Public Disclosure Authorized

Social Assessment Report for Provision of Essential Health Services Project (PEHSP)

UNICEF South Sudan

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Table of Contents

LIST OF ABREVIATIONS

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
GoSS	Government of South Sudan
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

This document is the Social Assessment report for the Provision of Essential Health Services Project (PEHSP) to be implemented by UNICEF in the former States of Jonglei and Upper Nile, historically amongst the most conflict-affected states in South Sudan with the least investment in infrastructure, and most difficult to access physically. This project is intended to complement existing activities carried out by the Government and development and humanitarian partners. Its primary objective is to deliver low-cost, high-impact essential health services to the majority of the population, especially women and children, living in the two former States. This includes provision of maternal, neonatal and child health services, including basic curative services at primary level and provision of basic and comprehensive emergency obstetric and newborn care; procurement and distribution of essential medicines and supplies; strengthening systems for emergency preparedness and response and disease surveillance and outbreak response as well as for service quality improvement through training, supervision and coaching.

This Social Assessment provides an overview of demographic, social, cultural and political characteristics of the vulnerable and disadvantaged groups in the participating states of the country. It highlights the project's potential beneficial and adverse effects on the vulnerable and disadvantaged groups and how the positive impacts can be enhanced, and social risks managed. It focuses in particular on the current health services and outcomes in the two states, as well as the project's potential impact on public health in target areas. The Assessment was informed by a desk study review of relevant documents and prior and informed consultations with vulnerable and disadvantaged groups that assessed whether there is broad community support for such activities.

Jonglei and Upper Nile states are located in the North-East of South Sudan and, along with Unity state, they were the hardest hit since the Sudanese People's Liberation Army (SPLA) / SPLA in Opposition (SPLA-iO) conflict spread from Juba in late 2013. Diverse ethnic populations characterize the two states: in Upper Nile the three largest groups are the Dinka, Shilluk and Nuer, while in Jonglei they are the Murle, Dinka and Nuer. Communal conflict has occurred between and within all these groups in recent years. The projected populations of the two states for 2018 are 1.44 million (Upper Nile) and 1.94 million (Jonglei), but these figures are impossible to verify, particularly in light of excess mortality as a result of the conflict and displacement, both within South Sudan and further afield. Access to the two states remains very challenging.

Widespread insecurity and the looting of health supplies and assets, including the closure of health facilities, reduce health service delivery in the two states, and reporting rates of delivery are also low. However, in recent surveys in parts of the two states, almost 80 per cent of the population said they have access to health care: this is presumed to be linked to the high presence of humanitarian actors in the area. However, a range of indicators remains particularly poor in the area, including antenatal care (first and fourth visits), delivery with skilled birth attendants, immunization coverage, and health care seeking behaviour for a range of childhood illnesses. Poor hygiene and malnutrition also affect health. Meanwhile, gender-based violence, both intimate partner violence and conflict-related violence, is endemic in the region, with only limited access to even the most basic services for the clinical management of rape.

In this context, the Social Assessment finds that implementation of the project is likely to improve access to low-cost, high-impact health services by communities (including internally displaced persons) in Jonglei and Upper Nile States and thereby reduces child and maternal mortality and the spread of vector diseases and generally improve the health of the population in the two states. The potential positive impacts of the project outweigh the negative impacts, and it should make a significant contribution to improving health status and livelihoods in rural areas. 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 project period. On the other hand, if inequitable service delivery is perceived, this could contribute to heightened conflict.

The desk review of previous reports/documents has highlighted multiple stakeholders that include, among others vulnerable groups, civil society organizations, donor agencies, and Government. In such situation, issues of equity are very pertinent with regard to appropriate gender and inter-generationally inclusive framework that provides opportunities for consultation at each stage of project implementation among the borrower, the affected vulnerable and disadvantaged groups communities, their representative organizations, and other local civil society organizations.

The desk review also encompasses the communications channels that are important for passing on health messages to communities, especially with regards to mobilization. It found that village chiefs are considered the main channel

for messages to be passed to communities, with other means including drumbeat and bell, peer-to-peer communication and social gatherings.

The study has analysed and concluded that the project activities will generate considerable social benefits to the communities in the project areas, though it may not meet all the health needs. The study has also established a number of social consequences that the project activities are likely to induce albeit on a small and localized scale. 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.

This study finds that PEHSP is expected to produce considerable benefits that include increased access to health services, including for women, internally displaced persons and other vulnerable groups, reduced maternal and child morbidity and mortality, provision of quality health services and procurement of pharmaceuticals. The potential negative impacts if adequate mitigation measures are not put in place include elite capture and other social ills. It is, therefore, necessary that the actions set out in this report be integrated into the project and for monitoring to be carried out to ensure compliance.

Next to those project-induced risks, contextual risks resulting from the Fragility Conflict & Violence (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. Security risks and mitigation measures have been assessed and developed and will be implemented in a proportionate and feasible manner, including regular security risk assessments, resources for security measures, and cooperation with all stakeholders along the Saving Lives Together Framework (SLT). Constant coordination between UNICEF, implementing partners (IPs), local communities and government, the wider UN system in the country, and the World Bank is thereby essential.

In order to realise maximum benefits, community structures where there is reasonable stability should be strengthened especially the women groups to address issues of gender-based violence and nutrition. Mechanisms should also be put in place for rapid response mechanisms in conflict prone areas in order to address emergencies. Infrastructure and resources also require serious consideration, but this will have to be carefully assessed and efficiently managed, including with the support of other stakeholders (e.g. Gavi, the Vaccine Alliance) given the scarcity of resources.

1 INTRODUCTION

This document is the Social Assessment report for the Provision of Essential Health Services Project (PEHSP) that will be implemented by the United Nations Children's Fund (UNICEF) in the states of Jonglei and Upper Nile, 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 and development and humanitarian partners. Like any other area in South Sudan, malnutrition is widespread in the project states and this, along with a preponderance of infectious diseases, accounts for a considerable proportion of the total burden of disease. Infectious diseases, including malaria and typhoid, respiratory infections and acute watery diarrhoea are among the major causes of death and morbidity. Internally displaced persons are among the most vulnerable populations living in this region, given the widespread inadequate access to basic services, limited economic opportunities, poor infrastructure, and food insecurity.

The primary objective of this project is to deliver low-cost, high-impact essential health services to the majority of the population, especially women and children, living in the Upper Nile and Jonglei States.[1] The main strategy is to support an agile mix of static modalities of implementation, complemented by outreach interventions, through fixed health clinics and integrated outreach services delivered by mobile teams (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. These front-line interventions will be supported in specific areas with the rollout of community-based health services, such as the Boma Health Initiative (including integrated community case management), in order to bolster community resilience and basic services provision, even while communities are exposed to shocks and cannot be accessed.

Specifically, to increase equitable access by vulnerable groups to essential health care services, the three main strategies will be:

(a) *Directly supporting facility-based health service delivery*: In close collaboration with the Ministry of Health (MOH), State Ministry of Health and county health officials, UNICEF will provide implementing partners (IPs) (NGOs) with technical assistance, supplies and financial support, as part of overall capacity development to strengthen the delivery of basic health services to children and women, with priority given to the poorest and most marginalized communities. This will entail a mix of national and international NGOs identified through an open selection process.

(b) *Enhanced routine outreach*: Health teams attached to supported health facilities will be supported to expand coverage and access to health services in areas with intermittent periods of stability and access. This would provide a broader package of services in a more systematic manner to locations outside the catchment areas of the fixed/functional health facilities and within displaced populations, especially where there is a deficit of health and nutrition services. These outreach services will be provided monthly where possible (at minimum every -3 months).

(c) *Advancing community health*: Targeting communities far away from existing health facilities, through the Boma Health Initiative, a network of trained community health workers (CHWs) will be responsible for delivering a standard package of community health services building on integrated community case management (iCCM). Delivered at the household level, these services will also focus on health education and promotion of Child Health, Safe Motherhood, and basic Community Surveillance, along with community engagement and social mobilization (e.g. during campaigns when outreach services are available).

Other activities are outlined in Table 4.

The target population in Jonglei and Upper Nile is equivalent to about 50 per cent of the total population estimated by the National Bureau of Statistics (3,631,202 people). This includes about 85,000 pregnant women; 82,000 children under one; and 382,000 children under five.

[1] A physical verification and mapping was completed to ensure the functionality of listed health facilities and no overlap with other donor-supported health facilities.

The areas of health care to be covered in the EHSP 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;
(vii) Disease surveillance and outbreak response; and,
(viii) Quality improvement and supervision.

Partnerships will be established with NGO partners to deliver the following essential primary health care services:

(i) Child health services: immunization; vitamin A supplementation and deworming; promotion of adequate infant and young child feeding and caring behaviours; and use of long-lasting insecticide treated nets;
(ii) Maternal health services: antenatal care (including home-based lifesaving skills and intermittent preventative treatment); skilled delivery; postnatal care; basic emergency obstetric care and family planning;
(iii) Basic curative services: treatment of malaria; treatment of acute respiratory infections; treatment of other illnesses; and treatment for survivors of gender-based violence.

Specifically, World Bank funding will support the following activities at health facilities:

- Direct personnel costs, incentives and support for health staff working in health facilities and communities;
- Support for running costs for health facilities;
- Procurement and distribution of drugs and vaccines to health facilities;
- Emergency and routine outreach activities;
- Community mobilization and engagement activities;
- Coordination and monitoring and evaluation (M&E) related costs (coordination meetings, incentives, tools).

The following costs will be supported at the county health department (CHD):

- Support CHDs for travel to health facilities for joint supervision and support visits;
- Technical Assistance to support existing CHD capacities in planning, coordination, monitoring and reporting.

The main strategy is to support an agile mix of static modalities of implementation, complemented by outreach interventions, through fixed health clinics and integrated outreach services delivered by mobile teams (especially during the dry season) to increase and expand equitable coverage and access, particularly for nomadic or hard-to-reach populations with intermittent periods of stability and access. These front-line interventions will be supported in specific areas with the rollout of community-based health services, such as the Boma Health Initiative (including integrated community case management), in order to bolster community resilience and basic services provision, even while communities are exposed to shocks and cannot be accessed.

1.1 Project rationale

At the time when the PESHP 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). 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.

At the beginning of the project, the fighting between the Government and SPLA-IO was still 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 country in Jonglei is one of the remained SPLA-IO strongholds and as such when the road conditions allow was vulnerable to Government advancement.

While civil conflict has primarily ceased in Upper Nile and Jonglei, there are also two other levels of conflict. Intercommunal conflict is taking place, for example between the Dinka Bor and the Murle, which involve cattle raids and mobilization, in Jonglei or Shilluk and Dinka Padang in Upper Nile. Finally, there is intra-communal conflict, for example, frequent clashes between sub-sections of the Dinka communities, or different age sets, for example within the Murle community. The different levels of conflict are interconnected with intercommunal and intra-communal conflict increasingly politicized. Some estimates have shown that in some locations, loss of lives has been higher from the 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 lack of equity; 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 the elite 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). On-going displacement of health workers, non-functionality of health facilities due to insecurity, inaccessibility widespread looting and vandalization continues 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 over-reliance 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 programs and procurement of basic pharmaceuticals.

Against this backdrop, the PEHSP project will play a crucial role for 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 The PEHSP objectives

The objective of this project is to deliver low-cost, high-impact essential health services to an estimated 50 per cent of the 3,631,202 people estimated by the National Bureau of Statistics to be living in the Upper Nile and Jonglei States (1.8 million people). This includes about 85,000 pregnant women; 82,000 children under one; and 382,000 children under five (National Bureau of Statistics, 2015).

1.3 Security risks and mitigation measures

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.

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.

1.4 Objective of the Social Assessment

In line with the requirements outlined in OP 4.10, the objective of the Social Assessment is to provide an overview of demographic, social, cultural and political characteristics of the different vulnerable and disadvantaged as well as ethnic groups in the participating states of the country and the project's potential and adverse effects of the vulnerable and disadvantaged groups and how the positive impacts can be enhanced, and social risks managed. In this regard, the assessment was based on desk study review of relevant documents and free, prior and informed consultations with vulnerable and disadvantaged groups and assessed whether there is broad community support to the project. The Social Assessment is also intended to provide the affected vulnerable and disadvantaged communities with all relevant information about the project (including an assessment of potential adverse effects of the project on the affected vulnerable and disadvantaged).

1.5 Methodology

UNICEF conducted this Social Assessment in September and October 2018 as part of the development process for the PESHP. The assessment was mainly based on a community-based social mapping exercise as well as a desk review of existing documents and reports. This Social Assessment was partially updated in September 2020 to incorporate

enhanced protocols related to security management for IPs and Significant Event reporting. As part of this partial update, minor adjustments were made to reflect significant contextual changes. However, the entire document was not updated.

UNICEF has been conducting community-based social mapping since 2015 to facilitate microplanning, partnership and monitoring of programme activities. Maps have been developed and regularly updated for each county in Upper Nile and Jonglei. UNICEF-supported community mobilizers requested the following information:

- Population: who are they and where are they located?
- What are the geographic features and infrastructure in the area?
- What is the administrative composition and basic information?
- Who can help us?
- How can they be reached?
- What are the key challenges?
- How many functional and non-functional facilities are there?
- How much risk is involved?
- How accessible is the area?

This was followed by micro-planning that entailed the

- Identification of possible missed areas
- Demarcation of deployment areas
- Logistics planning
- Division of areas - town/camp, villages and scattered settlements
- Planning activities and coverage areas
- Movement plans of frontline health workers and their supervisors
- Monitoring plan
- Proposed implementation plans in hard to reach and inaccessible areas, etc.

This exercise provided critical information to inform the social assessment. The PowerPoint entitled “Social Mapping” provides more details on this. Some sample county maps are attached. The social maps can be accessed through the link below, and updated versions are currently being prepared by UNICEF South Sudan’s Communication for Development Section. https://www.unicef.org/southsudan/reports_social-maps.html.

The data was reviewed and updated with new information and data drawing from reports that included key informant interviews and consultations with both rights-holders and duty-bearers, as well as analysis on the situation in the target area by the Government and international organizations (as set out in the Bibliography below).

1.6 Structure of the report

The report is organized in eight chapters. Following this introductory chapter, Chapter 2 reviews the health sector in South Sudan and the two states, while Chapter 3 describes the PEHSP components, and how the project will trigger social change in the area. Chapter 4 describes the baseline conditions and establishes the basis for discussion of project impacts in Chapter 6. Chapter 5 reviews legislation and policy relevant for the project. Chapter 6 highlights the potential social impact of the project, Chapter 7 reviews public perceptions, and Chapter 8 provides conclusions and recommendations.

2 OVERVIEW OF THE HEALTH SECTOR IN SOUTH SUDAN

South Sudan's healthcare system includes community, primary, secondary and tertiary levels. Community health care is based at village level and is manned by community health teams. The health services are supposed to be free and accessible to the whole population at primary and secondary levels. In South Sudan's decentralized system, the national MOH provides policy guidance, leadership, funding, monitoring and evaluation, while state level oversees health care delivery at other levels. In 2016, there were 168 operational health facilities in Jonglei and 177 in Upper Nile (MOH, 2017). A physical verification and mapping exercise was completed to update this data and to ensure no overlap with this project and other donor-supported health facilities. The country has a partially functioning health management information system because of the varied challenges resulting from the conflict. For instance, between January and July 2018 there was a rate of only 74 per cent completeness and 41 per cent timeliness in relation to immunization data. For other indicators (such as antenatal care visits), available healthcare management information system (HMIS) data was much less complete, with very limited data available from April 2018 onwards.

Despite this lack of definitive data, South Sudan is believed to have some of the worst health outcome indicators in the world. The maternal mortality ratio stands at 789 per 100,000 live births (World Health Organization (WHO) et al, 2015), while the neonatal and under-five mortality rates are 66 and 96 respectively per 1,000 live births (UNICEF et al, 2018). A significant disparity in health status across socio-demographic factors and geographical locations is well documented (WHO, 2018).

3 DESCRIPTION OF THE PROVISION OF ESSENTIAL HEALTH SERVICES PROJECT (PEHSP)

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; (vii) Disease surveillance and outbreak response; and (viii) Quality improvement and supervision.

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/nomadic or hard-to-reach populations with intermittent periods of stability and access. These front-line interventions will be supported with the roll out of community based health services, such as the Boma Health Initiative (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 ensure service continuity. Additional efforts also will to 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 facility-based service delivery in close collaboration with the MOH; (2) routine outreach to areas that are intermittently stable and accessible; and (3) training for community health workers on treatment of malaria, acute respiratory infections and diarrhoea among young children, disease surveillance and the reporting of service delivery data and vital statistics. UNICEF will work in partnership with NGOs to ensure continuity of services, and directly contract suppliers and service providers.

4 BASELINE SOCIO-ECONOMIC CONDITIONS OF THE PROJECT AREA

4.1 PEHSP operation areas

Jonglei and Upper Nile states are located in the north-east of South Sudan and, along, with Unity state, were the hardest hit from the point when the SPLA / SPLA-IO conflict spread from Juba in late 2013. Diverse ethnic populations characterize the two states: in Upper Nile the three largest groups are the Shilluk, Nuer and Dinka, while in Jonglei they are the Dinka, Murle, Nayuak and Lou Nuer. Communal conflict has occurred between and within all these groups in recent years. Pastoralism is widely practiced in the region, which results in entire families or sections of families moving with their herds of livestock (mainly cattle) as well as for agricultural purposes. Pastoralists are highly mobile and adaptive to changing contexts associated with the availability of water, land and cattle grass as well as inter and intra communal conflicts. Subsequently, most ethnic groups living in Jonglei and Upper Nile (e.g. Dinka, Nuer, Murle) are nomadic or semi-nomadic in nature with the Shilluk being amongst the most sedentary. Subsequently, this means that an agile mix of primary health care delivery is required in rural areas of the project: community-based approaches, whereby trained community health workers move with and provide basic health education and services to their communities; and mobile outreach services that reach pastoral communities with wider service provision when access permits.

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

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

Upper Nile State has become one of the most marginalized and impoverished regions in South Sudan because of the presence and activities of militias and harsh environmental conditions. Agriculture is the primary economic activity in Upper Nile, where people are nomadic agro-pastoralists that engage in both agriculture and the rearing of livestock, primarily cattle. Despite the number of private industry-based oil drilling sites in Upper Nile, the region remains extremely poor with negligible service levels in basic development indicators such as education, health, sanitation, and access to clean drinking water. In 2014 and 2015, Upper Nile State saw some of the most intense conflict in South Sudan, which, after a calmer 2016, reignited in 2017. Insecurity and logistical constraints make Upper Nile difficult to access for most humanitarian actors (REACH 2017). Upper Nile's dominant tribe is that of the Shilluk, but it also has residents from the Nuer and Dinka groups, the Bari-speaking groups, as well as Arabs. After years of war and instability, many areas of the state's border with the Gambella region in Ethiopia are prone to security issues and are dominated by armed groups, unresolved inter-communal disputes, multiple waves of displacement, and competition for land, water, services and citizenship. During the dry season, local water sources dry up and the area's various ethnic groups, including the Nuer-Lao, Nuer-Jikany and the Murle, drive their cattle toward the Sobat and Pibor rivers

in Akobo County. The seasonal concentration of cattle, combined with the multitude of tribes and armed groups in a small area, often results in increased tension and inter-ethnic fighting, continuing well into the rainy season (UNDP, 2012).

Humanitarian access in the two states is problematic. OCHA has reported, for example, that in August 2018 there were 19 humanitarian access incidents in Jonglei, including multiple detentions of staff and vehicles taken, while in Upper Nile there were 15 such incidents, and ongoing tensions in the Malakal Protection of Civilians (PoC) site hampered humanitarian access to about 24,500 people residing in the site (OCHA, August 2018). The OCHA South Sudan: Quarterly Humanitarian Access Snapshot (April to June 2020) continues to outline access challenges. Fighting between different groups in Jonglei resulted in the relocation of 66 humanitarian staff. The Greater Pibor area witnessed renewed fighting between armed youth groups and the looting of humanitarian assets and supplies. An increase in insecurity related to intercommunal violence had serious consequences on civilians and humanitarian workers. On 16 May, three humanitarian workers were killed after fighting erupted in and around Pieri town, Jonglei. On 28 June, a clearly marked ambulance transporting an injured person to a hospital following fighting was shot at in Cueibet County, Lakes. The driver, a national staff member of an international NGO that is providing health services in South Sudan, was killed, bringing the number of aid workers killed in South Sudan since the conflict began in 2013 to 120.

2.2 Health indicators

Health service delivery in Jonglei and Upper Nile continue to be extremely challenging due to widespread insecurity; and looting of health supplies and assets, including the closure of health facilities. In 2016, the following health facilities were reported by the HMIS in the two states.

Table 1: Types of health facility in Jonglei, Upper Nile and South Sudan

	HEALTH FACILITY TYPE										
STATE HUB	County Hospital	Hospital	Other	Mobile Clinics	PHCC	PHCU	Private Clinic	Specialized Hospital	State Hospital	Teach-ing Hospital	Total
Jonglei	3	0	0	10	31	117	2	0	1	0	164
Upper Nile	4	0	2	28	39	101	2	4	0	1	181
TOTAL (two project states)	7	0	2	38	70	218	4	4	1	1	345
TOTAL (South Sudan)	28	1	10	79	306	1,079	15	13	8	3	1,542

This number is likely to have changed over the past two years, given the continued conflict. In this context, a physical verification and mapping exercise is currently underway to update the data. Nevertheless, 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. Upper Nile and Jonglei have the lowest reporting rates to the Health Management Information System. In 2016, only 31 per cent of expected health facility reports were delivered in Upper Nile in 2016, and 51 per cent in Jonglei, compared to a national average of 68 per cent and far below the baseline acceptable standard of 80 per cent (MOH, 2017).

Meanwhile, according to 2016 Health Management Information System data (MOH, 2017) consultation utilization rates for all ages were lowest in Jonglei (at 0.2).

Antenatal care coverage (ANC) was particularly poor in the two states in 2016, with first visit coverage of 14.8 per cent in Upper Nile and 21.5 per cent in Jonglei compared to a national average of 50.3 per cent (in the 2015 LQAS the figures were 50 per cent, 40 per cent and 54 per cent respectively); and fourth visit coverage of just 7.8 per cent in Upper Nile and 9.5 per cent in Jonglei, compared to 22.6 per cent nationally (MOH, 2015: 22 per cent, 11 per cent and 23 per cent respectively).

Upper Nile and Jonglei also had the lowest rates of deliveries with skilled birth attendants in the 2016 HMIS, at 2.2 per cent and 2.3 per cent respectively compared to 10.1 per cent in the country as a whole.

Government population projections for 2018 for Upper Nile and Jonglei states show much higher numbers of males than females aged between 10 and 29 in both states. This may reflect a lack of access to healthcare services for females of reproductive age, as well as endemic problems of gender-based violence and gender inequality in society.

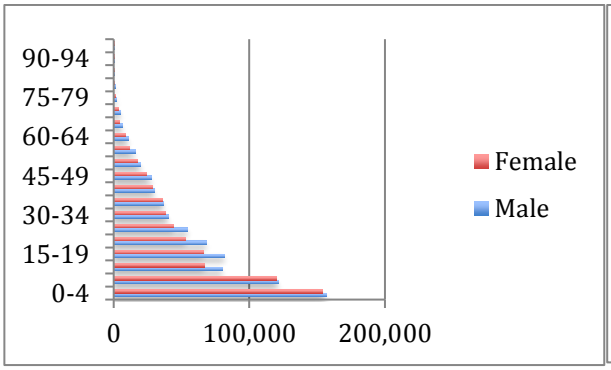

Figure 1: Projected population by age and sex, Upper Nile

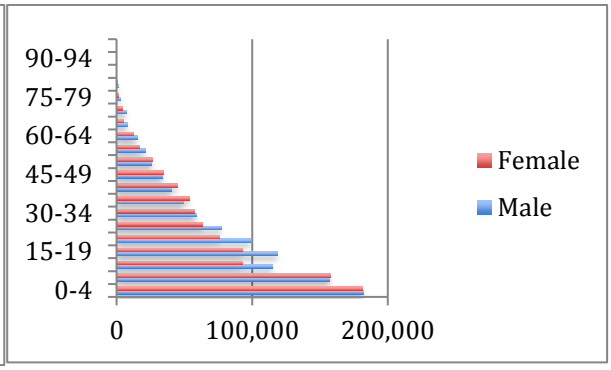

Figure 2: Projected population by age and sex, Jonglei

Meanwhile, immunization coverage is particularly poor in the two focus regions, with Penta3 coverage of only 13 per cent in Jonglei and 20 per cent in Upper Nile (MOH data, 2017). The resulting gap in immunity puts children at a high risk of malnutrition and vaccine preventable disease.

The 2015 Lot Quality Assurance Sampling (LQAS) conducted by the Liverpool School of Tropical Medicine for the Ministry of Health also found a range of other indicators for which Jonglei and Upper Nile were below the national average, as can be seen in the table below:

Table 2: Selected LQAS 2015 indicators for Jonglei, Upper Nile and South Sudan

	Jonglei	Upper Nile	South Sudan
Proportion of mothers of children 0-11 months who received two or more doses of tetanus toxoid during their last pregnancy and which was recorded in the maternal ANC card	8%	6%	14%
Proportion of women 15-49 using any form of modern contraception	1%	6%	6.5%
Proportion of children with fever who were treated with an appropriate anti-malarial within 24 hours of the onset of symptoms	1%	2%	8%
Proportion of children with diarrhoea whose mothers sought advice or treatment	17%	7%	22%
Children with suspected ARI two weeks before the survey whose mothers sought advice or treatment from an appropriate healthcare provider within 24 hours of onset of symptoms	12%	4%	14%
Proportion of children with suspected pneumonia two weeks before the survey who were treated with appropriate antibiotics within 24 hours of onset of symptoms	5%	1%	9%

4.4 Health and nutrition

The desk review of existing documents and reports consulted revealed that poor hygiene conditions also negatively impact the health situation in communities in Jonglei and Upper Nile. In focus group discussions previously carried out, some community members reported that none of the population in their village used latrines. Open defecation directly contaminates drinking water sources, which is a health threat to communities especially during wet seasons. Malaria was the primary health concern among the communities consulted, followed by pneumonia, typhoid, and malnutrition, UTIs, STDs and Hepatitis B most reported in Jonglei Diarrhoea, measles and respiratory infections are the most common childhood diseases in the consulted communities. Childhood illnesses are highly correlated to acute malnutrition (MOH consultations, 2017, as updated in 2018).

A variety of health concerns was also found in the results of two REACH assessments in Jonglei and Upper Nile in early 2018. Malaria was found to be the major concern in Jonglei, particularly along the Bor-Duk Corridor near the Sudd. In January, malaria was reportedly the main cause of death in 46 per cent of assessed settlements. This figure gradually declined in February (33 per cent) and March (20 per cent) with the progression of the dry season. The same assessment found that in Western Jonglei the major health concern was waterborne diseases and linked this to a lack of access to latrines (REACH, 2018a). However, in Upper Nile's Nasir and Ulang counties, a plurality of settlements reported typhoid to be the main concern (15 per cent), followed by conflict-inflicted injuries (14 per cent) and malaria (8 per cent). The assessment reported that malaria and waterborne disease would likely increase in significance later in the year with the onset of the rainy season (REACH, 2018b).

Jonglei and Upper Nile are among the most vulnerable in South Sudan for nutrition. In September 2018, 69.8 per cent of children in Upper Nile and 62.5 per cent in Jonglei were found by the Integrated food security phase classification (IPC) assessment to be living in crisis, emergency or catastrophic conditions, ranking third and fourth most serious nutrition situation of the 10 states in the country. The most vulnerable states, in catastrophic conditions in September 2018 and/or forecast to be in early 2019, included Canal/Piqi and Pibor in Jonglei and Panyikang in Upper Nile (IPC assessment, September 2018).

The level of global acute malnutrition (GAM) remains above the emergency threshold (15 per cent) in most of the county based SMART surveys conducted during the first seven months of 2018. A total of seven SMART surveys conducted in Jonglei found that GAM was above the cut-off rates for concern (15 per cent) in all seven counties surveyed: Nyirol (25.7 per cent), Duk (25.3 per cent), Twic East (24.1 per cent), Pibor (20.7 per cent) and Fangak (16.1 per cent), Akobo east (16.1 per cent), and Uror (16.0 per cent) (UNICEF, June 2018). During the same period, a total of seven SMART surveys conducted in Upper Nile showed GAM rates above the emergency threshold in five counties. The highest GAM rate was recorded in Renk county (26.9 per cent) and Renk camp (22.8 per cent) followed by Melut (21.7 per cent), Ulang (20.1 per cent) and Malakal county (18.5 per cent). The counties of Fashoda and Maban showed GAM rates of 13.3 per cent and 10.2 per cent respectively.

4.5 Status of health facilities and services

The July 2016 conflict further crippled the delivery of health services in Upper Nile and Jonglei states through looting and destruction of health facilities, displacement or relocation of health workers, mass evacuation of partners and fund managers, all contributed to further reduce the number of functional health centres, while the remaining ones provide minimal range of services. All these have negatively impacted on delivery of primary health services packages including basic consultations, vaccinations, emergency obstetric services, nutrition, and management, sexual and gender-based violence (GBV) (Ministry of Health, 2017, as updated in 2018). For instance, in 2017, out of 116 cold chain equipment newly installed, about 14 per cent were vandalized and looted, mostly in Upper Nile and Jonglei (6 per cent in each).

Access challenges are highlighted in UNICEF Humanitarian Situation Reports. In May 2018, it was reported that In Upper Nile, 16 Outpatient Therapeutic Programmes (OTPs) and 19 Targeted Supplementary Feeding Programmes were still suspended in Maiwut, Manyo, Fashoda and Melut counties. Meanwhile, movement was restricted across government and opposition held territories in Uror county in Jonglei and had affected programme activities in the area. UNICEF stated that as the rainy season intensified, many areas would become inaccessible by road, debilitating access to services, outreach and supply delivery to OTP sites (UNICEF, May 2018).

4.6 Common social vulnerabilities in the population as they relate to accessing healthcare

A social mapping exercise conducted by UNICEF's network of community mobilizers in the project area in August and September 2018, in combination with a desk review of recent sources on the area, revealed a range of social vulnerabilities, partly related to cultural characteristics, partly to recent social developments, that need to be taken into account in project design and implementation in line with the requirements of the World Bank's OP 4.10. Among most of the ethnic groups living in the two states, the following characteristics related to access to and delivery of health care were noted:

4.6.1 Gender-based violence

Gender-based violence (GBV) remains a severe life-threatening problem affecting the physical safety and wellbeing of women and children in South Sudan. Already rife prior to the conflict, it is now nearing epidemic proportions per Human Reports of 2016 on South Sudan. The full magnitude of the problem is unclear. Studies conducted in 2016 by

International Rescue Committee and partners indicate that some 65 per cent of women and girls have experienced physical and/or sexual violence in their lifetime, some 51 per cent have suffered intimate partner violence and some 33 per cent of women have experienced sexual violence from a non-partner, primarily during attacks or raids. The majority of girls and women experience sexual violence for the first time below age 18 (International Rescue Committee, 2017). UNICEF's 2018 mapping confirmed that women continue to be vulnerable to GBV including rape and abduction, related to conflict and social norms relating to women, whether they lived in government or SPLA-iO areas. It also reported cases of women being tortured in relation to the conflict. In Malakal: there were accounts of the Dinka host community attacking women from other ethnic groups who live in the PoC site, but who occasionally leave for livelihood purposes, based on their specific ethnic groups or vulnerability (UNICEF Mapping, 2018).

In Upper Nile State, the effects of the ongoing conflict continue to increase risk of sexual violence against women and girls. Regular focus group discussions conducted in Malakal PoC have revealed incidents of sexual violence (rape) against women and girls as they go out of the PoC site to fetch firewood and other livelihood opportunities. In Jonglei, particular in Pibor region, women and girls continues to experience GBV including sexual violence and physical violence during cattle raiding (Protection Cluster, 2018). Among the Murle, a Nilotic ethnic group inhabiting the Pibor County and Boma area in Jonglei State who are nomadic and associated with cattle raiding, women fear being kidnapped by other Murle clans or other ethnic groups in order to make them their wives. The Murle can similarly abduct children. This ethnic group therefore tends to live in hard-to-reach areas (deep remote rural areas), far away from towns, because they fear having their women and children kidnapped and/or fear having to give abductees back to those that they have kidnapped from, in case they are sought after (UNICEF Mapping, 2018).

Child marriage practices are also common in both Jonglei and Upper Nile State. In South Sudan, GBV is rooted deeply in harmful social norms anchored in patriarchal traditions, such as strict gender roles and identities, patriarchal authority, women's low social status and power imbalance such as their limited access to decision-making and reproductive rights, poverty, inequality in the area of employment or education, and discriminatory practices (Protection Cluster, 2018).

With overall reduced access to health service by population, clinical management of rape services including even the most basic GBV services are also limited, ad hoc and severely compromised by the lack of the right and quantities of skill sets able to deliver an effective response (Health Cluster Bulletin 1, January 2018).

Measures to mitigate risk of GBV include training of UNICEF's sectors and clusters on the Inter-Agency Standing Committee guidelines for GBV integrating GBV prevention and response in humanitarian action; conducting safety audits/safety assessments to identify safety needs for women and girls and engage relevant actors to address them; supporting partners to develop and implement specific action plans to improve women and girls' safety; and leading advocacy efforts in collaboration with other actors to improve women and girls safety interest. GBV risk mitigation efforts also include the training of UNICEF and partners' staff including contractors, consultants and volunteers on protection from sexual exploitation and abuse (PSEA). In addition, UNICEF had put in place enhanced mechanisms to mitigate the risks of PSEA and build capacity of IPs in this regard. UNICEF is also supporting partners in Juba and Malakal PoCs to implement community-based complaint mechanism to enable affected communities and populations to report any protection concerns including sexual exploitation and abuse and seek assistance.

4.6.2 Displacement in project areas.

As of August 2018, it was reported that 386,950 individuals were internally displaced in Jonglei and 364,357 in Upper Nile (OCHA, August 2018). Of these, 24,415 were in the Malakal Protection of Civilians (POC) site (7 per cent of internally displaced persons in Upper Nile) and 2,300 in Bor PoC site (0.6 per cent of the internally displaced in Jonglei) (PoC figures: United Nations Mission in South Sudan (UNMISS), August 2018).

PoC camps within the project areas are UNMISS-administered sites sheltering internally displaced persons in both Bor (Jonglei) and Malakal (Upper Nile). In the two camps, UNMISS provides security while other United Nations organizations such as UNICEF, the World Food Programme and the Food and Agriculture Organization provide services in nutrition; health; water, sanitation and hygiene (WASH); and food security with supplementary support from civil society organizations. In both PoC sites, service provision is inadequate due to large numbers and inadequate funding (Ministry of Health, 2017, as updated in 2018).

In Bor PoC, there is a clinic managed by a national NGO. The clinic provides only PHC and for secondary and tertiary treatment the patients are referred to Bor State Hospital, which is about 10km away, but ambulance services are not available. There are poor sanitation facilities with only a few latrines available. Most key diagnostic machines like stethoscopes and blood pressure machines are non-functional. Emergencies especially those that are life threatening cannot be handled at the PoC health facility that puts people's lives in danger. There is no electricity in the health facility, which is housed in a tent with limited aeration. There are widespread stock outs of logistic supplies like medicines and drugs. There is also no proper health care waste management plan at the facility and low awareness on HIV and AIDS, with stigma still causing low condom use. Acute watery diarrhoea accounted for most morbidity in the Bor PoC site: other conditions included malaria, pneumonia, typhoid and HIV (MOH, 2017, as updated in 2018).

Meanwhile, in Malakal, the PoC currently shelters around 25,000 Internally displaced persons. Health services are being provided at primary health care (PHC) level by International Organization for Migration and International Medical Corps (IMC), who run a PHCC providing comprehensive services. Whilst secondary health care is provided by Medicins Sans Frontieres' hospital, IMC's reproductive and surgical centre inside the PoC site equally ensures adequate coverage for complicated deliveries and acute surgical emergencies. All of these are conducted with technical and in-kind support from UNICEF, the United Nations Population Fund (UNFPA) and WHO. However, unlike the PoC, Malakal town is striving to access quality health care with three under-equipped health facilities and a non-functional hospital. Despite the reopening of the paediatric hospital, referral of complicated cases remains the biggest challenge. Currently the entire town depends on the PoC site for obstetrics and surgical emergencies: this is unsustainable and, most importantly, not possible after 6:00 p.m. (OCHA, 2017)

Although most of the IDPs in Upper Nile and Jonglei States live outside the POC sites, no data is available on their access to health care and health status. It is likely that health indicators for internally displaced persons living outside POC sites are lower than those of the populations of Upper Nile and Jonglei (see paragraph 2.2). Where POC sites are located (e.g. Bor and Malakal) every effort will be made to ensure host communities are served by the project, given that the population living in the POC sites are served by humanitarian agencies. Similar levels of services will be provided as resources permit to mitigate community perceptions of inequity. Section 7.1 *Communication Channels* provides more information on how women will be communicated with and conflict impacts mitigated.

4.6.3 Ethnicity of healthcare professionals

Another issue of concern raised in UNICEF's mapping exercise in Jonglei and Upper Nile is that health care workers are perceived as 'imported' from other tribes (from the Central Equatorial region). Partners therefore need to sensitize local communities about why they may need to bring skilled staff from elsewhere, if qualified staff (such as clinical officers as midwives) are not available for local recruitment. Partners also need to make efforts to recruit unskilled local workers as much as possible (e.g. cleaning staff). This is particularly the case in areas where young people are unemployed and lack livelihood opportunities. If attention is not paid to this, this can trigger incidents, especially when compounded by rumours such as in the recent situation of Maban, Upper Nile, in July 2018 [2]. Humanitarian organizations need to therefore ensure regular community engagement to ensure that community issues, rumours and concerns are regularly aired and discussed, as early as possible, before they can mushroom into incidents. IPs will be also be oriented by on local social issues and will be accompanied on an advocacy trip to visit local authorities and communities about the new project. IPs will also 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.

4.6.4 Violence against communities

As previously noted, Jonglei and Upper Nile are historically amongst the most conflict-affected states in South Sudan with the least investment in infrastructure, and most difficult to access physically. The level of conflict has reduced over recent years however there is still a high degree of inter-and intra-community violence, cattle raids and crime that has ravaged local and displaced populations. It is recognized that the Government of South Sudan has the primary responsibility of providing security to all communities however with limited resources and the current political environment, incidents against communities and those conducting humanitarian activities occur regularly.

[2] http://www.sudantribune.com/spip.php?article65913

To mitigate the risk against violence, UNICEF will support NGOs operating in Upper Nile and Jonglei based on the Saving Lives Together Framework (SLT). . This includes but is not limited to improved information sharing, training and security incident reporting protocols. Further details outlined in *the PESHP Security and Significant Event Management Framework.*

4.6.5 Additional challenges

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

5 OVERVIEW OF POLICY AND REGULATORY FRAMEWORK

5.1 Government health policy

The MOH in South Sudan developed the National Health Policy (NHP) 2016-2026, to provide the overall vision and strategic direction for development in the health sector. The NHP 2016-2026 which is to be implemented through two five year strategic plans: 2016-2021 and 2021-2026, draws its mandate from the Transitional Constitution of the Republic of South Sudan (2005), Vision 2040, the South Sudan Development Plan (SSDP), and is cognizant of the Comprehensive Peace Agreement (August 2015) and the Sustainable Development Goals agenda. The overall goal of the NHP is a strengthened national health system and partnerships that overcome barriers to effective delivery of the Basic Package of Health and Nutrition Services (BPHNS); and that efficiently responds to quality and safety concerns of communities while protecting the people from impoverishment and social risk (WHO, 2018).

Under the overarching framework of the NHP, South Sudan has developed a National Health Sector Strategic Plan (2017-2021), which will serve as a framework for action for UNICEF and partners once it is approved. The country is also updating its BPHNS and developing a costed multi-year plan for immunization (2018-2022) as well as a Reproductive, Maternal, Newborn and Child Health (RMNCAH) Strategy (2018-2022) and an Every Newborn Action Plan (ENAP). The current lack of finalized plans and guidelines have implications for the prioritization of key interventions, including support for newborn care.

As a strategy for mobilizing action at the household and community level for reducing the high rates of ill health and preventable, premature deaths in South Sudan, the MOH intends to expand coverage of part of the BPHNS at community level largely through the Boma Health Initiative. This initiative aims to deliver an integrated package that includes health promotion, integrated community case management, safe motherhood, and the control of common communicable diseases and epidemics. When PEHSP was first implemented, the Boma Health Initiative had not been rolled out at scale. Nevertheless, a review was undertaken of two pilots along with a costed analysis that is informing roll-out plans in 2019. In readiness for scale-up, training materials and resources are have been partially revised with work ongoing and a community health management information system is being developed.

5.2 World Bank policies

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. As a result, this Social Assessment has been prepared and broad community support has been assessed for project activities. As the policy applies to almost all citizens of the project area, no Indigenous Peoples' Plan is required, as results of the Social Assessment apply to all beneficiaries and the measures outlined in the Social Development and Monitoring Plan will be addressed by and mainstreamed into the overall project activities. In both states, many health facilities have been mapped for to enable the selection of NGO partners. The selection process will take into account ethnic considerations. The Expressions of Interest (EOI) stipulate that each NGO partner has to: (1) show understanding of local context and conflict sensitivity risks which differ from County to County and within different groups and demonstrated ability to translate contextual understanding into effective interventions, including community engagement; and (2) outline access constraints and security considerations and how the NGO will manage these, whilst integrating conflict sensitivity into the proposed interventions. The poor and underserved will remain central to the project in prioritization, with the restoration of services in the areas most affected the conflict and consequently least provided for, and monitoring will assess the coverage and inclusiveness of the health service provision and thus provide information that will constitute a basis for corrective actions, if necessary. 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.

5.3 UNICEF policies

The activities within this project fall closely within UNICEF's policy framework. UNICEF's work globally is guided by its Strategic Plan 2018-2021. The activities within this project fall under the Plan's Global Area 1: *Every child survives and thrives*. This theme is replicated in UNICEF's Eastern and Southern Africa Regional Office's 2018-2021 Regional Priority 1: *Enabling children to survive and thrive.* Finally, at country level, the first outcome in UNICEF South Sudan's Country

Programme Document 2019-2021 is *Children under five years and pregnant women use more equitable and better quality essential maternal, neonatal and child health services*.

UNICEF has a range of strategic approaches to ensuring that its programming has tangible social benefits and avoid doing harm to society. Its 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.

Prevention of exploitation and gender-based violence
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 women and 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.
GBV, already pervasive in South Sudan prior to the conflict, has been greatly intensified by the current crisis, and is being perpetrated by all parties to the conflict. Women and children require particular attention due to their overall disadvantaged status in society – based on both gender and age – which makes it more difficult for them to access services, overcome security barriers, and advocate for themselves. Therefore, it is essential to make additional efforts to address the plight of women and child survivors and for life-saving services to be extended to improve accessibility. 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.

Emergency Preparedness and Response
UNICEF will ensure that IPs, in collaboration with appropriate and relevant authorities and third parties (e.g. WHO/Health Cluster), will be prepared to respond to 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 our core commitments.

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

For purposes of both security management and Significant Event management, the PEHSP SSEMF takes into account both UNICEF and IP personnel, premises and assets. The SSSEMF 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 Reporting[3] Protocol.

Accountability to Affected Populations (AAP)
UNICEF has an established culture of engaging the community from the initiation of the project in order for the community to own it. Stakeholders meetings will be held in the location identified for implementation of the response. The community will be routinely consulted and provided with information regarding the project implementation. This will include engaging existing South Sudan's Relief and Rehabilitation Commission (RRC), State and County Health Department representatives, community elders, women, youth groups, religious leaders and representatives of beneficiaries. Aside from through UNICEF field and Juba-based offices, this will be the medium through which communities will be encouraged to express their concerns, views and provide regular feedback to the IP in a regular structured modality. Other reasonable modalities for feedback that is useful to the communities/beneficiaries will also be considered. These feedbacks will form part of the project performance reporting to the health cluster and will help guide the fine-tuning of the project to enhance positive beneficiary experience.

6 POTENTIAL SOCIAL IMPACTS AND MITIGATION MEASURES

6.1 Social impacts

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 and comprehensive emergency obstetric and newborn care and basic curative services; 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 reduce child

[3] Significant Event is defined term in the Financing Agreement between UNICEF and the World Bank.

mortality, maternal mortality and the spread of vector diseases and generally improve the health of the population in the two states.

The ultimate beneficiaries include the women, children, and the poor, insecure and most vulnerable people in the two states. Potential social impacts can occur at various stages of implementation and can be positive or negative, temporary or permanent, and cumulative. On balance, the potential positive impacts of the project outweigh the negative impacts, and it should make a significant contribution to improving health status and livelihoods in rural areas.

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 project period. On the other hand, if inequitable service delivery is perceived, this could contribute to heightened conflict.

The project has been designed in line with the project's principles of the policy. It applies extensive community consultation activities through local facilitators of IPs who can speak local languages and are familiar with the context. Community outreach programmes ensure the inclusion of vulnerable communities and households. Health facilities provide services to local communities as well as internally displaced persons. Through village health committees, women and other vulnerable groups will actively participate in monitoring disease outbreaks, distributing malaria nets and community outreach activities.

Table 3: Project Positive Impacts, Drivers and Benefits to Society

Impact	Impact driver	Expected beneficial impacts
Improved childhood health	• Increase in medical waste in areas of operation • Health education • Routine immunization (including via outreach) • Integrated management of neonatal and childhood illnesses (IMNCI) and referral for complicated cases • Insecticide bed net distribution • Vitamin A supplementation and deworming • Promotion of adequate infant and young child feeding behaviours • Nutrition screening and referral to adjacent nutrition therapeutic programmes.	• Improved childhood health is an intrinsic social benefit • Provision of medical supplies and having healthier children will reduce the costs for parents of health care and supervision, and free up household resources to meet other livelihood needs • Not having to care for sick children will increase parents' and carers' livelihood opportunities • Investing in a child health in the early years of life will contribute to early childhood development as a whole. It will improve not only health but also productivity and social cohesion along the life course and has intergenerational benefits. The health sector has a special role to play in early child development because of its reach to families and children in the early years
Improved maternal and neonatal health	• Health education • Antenatal care (ANC4+) • ANC interventions (2TT, deworming, iron folate supplementation, integrated preventive treatment, and insecticide bed net distribution) skilled delivery • Postnatal care of mothers and newborns • Family planning • Referral (if required) for secondary health services • Basic and comprehensive emergency obstetric and newborn care at the primary health care centre (PHCC) and hospital level	• Improved maternal and neonatal health is an intrinsic social benefit • Provision of medical supplies and having healthier mothers and newborns will reduce the costs of health care and supervision, and free up household resources to meet other livelihood needs • Healthy women will have more opportunities to contribute to household and community livelihoods • Not having to care for sick babies will increase parents' and carers' livelihood opportunities

Impact	Impact driver	Expected beneficial impacts
Availability of basic curative services and essential medicines and supplies	• Treatment of malaria, acute respiratory infections, diarrhoea and other endemic illnesses • Identification, counselling, management and proper referral for victims of GBV violence, including rape victims • Procurement and distribution of vaccines; vitamin A; oral rehydration solution/zinc; medicines for deworming; antibiotics; and other essential medical supplies	• Will contribute to general health and increase livelihood opportunities for all • Will contribute to maternal, neonatal and child health and bring about the beneficial social impacts above • Will support the rehabilitation and reintegration of victims of gender-based violence
Improved diseases surveillance and outbreak response	• In line with the nationwide Integrated Disease Surveillance Response and Early Warning Alert and Response systems, partners will collect data from health facilities, participate in field investigations and activities to respond to outbreaks such as cholera, viral haemorrhage fever, malaria and so on	• Will reduce the spread of disease during outbreaks • Will contribute to general health and increase livelihood opportunities for all
Improved quality of healthcare services provided	• In-service training (with a focus on competency-based training) • Continuous staff coaching and quality improvement activities • Promotion of Infection prevention activities • Strengthened supportive supervision • Promotion of procedures for proper waste management and disposal of sharps and other waste.	• Better trained staff and better procedures will improve the quality of healthcare provided to the population, and thereby contribute to the positive social impacts outlined above

For an assessment of the project's potential impacts and mitigation measures, see the Social Development and Monitoring Plan below

6.2 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. The associated costs will be mainly covered by World Bank project funding in addition to UNICEF's own funding.

Table 4: Social Development and Monitoring Plan

Project activities	Potential impacts	Proposed mitigation measures	Responsible party	Monitoring indicator
Health service delivery via facilities or community outreach	• 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	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 8. Monitor IP compliance with UNICEF's policy and measures on PSEA	UNICEF UNICEF UNICEF and IPs UNICEF	• 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
		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	
	• Increase in medical waste in areas of operation • Poor hygiene, water and sanitation in health facilities negatively impacts safe delivery of health care services	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	UNICEF IPs UNICEF, IPs, CHD officials	• Number of health workers trained • Development of guidelines • Number of waste management plans • Number of programme monitoring visits • Tracking of corrective actions
	•IPs are not prepared nor equipped to respond to emergencies, including disease outbreaks	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	UNICEF (with WHO) UNICEF and IPs UNICEF	• Number of health workers trained in emergency preparedness and response • Availability of pre-positioned supplies
	• 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	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	UNICEF UNICEF, IPs, local health officials, 3rd party monitor IPs	• 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)

Project activities	Potential impacts	Proposed mitigation measures	Responsible party	Monitoring indicator
	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 .	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 standardized performance incentives of PHCC/PHCU workers 7. Provide on-time compensation to staff		• Standardised Package of Performance-based incentives available
	• 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	1. Involve key local stakeholders in Boma Health Team / Community Health Worker (BHT/CHW) selection and implementation processes to ensure buy-in, recognition, and acceptability from the community 2. Strengthen the ability of community health leaders and structures (particularly Boma Health Committees) to enable accountability, monitor community health initiatives and support CHWs 3. Adapt BCC messaging to address local myths and misconceptions and to encourage care seeking from CHWs 4. Ensure recruitment of female CHWs (minimum 30%) to reduce gender barriers to services	UNICEF and IPs	• Number of Community Health Workers (males/females) recruited and trained • Number and type of community engagement activities • Number of people reached
	• 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	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)	UNICEF and IPs	• 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
		5. Development & distribution of community data collection tools linked to the HMIS	UNICEF and MOH	
Procurement and distribution of pharmaceuticals and medical inputs	• 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	1. 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 2. Procure kitted drugs, pre-packaged at UNICEF supply headquarters in Copenhagen to reduce distribution time and risk of drug shortage at health facility level 3. Recruit IPs with capacity in logistics and supply chain management and stock reporting while ensuring that reporting tools are available 4. 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 5. Strengthen verification along the supply chain by requesting receipts of drugs from UNICEF to IPs as well as from IPs to Health Facilities 6. Monitoring of drugs will be included in all supervision visits and reports of staff and third-party monitors	UNICEF UNICEF and IPs	• 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
Targeting of health institutions by parties to the conflict / protection mechanisms / looting.	• Inequitable availability and access to service delivery in areas that are not highly vulnerable • Essential health services are disrupted	1. Strengthen community engagement and dialogue to reduce targeting of health institutions when conflict occurs 2. Coordination with UNMISS Force Protection in accessing conflict prone areas, permitting project implementation and monitoring by UNICEF and its partners 3. Utilise the goodwill of UNICEF with beneficiary communities to gain access and secure an enabling and secure environment	UNICEF and IPs	• Number of health facilities and communities supported • Number and type of community engagement activities • Number and type of incidents reported

Project activities	Potential impacts	Proposed mitigation measures	Responsible party	Monitoring indicator
		4. Minimal quantities of drugs stocked at CHDs, PHCCs and PHCUs to minimise loss through looting. Work with IPs to gauge and stock adequate quantities per period 5. Health kits and supplies are prepositioned nearby in secure locations for emergency response/replenishment 6. Circulate to partners the SOP for immediate reporting of loss and looting incidents		
Security of Project Personnel embedded in the communities	• Shortage of suitably qualified staff or presence of lowly skilled medical staff • Inequitable availability and access to service delivery in areas that are not highly vulnerable. • Essential health services are disrupted • Injury or loss of life of Project Personnel due to targeted or non-targeted security incidents	1. UNICEF will continue to work closely with UNMISS and OCHA to utilize their channels for lobbying for access in conflict areas to allow programmatic assessments and interventions, monitoring and vital distribution of life saving drugs by UNICEF and its partner' access. 2. Bolster security in hospitals, PHCCs, PHCUs through manned guarding of facilities, and securing of points of entry. UNICEF shall support partners with relevant financial resources to strengthen security at facilities. 3. Strengthen regular and ongoing community engagement and dialogue to reduce targeting of health institutions when conflict occurs 4. Strengthen support to IPs via the SSEMF, including financial support to strengthen security management capacity of the IPs. 5. Improve security related Significant Event reporting to enhance information sharing and ability to inform decisions around Project Personnel security and service provision.	UNICEF and IPs	• Number and type of incidents reported • Number and type of community engagement activities

7 PUBLIC CONSULTATIONS AND DISCLOSURE

During mid-August and September 2018, UNICEF's network of community mobilizers conducted a health facility mapping exercise as part of preparations for the new project in Jonglei and Upper Nile. The community mobilizers visited as many health facilities as they could (91 per cent of 323 health facilities) in order to verify the status of the health facilities and to consult with beneficiaries (community members living in the facility catchment areas) as well as frontline health care workers. The results of this mapping have been integrated into Section 4.6 above, and Section 7.1 below. The study also drew to a limited extent on previous consultations by the MOH in 2017 and early 2018.

7.1 Communication channels

Communication with communities, and women in particular, can be strengthened by knowing the different community structures in place in the catchment area that the health facility serves. Social mapping (see attachment) is regularly conducted by UNICEF's integrated community mobilisation network to help to establish this, in consultation with local partners. Then, UNICEF and partners will work with and empower the community leaders in these structures to foster two-way communication and community engagement. Community leaders and structures in South Sudan – such as women's groups, youth leaders, religious leaders and chiefs – play a key role. Once empowered these structures and community leaders are proactive with engaging their respective communities. So, at the onset of the project, with the support of health and communication for development colleagues, each partner will map and know the structures and communication channels in the communities that they serve. Special efforts will be made to engage women's groups, given gender dynamics in South Sudan, as women may be reluctant to discuss issues with men but prefer to raise and discuss issues and concerns with other women (their peers). In addition, when community health workers are identified, each NGO partner will be encouraged to identify women where feasible (with a view to obtaining at least a 30 per cent quota). In the SPLA-IO-controlled areas/former controller SPLA-IO areas, in addition, the humanitarian wing of the Government of South Sudan, known as the Relief and Rehabilitation Commission (RRC) will be engaged.

The UNICEF-supported integrated community mobilization network will be mobilized to assist with this process, given that they live in their communities and that most community engagement activities occur at the community level rather than at the health facilities. Moreover, in collaboration with other development and humanitarian partners working in South Sudan's health and protection sectors/clusters, many partners have programmes addressing GBV in South Sudan. In close collaboration with these actors and stakeholders, this project will significantly scale-up attention and efforts to improve access to services for victims of GBV. For example, the project will support the work of Gender and Social Inclusion experts at UNICEF to scale up training programmes for health professionals and expand the network of service providers offering GBV counselling and treatment services in Upper Nile and Jonglei.

Moreover, because of the high illiteracy rates, densely printed informational, educational and communications (IEC) materials have limited value with some communities. Messages will be therefore tailored according to the community, based on communication needs assessments – e.g. verbal notices will be done via community channels rather than through posters and other forms of written communication (e.g. megaphones). IEC materials, when used will be visually illustrative in nature.

7.2 Grievance redress and feedback mechanisms

The equivalent of a Grievance Redress Mechanism for UNICEF is "Accountability to affected populations" (AAP), which includes a complaints and feedback mechanism. To develop such a mechanism, local structures will be mapped and used to enable patients to voice grievances and complaints. 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 or email). These will be escalated to Juba as per UNICEF South Sudan standard operating procedures (2017/25 and 2018/21) and partner obligations outlined in the partnership and co-operation agreement legal framework. Furthermore, during field monitoring visits and spot checks conducted by third party institutions and UNICEF staff, community members will be routinely and systematically consulted in order to give them an opportunity to air their concerns. In addition to having pictorial posters and information empowering patient communication (including on how they can report their issues and concerns), health care workers will undergo regular capacity development on interpersonal communication (through listening, verification and feedback) as well as basic psychosocial support.

Currently, NGO partners tend to lack accountability mechanisms. Therefore, in line with UNICEF's global commitment to AAP and building on local structures, UNICEF South Sudan has established a grievance redress mechanism (GRM, typically known by UNICEF as a Complaints and Feedback Mechanism at central and project level to ensure that beneficiaries may communicate issues and concerns associated with the health care services they are being provided. This includes concerns regarding their security as well as Significant Events that may impact on their safety. The GRM has multiple access points (telephone, website, email and postal address – see below). This information will be posted by the IPs at all health facilities. This system will respect confidentiality, and female staff will be empowered in health facilities to enable female patients to share or confide about any issues or complaints that affect them. Community engagement and social accountability will also be fostered at the local level though 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, security 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.

In order to address feedback, complaints and grievances, 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. Guidelines and obligations to ensure accountability to affected populations will be integrated into partnership agreements with IPs. Capacity for AAP will also be built among selected partners, as a critical first step. Lead NGOs will also be encouraged to have dedicated staff to look at this specific area, as well as to consolidate information and follow-up.

UNICEF has its own mechanisms in place to deal with sensitive issues from the programme side. In 2016, the United Nations Special Coordinator on Sexual Exploitation and Abuse convened an inter-agency SEA working group at global level. 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 prevent and respond to sexual abuse at country level. A diagram of the process is reproduced below[4]:

[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 update of this document did not include a complete revision of content.

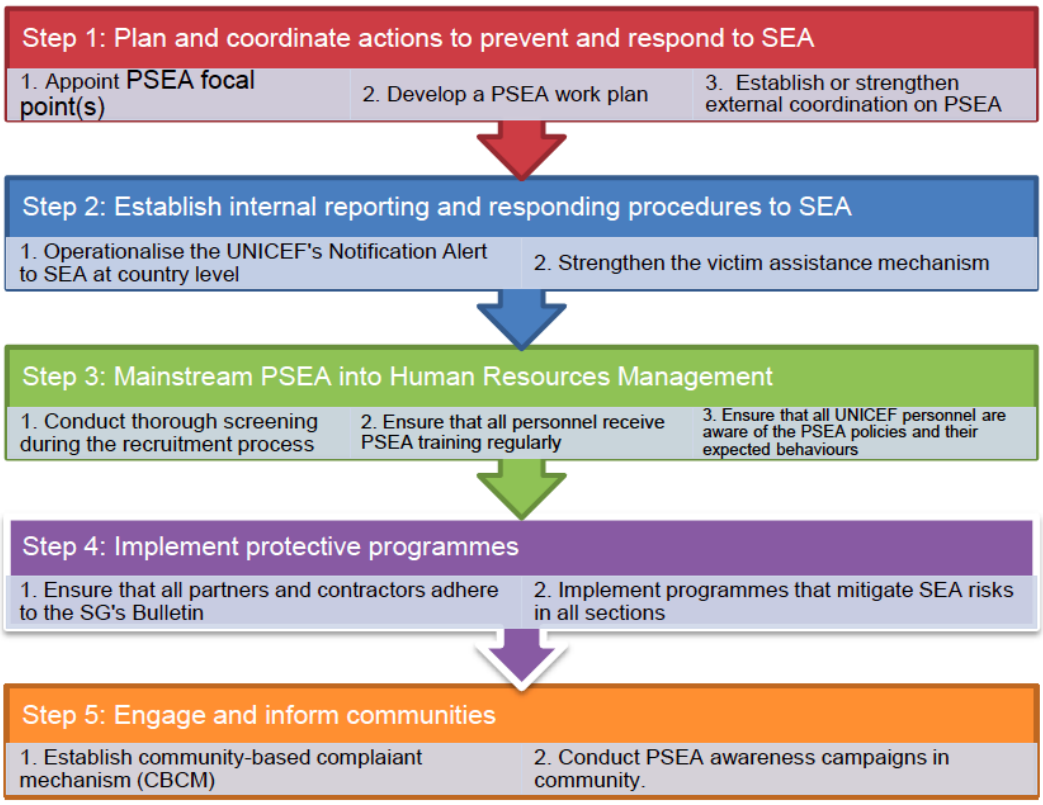

Figure 3: Five steps to respond to SEA at country level, UNICEF ESARO, August 2017

In line with the attached regional protocol and Country Office SOP, UNICEF South Sudan:

1. *Ensures that all UNICEF personnel in UNICEF South Sudan are aware of the PSEA policies and their expected behaviours*. Country offices must 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.
2. *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*. Most international NGOs and some local NGOs have appropriate policies and system in place for preventing and responding to SEA. However, not all national NGOs, CBOs, government partners and private companies have similar policies and system. Given the critical role that UNICEF's partners and contractors play in programme implementation, UNICEF must invest in building capacity of those partners that do not have adequate capacity on PSEA. UNICEF's standard Programme Cooperation Agreement (PCA) with civil society 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").
3. *Has developed and implemented a Country Office protocol that includes the following 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)
    e. Via email: SSD_PSEAinfo@unicef.org

4. This information will be posted by 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.

Please see the attached UNICEF East and Southern African Regional guidance and the UNICEF South Sudan Country Office protocol (2018/21) for more details.

8 CONCLUSIONS AND RECOMMENDATIONS

From the assessment, the region still faces a number of challenges that directly affects service delivery including health. The continuing conflicts, which are both ethnic and political, pose a threat to service as the resources meant for service delivery, are diverted to efforts to contain the conflicts. The ethnic clashes that are constant 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 gender-based violence in form of rape and battering. In the face of conflict, people continue moving from place to place and providing services is further constrained. In PoC camps services are overwhelmed by numbers. In host communities and places outside the camps, the infrastructure is dilapidated due to vandalism and lack of maintenance.

The study has analysed and concluded that the project activities will generate considerable social benefits to the communities in the project areas, though it may not meet all the health needs. 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. In this regard, it is possible to mitigate these negative impacts as long as the recommendations given in the Social Development and Monitoring Plan are implemented. This is in line with the efforts of the Government to improve on health care of the rural population.

This study finds that EHSP 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 potential negative impacts if adequate mitigation measures are not put in place include elite capture and other social ills. It is, therefore, necessary that the actions set out in this report be integrated into the project and for monitoring to be carried out to ensure compliance.

However, in order to realise maximum benefits community structures where there is reasonable stability should be strengthened especially the women groups to address issues of GBV and nutrition. Mechanisms should also be put in place for rapid response mechanisms in conflict prone areas in order to address emergencies. Infrastructure and resources also require serious consideration, but this will have to be carefully assessed and efficiently managed, including with the support of other stakeholders (e.g. GAVI) given the scarcity of resources. Without appropriate infrastructure such as cold chains, stores for medicines, hospital beds, wards, and human resource, service delivery becomes difficult.

In the context of the social vulnerabilities, the new project design is intended to deliver 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, especially for mobile or hard-to-reach populations with intermittent periods of stability and access. These frontline interventions will be supported in specific areas with the rolling out of community-based health services, such as the Boma Health Initiative (including integrated community case management), in order 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 ensure service continuity. Moreover, innovative new cold chain devices (such as the Arktek cold box) will be used to bolster last mile delivery of safe, potent vaccines at service delivery points. It will also be essential to make additional efforts to address the plight of women and child survivors and that life-saving services be extended 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 administration of clinical management of rape services, access and provision of confidential and sensitive health services to survivors of all forms of GBV. In summary, the three main strategies will be:

(a) Directly supporting service delivery: In close collaboration with the MOH, State Ministry of Health and county health officials, UNICEF will provide IPs (NGOs) with technical assistance, supplies and financial support, as part of overall capacity development to strengthen the delivery of basic health services to children and women, with priority given to the poorest and most marginalized communities. This will entail a mix of national and international NGOs identified through an open selection process.

(b) Enhanced routine outreach: Health teams attached to health facilities will be supported to expand coverage and access to health services in areas with intermittent periods of stability and access. This would provide a broader package of services in a more systematic manner to locations outside the catchment areas of the fixed/functional health facilities and within displaced populations, especially where there is a deficit of

health and nutrition services. These outreach services will be provided monthly where possible (at minimum every 2–3 months).

(c) Advancing community health: Targeting communities far away from existing health facilities, through the Boma Health Initiative, a network of trained CHWs will be responsible for delivering a standard package of community health services building on integrated community case management. Delivered at the household level, these services will also focus on health education and promotion of Child Health, Safe Motherhood, and basic Community Surveillance, along with community engagement and social mobilization (e.g. during campaigns when outreach services are available).

All activities described in this document will be implemented directly or with supervision by UNICEF; and UNICEF takes respective responsibility to ensure outcomes as outlined above, including for sub-contracted parties. The necessary resources will be provided by UNICEF either as part of the World Bank funded project costs or mobilised from other resources from UNICEF, subject to availability. As such, the measures are limited by scope. UNICEF will report regularly on performance, as well as eventual incidents in case necessary, and thus provide transparent information on the implementation of measures and related achievement of targets as noted in this Social Assessment.

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ANNEX 1: STAKEHOLDER ANALYSIS MATRIX (based on secondary data consulted)

Stakeholder	Interests	Effect of project	Importance of stakeholder	Degree of involvement in the project
Government				
Ministry of Health	Service delivery and governance		Critical player	Authorization, political support, mobilization and supervision
Government healthcare facilities	Providing services	Positive as it improves people's livelihoods	Critical player	
Relief and Rehabilitation Commission	Coordination of efforts of IPs/NGOs.	Positive as it supplements its efforts	Critical player	Government Arm of coordinating Development partners. Strengthened coordination can improve service delivery.
International organizations				
World Bank	Donor		Critical player	Supporting Rapid Result Health Project 2014-2018 in project area
UNICEF	Project implementer		Key actor	UNICEF is critical in Health, Nutrition, and WASH.
WHO	Partner			Providing emergency healthcare services and training around South Sudan, including water quality and malnutrition surveillance in target areas
IOM	Partner			Runs clinic at Malakal PoC
UNHCR	Partner			Supports healthcare projects among refugees and other persons of interest in Upper Nile project with IMC, DRC and Relief International
NGOs				
Save the Children		Positive as it improves people's lives	Critical player	Nutrition to children and mothers, WASH, Outreach.
Lutheran World Federation		Positive as it supplements its efforts.	Very Important	Has IPs and experience in former Jonglei state. It has church roots and also engages in agricultural production as it has a big membership
Oxfam		Positive as it supplements its efforts.	Critical player	Global experience
ACTED				Small-scale health projects with refugees in Upper Nile

MSF				Providing decentralized medical outreach services to some of the most isolated places in the region from its main hospitals in the state
Interchurch Medical Assistance (IMA)	Possible IP	Positive as it improves people's livelihoods	Critical player	Subcontracts NGO partners as lead agencies in 5 counties, which support County Health Departments and all PHCCs and PHCUs in that county. IMA provides additional support to an NGO to support the county hospital in Duk. The remaining counties are served in partnership with CHDs.
NHDF (Uror Akobo), CMA(Nyirol Fangak),SMC (Bor Duk (later reassigned to CHD), JDF(Duk CH) and IMC (Akobo CH)		Positive as it improves people's livelihoods	Critical player	IPs
Health Link South Susan	Possible IP	Positive as it improves people's health	Critical player	Provision of health services, like routine consultations, treatment of general cases, maternity services, vaccinations to IDPs in Bor Camp and other areas.
Community level actors				
Women and youth groups.	Involved in selection criteria, mobilization of communities, carrying out reaches and sensitization of mothers on sanitation	Positive as such groups make the project more known and appreciated by communities. Have been trusted by people and can help the project to achieve its PDO	Critical player	Community support to the project, positive impact to the vulnerable group, which eliminates elite capture.
Community Nutrition Volunteers	Under UNICEF	Members of the community playing vital role in awareness and sensitization on nutrition mostly to mothers about children	Critical player	Community support and involvement to the project, creates awareness.

Community drug distributors	Community health through drug distribution.	Bring medicine close to people and enable the project to help the most vulnerable members of the community	Critical player	Community support and involvement to the project, creates awareness. Trained in assessing signs and symptoms of malaria and high fever and provided with basic equipment and patient registers
Internally displaced persons outside POCs	Beneficiaries	Crucial for meeting needs (as long as they can access primary healthcare services)	Beneficiary	Beneficiary
Internally displaced persons inside POCs	Beneficiaries (though also receiving healthcare from POC clinics outside the RRHP)	Beneficial as strengthening general healthcare in project areas	Partial beneficiary	Partial beneficiary
Persons with disabilities and elderly persons	Beneficiaries, generally requiring additional levels of healthcare support	Crucial for meeting needs (as long as they can access primary healthcare services)	Beneficiary	Beneficiary