-type: none"> • Mobility of communities; people keep moving from place to place due to several reasons and this interrupts their treatment and worsens health conditions. 	<ul style="list-style-type: none"> • Government involvement in providing security to communities affected by conflicts.
<ul style="list-style-type: none"> • Poor sanitation in the community, only a few latrines are available. People also use open places, which makes the situation worse during rainy season. 	<ul style="list-style-type: none"> • Sensitization and awareness campaigns on dangers of open defecation to communities.
<ul style="list-style-type: none"> • Low awareness on HIV/AIDS and stigma still exists, hence low condom use and those with HIV find it hard to keep on the drugs. 	<ul style="list-style-type: none"> • Sensitization and awareness campaigns on use on ARVs and condoms.
<ul style="list-style-type: none"> • Rampant stock outs of logistic supplies, such as medicines. 	<ul style="list-style-type: none"> • Government and IPs to help in equipping health facilities with drugs and other necessary equipment.
<ul style="list-style-type: none"> • Low morale of workers as Government salaries are too low and delayed, hence absenteeism and late coming to work. 	<ul style="list-style-type: none"> • Government should improve on the conditions of health workers to motivate them work better.
<ul style="list-style-type: none"> • Lack of irrigation infrastructure to carry out farming during dry seasons. Hunger still persists 	<ul style="list-style-type: none"> • State Ministry of Agriculture to help train farmers to carry out irrigation and provide them with necessary equipment.
<ul style="list-style-type: none"> • Land belongs to communities as the land Act has not been approved and this makes making decisions on land matters complicated. 	<ul style="list-style-type: none"> • Consult government officials and other concerned parties in case any development is to take place in an area.
<ul style="list-style-type: none"> • Inaccessibility to health services due to both physical and non-physical factors. Physical barriers include flooding and poor roads. Non-physical factors include ethnic conflicts and political conflicts that persist. 	<ul style="list-style-type: none"> • The communities recommended opening up of many health facilities at lower levels where people can easily access the services, rehabilitation of roads and creating security.
<ul style="list-style-type: none"> • High levels of vulnerability. High number of vulnerable groups: the conflicts have left many orphans and widows in the communities who cannot meet daily basic needs. 	<ul style="list-style-type: none"> • Lobbying for support from government and other humanitarian groups to help the needy and most vulnerable.
<ul style="list-style-type: none"> • High disease burden among people (Malaria, typhoid, Hepatitis B, HIV/AIDS, TB, and Cholera) that include malnutrition in children; this is worsened by food and nutrition insecurity. 	<ul style="list-style-type: none"> • Strengthening health sector to meet health needs of people. Training of health workers on management of common cases and provision of treatment guidelines and protocols.

Challenge	Recommended Action
<ul style="list-style-type: none"> • High cases of GBV. Women consulted reported high cases of GBV that involve; early marriages mostly done to get bride price, polygamous marriages leading to family and child neglect, beating of women by men, rape cases, abduction, kidnapping of women for marriage. 	<ul style="list-style-type: none"> • Sensitizing communities against GBV.
<ul style="list-style-type: none"> • Lack of basic facilities at health centres and dilapidated structures 	<ul style="list-style-type: none"> • Minor renovation of some of the health units and provision of equipment.

UNICEF conducted limited direct consultations with beneficiaries given the very tight schedule for submission of this document.

5.2 Grievance Redress Mechanism

In line with the Accountability to Affected Populations humanitarian framework¹³ and the UN Secretary General's bulletin¹⁴, UNICEF South Sudan has established a grievance redress mechanism (GRM, typically known by UNICEF as a Complaints and Feedback Mechanism) both at central and project level to ensure that beneficiaries may communicate issues and concerns associated with the health care services they are being provided. The GRM has multiple access points (telephone, website, email and postal address). As described above and in line with office's standard operating procedure (2018.21), all complaints should be reported verbally or in writing to:

- a. Designated PSEA focal persons
- b. Chiefs of field offices
- c. Country Representative
- d. Via phone:
 - i. +211 920 111 333 (English)
 - ii. +211 920 111 888 (Arabic)
- e. Via email: SSD_PSEAinfo@unicef.org

This information will be posted by the IPs at all health facilities. Community engagement and social accountability will also be fostered at the local level through community feedback mechanisms (e.g. Boma Health Committees). The Chiefs of Field Offices and the Chief of the Health Section at UNICEF will have overall responsibility to address 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 the World Bank 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 (C4D) 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.

Incident reporting in the conflict-affected context of South Sudan usually involves partners reporting the loss, looting and fraud of cash, supplies and equipment. Under UNICEF South Sudan SOP 2017/25 of 21 September 2017, all UNICEF staff and staff of IPs have the responsibility and duty to actively contribute to preventing, detecting and combatting the risks of loss, incidents and fraud as well as to immediately bring to the attention of UNICEF any knowledge of these incidents. For purposes of the PEHSP, IPs will be required to report a per the SSEMF and orientation to IP staff will be provided.

¹³http://www.unicefinemergencies.com/downloads/eresource/accountability_to_affected_populations.html

¹⁴ Secretary-General's bulletin ST/SGB/2008/5: Prohibition of discrimination, harassment, including sexual harassment, and abuse of authority

To strengthen anti-fraud governance, a register of losses, incidents and fraud reported by IPs was introduced in the South Sudan Country Office in August 2016. This register is updated and managed by the Country Office's programme specialist (Quality Assurance) and captures on a timely basis all reported cases of loss, incidents and fraud related to UNICEF supplies and resources, in UNICEF and IPs. All reported cases of loss, incidents and fraud should be reported and investigated discretely and without prejudice. If a UNICEF or IP staff member is found guilty, disciplinary measures will be pursued as appropriate. Failure to report cases of loss, incidents and fraud is considered misconduct in itself. To bolster this process, the UNICEF South Sudan Country Office SOP addresses timely reporting of loss, incidents and fraud, defines clear and unambiguous reporting channels to strengthen the quality of reports and identifies responsible staff members and their respective accountabilities. This includes ensuring that IPs understand their role and responsibilities and are aware of how to report incidents of theft and looting to UNICEF through a standard incident reporting form. This is reinforced in standard partnership agreements as well as in UNICEF training with IPs.

6. CONCLUSIONS

From the assessment, the project region still faces several challenges that directly affect service delivery, including health. The continuing conflicts, which are both ethnic and political, pose a threat to service as resources meant for service delivery are diverted to efforts to contain and respond to the conflicts. The ethnic clashes that are relentless in Jonglei and Upper Nile further complicate service delivery. The women and children suffer most in the conflicts where children are abducted, and women face the brunt of GBV, in form of rape and battery. In the face of conflict, people continue movement from place to place and providing services is further constrained. Services in PoC sites are overwhelmed by numbers. In host communities and places outside the camps, infrastructure is dilapidated due to vandalism and lack of maintenance. In addition, given the instability in the area and security risks, the project's SSEMF complements the ESMF to support the mitigation of environmental, social and security risks.

The study has analysed and concluded that PEHSP is expected to produce considerable benefits that include: adequate access to health services; improved access to health facilities for women, internally displaced persons and other vulnerable groups; reduced maternal and child morbidity and mortality rates; provision of quality health services; and procurement of pharmaceuticals. The study has also established several social and environmental consequences that the project activities are likely to induce, albeit on a small and localized scale. Social negative impacts could include elite capture of health services resulting in social disruption and conflict, and that will need to be mitigated by equitable delivery of health services. The project is likely to have limited and reversible environmental impacts, that can readily be mitigated. There are no significant and/or irreversible adverse environmental issues anticipated from the activities to be financed under the PEHSP. The main environmental risks will result from inadequate medical waste management and, to a lesser extent, risks associated with basic facility repair. Where potential risks and impacts are anticipated, the project will implement alternative measures to avoid, minimize and mitigate adverse environmental impacts, ensuring the project complies with the World Bank's safeguard policy on Environmental Assessment (OP/BP 4.01).

REFERENCES

Health Cluster. 2018. Health Cluster Bulletin #4.

<http://www.who.int/health-cluster/countries/south-sudan/South-Sudan-Health-Cluster-Bulletin-1-30-April-2018.pdf>

Mayai, A.T. 2016. The impact of public spending on infant and under-five health in South Sudan. American Journal of Medical Research, 3(1), p.207.

Ministry of Health. 2012. Development of a Medical Waste Management Plan for South Sudan. <http://documents.worldbank.org/curated/en/473271468000911143/pdf/E41280EAOP132101300SSOMW0Final0Rep.pdf>

Ministry of Health. 2018. Environmental and Social Management Framework for Rapid Results Health Project.

Ministry of Health. 2016. National Health Policy, 2016-2026
http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/south_sudan/south_sudan_national_health_policy_2016_to_2025_2.pdf

GoS. 2001. Environmental Protection Act, 2001.
<https://www.informea.org/en/legislation/environmental-protection-act-2001>

GoS. 1975. Environmental Health Act, 1975, amended in 2009 (Sudan).
<https://www.ecolex.org/details/legislation/environmental-health-act-of-1975-lex-faoc018382/>

GoS. 1975/2008. Public Health Act, 1975 & 2008 (Sudan).

GoSS. 2011. Transitional Constitution, 2011.
<http://www.wipo.int/edocs/lexdocs/laws/en/ss/ss018en.pdf>

WHO. 2014. Safe management of wastes from health-care activities, second edition
http://apps.who.int/iris/bitstream/10665/85349/1/9789241548564_eng.pdf .

Annex 1: Social Development and Monitoring Plan

The Social Development and Monitoring Plan is designed to ensure that the management plan is implemented through participation and input of all the relevant stakeholders. The basic principles of Social Development and Monitoring Plan are to ensure that the mitigation measures are followed up and implemented through the planned activities and regular checks and monitoring.

Project activities	Potential impacts	Proposed mitigation measures	Responsible party	Monitoring indicator
Health service delivery via facilities or community outreach	<ul style="list-style-type: none"> • Inequitable availability and access to service delivery in areas that are not highly vulnerable. • 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 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 the conduct of hostilities. 3. Strengthen dialogue with local stakeholders to effectively negotiate for people's access to services. 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. Boma Health Committees) for self-monitoring. 7. Develop a Grievance Redress Mechanism as part of UNICEF's Accountability for Affected Populations strategy. 	<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/PSEA

Project activities	Potential impacts	Proposed mitigation measures	Responsible party	Monitoring indicator
		<ol style="list-style-type: none"> 8. 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 3rd party audit institutions (programme visits, spot checks, audits) 	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. Develop waste management plans for each health facility. 4. 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 waste management plans • 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

Project activities	Potential impacts	Proposed mitigation measures	Responsible party	Monitoring indicator
	<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 lifesaving services. • Salaries meant for health workers not being remitted to staff resulting in absence of health personnel at facilities and disruption of services. 	<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. 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 5. Provision of technical assistance to strengthen the capacity of CHDs, IPs and NGOs in delivering programme results. 6. Nominated IPs will pay standardised performance incentives of PHCC/PHCU workers 7. Provide on-time compensation to staff. 	<p>UNICEF</p> <p>UNICEF, IPs, local health officials, 3rd 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	Potential impacts	Proposed mitigation measures	Responsible party	Monitoring indicator
	<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"> 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. Strengthen the ability of community health leaders and structures (particularly Boma Health Committees) to enable accountability, monitor community health initiatives and support CHWs. Adapt BCC messaging to address local myths and misconceptions and to encourage care seeking from CHWs. 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 Number of Boma Health Committees in place

Project activities	Potential impacts	Proposed mitigation measures	Responsible party	Monitoring indicator
	<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 & distribution of community data collection tools linked to the HMIS. 	<p>UNICEF and IPs</p> <p>UNICEF and MOH</p>	<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	Potential impacts	Proposed mitigation measures	Responsible party	Monitoring indicator
Procurement and distribution of pharmaceuticals and medical inputs	<ul style="list-style-type: none"> Expired and damaged drugs negatively affecting communities in the areas where the project is implemented. Social ills like sale of drugs for private gain Poor distribution and frequent stock outs affecting ability to meet minimum project expectations 	<ol style="list-style-type: none"> Conduct a diagnostic assessment to assess how the supply chain can be improved to ensure adequate delivery to health facilities located in SPLA-IO areas/former -IO areas as well as other hard-to-reach areas. Procure kitted drugs, pre-packaged at UNICEF supply headquarters in Copenhagen to reduce distribution time and risk of drug shortage at health facility level Recruit IPs with capacity in logistics and supply chain management and stock reporting while ensuring that reporting tools are available Inclusion of drug monitoring in programme design and programme documents to strengthen monitoring of drugs availability in PHCCs and PHCUs through NGOs / CBOs and community mobilizers working on the ground. Strengthen verification along the supply chain by requesting receipts of drugs from UNICEF to IPs as well as from IPs to Health Facilities. Monitoring of drugs will be included in all supervision visits and reports of staff and third-party monitors. 	<p>UNICEF</p> <p>UNICEF and IPs</p>	<ul style="list-style-type: none"> Pooled procurement mechanism of drugs Drugs and supplies are procured and kitted by UNICEF Supply HQ Inventory count of drug supply in UNICEF warehouses Supply chain verification in place Supply chain diagnostic study carried out Drug monitoring evident in supervisions by UNICEF and Third-Party monitoring
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. 	<ol style="list-style-type: none"> 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. 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 to strengthen security at facilities. 	UNICEF and IPs	<ul style="list-style-type: none"> Number and type of incidents reported Number and type of community engagement activities

Project activities	Potential impacts	Proposed mitigation measures	Responsible party	Monitoring indicator
	<ul style="list-style-type: none"> • Injury or loss of life of Project Personnel due to targeted or non-targeted security incidents. 	<ol style="list-style-type: none"> 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 SSMEF, including financial support 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. 		

Annex 2: Generic Medical Waste Management Plan

Location and organization of collection and storage facilities

1. A drawing of the health care facility (HCF) showing **designated waste sites**; each waste site shall be appropriately designated for health-care waste or other waste.
2. A drawing showing the **central storage site** for health-care waste, as well as a separate site for other waste. Details of the **type of containers, security equipment, and arrangements for washing and disinfecting waste-collection trolleys** (or other transport devices) should be specified, along with the path of the waste collection through the HCF, with clearly marked individual collection routes.
4. A **collection timetable** for each trolley route, the type of waste to be collected, the total number of sites, and the relevant disposal point.

Design specifications

5. A drawing showing the **type of waste bin/receptacle** to be used for each site within the HCF.
6. A drawing showing the **type of trolley or wheeled container** to be used for collection.
7. A drawing of **sharps containers**, with their specification.

Required material and human resources

8. A current staff member of the HCF should be appointed as **Waste Management Officer (WMO)**.
9. **Notice of this appointment** should be widely circulated, with a summary of the Terms of Reference of this Officer, and updates should be issued when changes occur.
10. **An estimate of the number of personnel required** for cleaning and waste collection.
11. **An estimate of the number and cost** of waste receptacles and collection trolleys.
12. **An estimate of the number of sharps containers** and health-care waste drum containers required annually, categorized into different sizes if appropriate.
13. **An estimate of the number and cost of yellow and black plastic bags** to be used annually.

Responsibilities

14. **Definitions of responsibilities, duties, and codes of practice** for each of the different categories of personnel who, through their daily work, will generate waste and be involved in the segregation, storage, and handling of the waste.

Procedures and practices

15. A simple diagram (**flow chart**) showing procedure for waste segregation.
16. The procedures for segregation, storage, and handling of wastes requiring special arrangements, such as autoclaving.
17. Outline of monitoring procedures for waste categories and their destination.

18. Protocol for reporting and documenting failures in the waste handling, segregation, storage, transport, or disposal system, or waste management incidents that result in injury should be reported as soon as possible to the WMO, who will take action as necessary per agency protocol.

19. **Contingency plans**, containing instructions on storage or evacuation of healthcare waste in case of breakdown of the treatment unit or during closure down for planned maintenance.

20. Emergency procedures.

Training

21. Training courses needed, including an outline of content to be covered, participants targeted, expected outcomes, and budget. The Waste Management Officer should organize and supervise training programs for all staff. Initial training sessions should be attended by key staff members, including medical staff, who should be urged to be vigilant in monitoring the performance of waste disposal duties by non-medical staff. The Officer should choose the speakers for training sessions and determine the content and type of training given to each category of personnel.

Monitoring, Reporting, Updating

22. The Head of the HCF, with the WMO, **should review the WMP annually and initiate changes** necessary to upgrade the system. Interim revisions may also be made as and when necessary.

23. The WMO should prepare an **annual report** summarizing the actual practices vis-a-vis disposal of health-care wastes, providing data on waste generation and disposal, personnel and equipment requirements, and costs. Parameters to be monitored in this report could include:

(1) **Waste generated** each month, by waste category; treatment and disposal methods. (2) **Financial aspects of health-care waste management** (direct costs of supplies and materials used for collection, transport, storage, treatment, disposal, decontamination, and cleaning); training costs (labour and material); costs of operation and maintenance of on-site treatment facilities; and costs for contractor services (if any); and (3) **Public health aspects**, i.e. incidents resulting in injury, "near misses", or failures in the handling, separation, storage, transport, or disposal system, which should also be reported to the Infection Control Officer; this will be the basis for preventive measures to prevent recurrences.

25. The existence of the above details of the waste management plan, the implementation of these details, as well as the presence and content of the annual report will constitute the basis of outside supervision of the quality of waste management for this HCF.

