



# Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

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Concept Stage | Date Prepared/Updated: 21-Nov-2018 | Report No: PIDISDSC25513



**BASIC INFORMATION**

**A. Basic Project Data**

Country South Sudan	Project ID P168926	Parent Project ID (if any)	Project Name Protection of Essential Health Services Project (P168926)
Region AFRICA	Estimated Appraisal Date Dec 05, 2018	Estimated Board Date Jan 29, 2019	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) International Committee of the Red Cross, UNICEF	Implementing Agency International Committee of the Red Cross, UNICEF	

**Proposed Development Objective(s)**

The Project Development Objective is to increase the utilization and quality of an essential package of health services in the Republic of South Sudan, with a particular focus on the former states of Upper Nile and Jonglei

**PROJECT FINANCING DATA (US\$, Millions)**

**SUMMARY**

<b>Total Project Cost</b>	74.50
<b>Total Financing</b>	74.50
<b>of which IBRD/IDA</b>	105.40
<b>Financing Gap</b>	0.00

**DETAILS**

**World Bank Group Financing**

International Development Association (IDA)	105.40
IDA Grant	105.40

Environmental Assessment Category

B - Partial Assessment

Concept Review Decision

Track II-The review did authorize the preparation to continue



Other Decision (as needed)

## B. Introduction and Context

### Country Context

- 1. Long before independence, South Sudan (known as the Southern Sudan region) has experienced significant levels of fragility, conflict and violence.** This is not only with the North, with which the conflict has been ongoing for half a century, but also significant inter- and intra-communal, ethnic based and intra liberation movement has been ongoing for over a generation. The secession from the North came after decades of fighting, followed by a brief period of the Comprehensive Peace Agreement (CPA), 2005-2011) with the final decision being made through a referendum. South Sudan descended into this latest manifestation of violence two years after it gained the independence it had fought for half a decade. Basically, the country has been through two generations without much investment in development.
- 2. At independence 2011, South Sudan was one of the most fragile countries in the world.** In late 2013, the political settlement brokered within the ruling Sudan People's Liberation Movement (SPLM) fell apart. An armed conflict ensued, primarily between the SPLA Government forces and Sudan's People's Liberation Army In Opposition (SPLM and SPLA-IO). There was a period of optimism brought about by the signing of the Agreement on the Resolution of the Conflict in the Republic of South Sudan in August 2015. However, open conflict escalated in July 2016 in Juba and rapidly spread throughout the country. The renewed conflicts after December 2013 through July 2016 have undermined the development investments and gains achieved since the CPA and independence and worsened the humanitarian situation. The Revitalized Peace Agreement, signed in September 2018, provides an opportunity for potential progress, yet the effects of the protracted conflict are still affecting the majority of the country's population.
- 3. Despite its endowments in oil, agriculture and other natural resources, South Sudan's economy is collapsing mostly due to economic mismanagement, the war, corruption and rent-seeking behavior.** South Sudan has one of the least diversified economies in the world, a result of being extremely oil dependent. The large drop in oil prices (2014) together with lowered oil production due to insecurity significantly reduced fiscal revenues, at the same time increased military expenditures have deprived South Sudan of foreign exchange. As a result of the large drop, the economy was estimated to have contracted by about 11 percent in FY16 and further contracted by about 6.9 percent in FY17, and fiscal deficit was estimated at about 14 percent of gross domestic product (GDP) in FY17. This has contributed to a large-scale depreciation of the domestic currency from 3 SSP per USD in December 2015 to more than 200 SSP per USD today. With less foreign exchange available to purchase goods and services from outside, imports including imports of food reduced considerably contributing to increased domestic prices. The annual Consumer Price Index (CPI) increased by 203 percent from February 2015 to 2016 and another 426 percent to February 2017. An acute example of this collapse is the fact that civil service salaries have not been paid for over half a year.
- 4. The majority of South Sudanese population has lived in poverty for generations, currently more than half of South Sudan's population live below the poverty line.** In 2016, it was estimated that 66 percent of the population lived



below the poverty line (\$1.90 per day). This is a considerable increase in poverty from an already high level of 52 percent in 2009. Poverty incidence varies across states, with the highest rate of 81 percent in Eastern Equatoria and the lowest rate of 40 percent in Central Equatoria. Poverty in urban areas of South Sudan increased from 49 percent in 2015 to 70 percent in 2016. Inequality amongst the poor also worsened, and the poverty severity index doubled from 0.10 in 2015 to 0.20 in 2016. Poverty manifests in all dimensions, lack of access to clean water, access to health and education and a non-existent safety net to cushion the most vulnerable.

**5. Estimates of the effects of the conflict range significantly across studies but remain systematically high.**

According to the Uppsala Conflict Database Program violence and conflict has claimed 4,289 lives between independence (2011) and 2016<sup>1</sup>, while a recent study by the London School of Hygiene and Tropical Medicine estimates that nearly 400,000 lives have been lost since 2013 due to the conflict<sup>2</sup>. In addition, the deepening economic crisis is exacerbating humanitarian needs nationwide. The open conflict, coupled with economic mismanagement and failed state-building efforts have caused an erosion of the already limited physical and social infrastructure. Of the country's 12.5 million people, there are an estimated seven and a half million people in need of humanitarian assistance, six million of whom are severely food insecure. As much as 85 percent of the working population is engaged in non-wage work, chiefly in subsistence agriculture and livestock rearing (about 78 percent of the working population). that are severely undermined by conflict and drought. 51 percent of the population is under 18 years of age and more than 50 percent of the population between the ages of 15 and 24 are unemployed. Given there are limited opportunities for young people outside war, a significant proportion of young men are recruited into the various armed factions. Ongoing fighting and surges of violence in new areas have forced more than 4 million people to flee their homes. As of September 2017, refugees and asylum seekers reached up to 2 million, with nearly 85 percent estimated to be children and women. Of these people, one million have fled to Uganda alone. The number of internally displaced people (IDP) is estimated to 1.9 million, most of these people are from Jonglei and Upper Nile. Working conditions for aid workers are getting worse, resulting in less access, less information and less aid reaching them.

**6. When it comes to accessing basic services, the South Sudanese population faces the most acute barriers.**

Whether it be ever-evolving allegiances and battle lines in a complicated conflict, geographic accessibility including long distances, seasonal shifts in delivery challenges, or an overall lack of basic infrastructure, the situation in South Sudan is dire, prompting a large humanitarian effort that provides a lifeline for most basic needs. Most of health and education services are provided through or by NGOs, many of which have been operating in the Southern Sudan region for decades before independence and remain in country.

**7. Working conditions and safety of aid workers is a growing concern, with South Sudan being called the most dangerous place in the world for aid workers for several years in a row<sup>3</sup>.**

The statistics on aid workers in South Sudan are extremely bleak: in the past few years, dozens of aid workers have been kidnapped, and a substantial amount of health facilities and schools have been destroyed. There is a concern that the situation is worsening as aid workers become targets for looting and extortion of food, fuel, for example.

**8. Women are highly disadvantaged, with much lower levels of education and more limited access to economic/productive activities.** Women and girls face a disproportionate burden of violence. The roles and responsibilities of South

<sup>1</sup> Uppsala Conflict Database Program, [www.ucdp.uu.se](http://www.ucdp.uu.se), accessed May 14, 2018. It should be noted that the number of conflict-related deaths for Afghanistan, a country implementing a similar health sector program, has witnessed 70,718 deaths during the same period.

<sup>2</sup> Checchi, F, et al. September 2018. "Estimates of crisis-attributable mortality in South Sudan, December 2013-April 2018. London School of Hygiene and Tropical Medicine.

<sup>3</sup>Voice of America, "South Sudan - The Most Dangerous Country for Aid Workers", September 11, 2017



Sudanese women have evolved throughout periods of conflict and peace, though insecurity has left many households headed by women, undermining their safety and overall well-being. The normalization of sexual violence as a weapon against women is made worse by the stigma associated with it that prevents survivors from seeking health and legal services. Similarly, entrenched patriarchal norms perpetuate acceptance and perpetration of intimate partner violence, as well as other harmful practices such as Female Genital Mutilation.

9. **There is a very high incidence of sexual and gender-based violence (SGBV) in South Sudan and widespread impunity for SGBV offenses.** Conflict-Related Sexual Violence (CRSV) remains a common tool used by all sides in the conflict, impacting not only women targeted by the violence, but also households and entire communities where these women reside. The UN Independent Commission on Human Rights in South Sudan has referred to “epic proportions” of sexual violence in the conflict<sup>4</sup>. It is impossible to get national level estimates due to chronic underreporting, but it is accepted that SGBV rates are very high. A large number of women report cases of rape, sexual assault, domestic violence, forced and early marriage, sexual exploitation and abuse. SGBV affects mostly women, and girls (representing of 98 percent of known victims) but also men and boys<sup>5</sup>. As a weapon, SGBV destroys family and community cohesion and undermines processes of reintegration and rehabilitation, impoverishing women and their families. The high prevalence of SGBV in the country heightens the risk of HIV for survivors. Access to health and counselling services for victims of rape and other forms of gender-based violence are extremely limited.

10. **In recent months, peace talks facilitated by the governments of Sudan and Uganda have led to a draft peace and power-sharing agreement that was signed in August 2018.** The agreement proposes a reorganization of the government with three vice-presidents and a carving out of new states across the country. Currently the progress made through the talks has produced some level of optimism in the country, and weapon-wounded casualties have seen a decline since the cease-fire was achieved. Yet the international community remains highly concerned by past failed attempts at ending violence and fighting, and despite the recent progress made in the peace agreement, funding for development assistance continues to decline in favor of programs more linked to emergency and humanitarian assistance.

11. **While peace talks through various avenues continue, there are concerns on the increasingly challenging conditions for delivery of assistance to those most in need, as large areas under opposition remain inaccessible apart from a few actors.** The cost of delivering assistance, providing security for staff and safeguarding the beneficiaries (and non-beneficiaries) of assistance remains high, particularly in areas affected by conflict or in control by the opposition forces such as the SPLA-IO. There is however an understanding that despite the significantly higher costs of providing basic assistance to the most vulnerable in these areas, it remains essential to ensure that critical assistance is provided to meet health needs for women and children who bear the brunt of the effects of the conflict.

#### Sectoral and Institutional Context

12. **South Sudan has some of the worst health outcomes globally.** Child mortality and morbidity rates are high: under-five mortality is 91 per 1,000 live births while neonatal mortality is 39; child malnutrition is severe, with underweight prevalence at 23 percent of children (UNICEF, 2016). Maternal mortality is among the highest in the world, estimated at 789 per 100,000 births. Endemic diseases pose a heavy burden, particularly malaria, which accounts for 20–40 percent of all health facility visits. The health care system is extremely stretched: only about 40 percent of the population can access

<sup>4</sup> UN independent Commission on Human Rights in South Sudan, December 2016.

<http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20979&LangID=E>, March 2017

<sup>5</sup> GBV Sub-Cluster Strategy South Sudan 2017

[https://reliefweb.int/sites/reliefweb.int/files/resources/gbv\\_sub-cluster\\_strategy\\_final\\_1.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/gbv_sub-cluster_strategy_final_1.pdf)



health care within a 5-km radius. The health and nutrition needs of the South Sudan population are profound (see Table 1 for key indicators). Life expectancy at birth is low (56 years for both men and women)<sup>6</sup>.

Table 1: Key health outcomes in South Sudan

Indicator	South Sudan	East/Southern Africa (2010-2015)
Maternal Mortality Ratio per 100,000 live births	789	417
U5 mortality Rate per 1,000 live births	91	67
Contraceptive prevalence rate	4 percent	40 percent
Percent (%) of children under 5 wasted	23 percent	6 percent
Immunization coverage of DTP3	26 percent	80 percent
Mothers receiving at least 4 antenatal care visits	17 percent	45 percent
Percentage (%) of births attended by a trained health professional	19 percent	49 percent

Source: UNICEF,2016. State of the World’s Children

13. **South Sudan is one of the most dangerous places to give birth; the maternal mortality rate has remained exceptionally high across South Sudan with an estimated 789 women dying for every 100,000 births<sup>7</sup>.** Approximately 86 percent of deliveries happen in the home. The Caesarean section rate is very low at 1 percent giving an indication of limited access to comprehensive emergency obstetric and neonatal care (CEmONC) which is currently only available in three urban centers. Women have on average 5 children, a direct result of only 4 percent using modern contraceptive methods (UNICEF, 2016). Early marriage and early first pregnancy are both common risk factors in the S Sudan context. In addition, there is a lack of trained traditional birth attendances, who if trained and deployed in communities, could be an important actor to reduce geographic barriers during the rainy season as well as the general long distances to health facilities.

14. **The survival outcomes of children in South Sudan are some of the most abysmal in the world. Neonatal, infant mortality and under five deaths rates are very high.** 39 babies in every 1000 die in the first 28 days of life with the main causes being low birth weight and premature birth, injuries sustained during birth and infections. Close to 10 percent of children die before the age of 5, mostly from preventable conditions such as diarrhea, pneumonia and measles (UNICEF, 2016). This is in part due to extremely low immunization coverage and high mortality linked to infectious diseases. Malaria is endemic across South Sudan and nearly half (44 percent) of all children who seek medical attention will have malaria and many more will be infected but have minor symptoms<sup>8</sup>. Lack of access to essential maternal and child care, such as prenatal care, skilled delivery and post-natal care and immunization are significant, with some of the lowest results in terms of population coverage in the world.

15. **Coupled with the conflict, the country is constantly battling disease outbreaks.** There has been a dramatic increase in the scale and frequency of outbreaks of epidemic prone diseases, due to poor sanitation, lack of access to safe water and crowded living conditions. Preventable and curable diseases, such as malaria and acute watery diarrhea became major causes of death in the country. This has especially affected displacement sites where malnutrition and poor

<sup>6</sup> UNICEF, State of the World’s Children 2016 (2016). Available at <https://www.unicef.org/sowc2016/>

<sup>7 7</sup> UNICEF, Monitoring the Situation of Children and Women,2017 (2017)

<sup>8</sup> Government of the Republic of South Sudan, Ministry of Health, 4th Annual HMIS Report (2015).



immunity makes young children and pregnant women particularly vulnerable. Since 2011, South Sudan has experienced some of the longest and deadliest cholera outbreaks recorded in the country. Between June 18, 2016, and June 25, 2017, more than 17,242 cholera cases were reported including at least 320 deaths, with a case fatality rate of 1.8 per cent, exceeding the UN World Health Organization (WHO) emergency threshold of 1 percent<sup>9</sup>.

16. **Disease surveillance systems are extremely weak, leaving the population at high risk for outbreaks, epidemics and even cross-border pandemics.** With the recent Ebola outbreaks in the Democratic Republic of the Congo, which shares a long and porous border with South Sudan, there are even greater concerns that South Sudan's health system will not be able to respond accordingly to prevent transmission in to the country and potentially a widespread outbreak. Funding to support South Sudan's Ebola Preparedness Plan remains insufficient, with as of end of August 2018 less than US\$400,000 being mobilized out of the \$US4 million needed to fully finance the plan.

17. **Acute malnutrition remains a major public health emergency in South Sudan.** As of July 2017, 6 million were estimated to be severely food insecure (UNOCHA, 2017). The magnitude of this is unprecedented with malnutrition a contributing factor in nearly 1 in 2 (45 percent) of all child deaths, (UNICEF, 2017)<sup>10</sup>. Given the worsening conflict, displacement and food insecurity since then, these figures are considered to be a gross under-estimate of the current situation.

18. **The overall response to SGBV remains inadequate in reach, quantity and quality.** The availability of trained medical personnel to handle CMR (clinical management of rape) and basic psycho-social support continue to be insufficient, with almost no health professionals being trained in appropriate counseling and psycho-social support throughout the country. Specialized mental health expertise is almost entirely absent from the context, with currently only one South Sudanese psychiatrist working in the entire country. Some organizations have integrated Mental Health and Psycho-Social Support (MHPSS) into the package of services they support but remain at small-scale, high cost and mostly provided by international staff, limiting their ability to be expanded to meet the needs of the population.

19. **The Public Expenditure Review for South Sudan's health sector, conducted in 2016, shows that public financing for health has been a low priority for the government and continues to decline with time<sup>11</sup>.** Since the Comprehensive Peace Agreement, the share of health in overall government expenditure has been decreasing from 3.8 percent in 2006 to 2 percent in 2015. The commonly cited government expenditure figure of 4 percent is based on the approved budget, not on actual expenditure. Social budget allocations remain low while aid as a percentage of the government budget has risen significantly over the last few years. Health has consistently been a low priority in terms of government budget allocation and expenditure, being among the three sectors receiving the lowest resources since 2007.

20. **Since the CPA (2005), the share of health in overall government expenditure has been decreasing from 3.8 percent in 2006 to 2 percent in 2015.** The commonly cited government expenditure figure of 4 percent is based on the approved budget, not on actual expenditure. This low level of expenditure is the result of prioritizing the security sector (47 percent of total expenditure) over human development needs. While the conflict and political instability continues, the government feels that the high security expenditures are justified. On the other hand, the role that humanitarian and development actors play in financing and delivering health services also allows the government to prioritize other sectors when allocating public resources.

<sup>9</sup> UNOCHA, South Sudan Humanitarian Bulletin, June 2017

<sup>10</sup> UNICEF, Monitoring the Situation of Children and Women, 2017 (2017). Available at <http://data.unicef.org/topic/nutrition/malnutrition/>

<sup>11</sup> World Bank, South Sudan Health Expenditure Review, May 2016.



21. **Households' out-of-pocket expenditure on health is likely to exceed government expenditure, potentially reaching as high as 79 percent of total health expenditure.** Robust data on household health-related expenditure is unavailable, but estimates suggest that the amounts are quite high, especially in urban areas. While 77.6 percent of South Sudan's population live with less than US\$3.1 a day<sup>12</sup>, high out-of-pocket health expenditures is a significant constraint for healthcare access. It also reinforces inequities across socioeconomic groups, increases household vulnerability to catastrophic expenditure, and undermines the principles of universal health coverage.

22. **Service delivery for a fragile, conflict and violence affected state like South Sudan remains a huge challenge.** Several states are in active conflict, or with periodic flare-ups of conflict, have health systems that are doubly burdened, by acute surges in trauma and injuries and by supply disruptions. In such settings, vulnerable groups, especially those targeted due to tensions between ethnicities, and others who may already be disadvantaged, often end up being disproportionately excluded from receiving services. In addition, significant disadvantages arise due to political affiliations, which change often and in unpredictable ways, as allegiances shift between warring sides.

23. **Provision of the most basic services has largely been provided by non-state actors since well before independence and continues as such today<sup>13</sup>.** The establishment of a national health system started at Comprehensive Peace Agreement in 2005, and never really picked up pace. Whatever efforts made between 2005 and 2013 were decimated by the resumption of violence. The country had extremely low ratios of qualified health workers to population at independence, with services mostly provided by humanitarian and other non-state actors. This continues to be the case, mostly due to ongoing conflict but also limited capacity to begin with. There is a severe shortage of skilled human resources to respond to frontline health needs. It is estimated that there is only one doctor per 65,000 patients and one obstetrician/gynecologist per 200,000 people. There are no pediatricians in South Sudan (WHO, 2016). There are some positive trends, with the number of midwives has increased significantly since 2010, from only 8 in 2011 to over 600 trained with essential professional midwifery competencies (UNFPA, 2018).

24. **High levels of insecurity have dramatically reduced the capacity of the health care system to deliver services.** Health facilities have been attacked, damaged and looted. As reported by WHO, over 50 percent of the health facilities are non-functional. In Unity, there is only one county hospital for more than one million people (WHO 2017). Basic services such as vaccination, malnutrition screening and antenatal care have been interrupted, while surgery and referral services are limited or non-existent.

25. **There remain significant concerns with regards to the safety of service providers, and in many areas of the country aid organizations need to negotiate with arms bearers to get access to at-risk populations.** Oftentimes emergency operations need to be organized during short-term lulls in fighting, with all inputs for service delivery (health professionals, essential commodities, etc.) being flown in by air and wounded patients evacuated to a safer location by helicopter or plane.

26. **Among the approximately 1,500 health facilities in South Sudan, over 50 percent need significant investments to be able to deliver a basic package of health services.** Approximately 376 (26 percent) are in good condition, 347 (23 percent) require minor renovation, 274 (18 percent) require major renovation and 490 (33 percent) need complete replacement<sup>14</sup>. Almost all facilities lack medical equipment, transport and communication, water and power supplies. The government currently does not have the capacity or resources to deliver health services independently, and almost all

<sup>12</sup> World Bank 2016, "Macroeconomic and Poverty Outlook – South Sudan, n. 275, April 2016

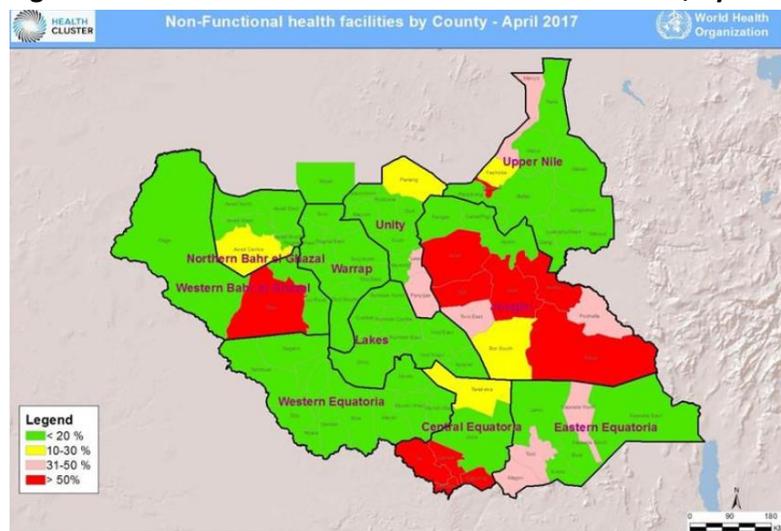
<sup>13</sup> The WHO estimates that around 80 percent of health services are delivered by NGOs. WHO, 2014. Cooperation Strategy 2014-2019: South Sudan. WHO Regional Office for Africa.

<sup>14</sup> South Sudan Health Sector Development Plan, 2016-2020.



health facilities are supported by NGOs. The former states of Jonglei and Upper Nile have the highest percentage of non-functional facilities in the country (Figure 1).

Figure 1: Non-functional health facilities in South Sudan, by county



Source: WHO, Health Cluster Bulletin, April 2017

27. **The delivery of essential health services remains highly limited.** Only 3.7 percent of the 1332 reporting facilities provide the full-service package as per the MOH Basic Package of Health and Nutrition Services (BPHNS)<sup>15</sup>. Furthermore, 52.4 percent of reporting facilities were providing half the required services. For example, OTP (outpatient therapeutic programs) and TSFP (targeted supplementary feeding program) for nutrition are currently at 35.5 percent and 43.5 percent, respectively.

### ***Development partners and the World Bank's engagement in South Sudan's health sector***

28. **The Bank has been engaged and supporting the health sector before South Sudan became independent.** Under the Multi-Donor Trust Fund for South Sudan, several operations were processed to support the development of the country's health sector. This include the HIV/AIDS project, the MDTR Umbrella health program phase 1& 2, as well as the first financing of the HRRP. The ICR rating of the HIV/AIDS project was Unsatisfactory, deemed to be due to the ambitious nature of the programs, which did not take into context the complex nature of the operating environment. The first Additional Financing (AF) of the HRRP was the first IDA-supported operation in the Bank's South Sudan portfolio. The health portfolio has since grown to include a second (AF) and the new operation proposed here. The Bank together with other partners were among the first to provide system building support and contributed to the setup of the first Ministry of Health in Southern Sudan, defining its structures and the development of the health strategies.

29. **The proposed project takes on board over a decade of Bank experience in working in the health sector in South Sudan, supporting two of the most conflict prone states in the country.** The Bank has been part of donor coordinated efforts to provide basic health services in South Sudan since the time of the CPA. Therefore, in addition to lessons from the health sector, the project also draws on lessons from the portfolio, including the Social Safety Nets (which includes cash payments to beneficiaries despite the challenging environment). The project also takes on board experience from

<sup>15</sup> WHO, Health Service Functionality Bulletin, April 2018.



other FCV contexts, and the key recommendations of the 2011 World Development Report on Fragility, Conflict and Violence which emphasized the need to strengthen legitimate institutions to reduce the fragility of countries facing protracted cycles of violence and moving from violence to resilience in order to realize development goals. The technical risks involved in operating in this context are familiar to the Bank and others that have supported the sector for generations.

30. **In addition, there are key risks that require careful and measured approaches.** These include: Escalating violence limiting access to opposing sides; inability to target across warring sides; safeguarding against abuses; attacks on and displacement of civilians visiting facilities; looting of commodities and destruction of facilities; lack of local information on power dynamics in a particular area and how it affects access; lack of information on who is who leading to contractual relationships with beneficiaries of project proceeds that are questionable, and potentially linked to government forces; direction of war; governance; and corruption. These risks, mitigation measures, and lessons from the portfolio, dialogue with partners provide clear red lines as discussed under the Risks section.

31. **Delivery of essential health services, whether they be for conflict-affected populations or the general population, is almost completely provided by the Health Pooled Fund and the World Bank.** This is part of the agreement reached in 2012, to ensure distribution of support to providing health services across the country. The main donor-funded programs support health service delivery in the 10 former states: The Health Pooled Fund (HPF)<sup>16</sup>, managed by DFID and currently under preparation to start HPF3 in early 2019, covers Central, Western and Eastern Equatoria, Lakes, Warrap, Unity, Western Bahr-el-Ghazal, and Northern-Bahr-el-Ghazal, while the World Bank supports Jonglei and Upper Nile States through the Health Rapid Results Project (HRRP, P127187). Critical functions of the health system depend on these programs, including the recruitment and training of health care workers, payment of salaries, procurement and distribution of pharmaceuticals, and monitoring and evaluation (M&E).

32. **Since the launching of HRRP in 2013 the Bank has been supporting the former states of Jonglei and Upper Nile, which are amongst the most affected by the conflict, population dislocation, and economic conditions.** The delivery of health services to both these states has been almost entirely financed by the World Bank since the launch of HRRP. While the project was designed to support services in a period of conflict (mostly intra and inter communal fights, as well as a number of smaller rebel movements), the design was not necessarily tailored for the more acute levels of violence that have affected the two former states for the past few years.

33. **The HRRP was designed to address critical health care needs and constraints in two of the most challenging states in South Sudan.** Not only are these historically the most conflict-affected states (proximity to border with the North), they also received little investment in infrastructure because of the challenging swampy terrain and seasonal heavy rains, and as such are also the most difficult to access physically. After two additional financings (AF) and several restructurings, the project is expected to close on March 31, 2019.

34. **Given the challenges the Bank has in providing direct implementation support and supervising activities in these two states, various third-party monitoring and verification measures have been put in place to ensure the results reported have been achieved.** Even during times of relative peace, travel to the most remote areas of South Sudan was a challenge. Rains made large swathes of land inaccessible for 6 months of the year, dirt landing strips turned to mud paths and navigation over the Nile require use of hired boats and dry season were probably the most violent months. In such circumstances, third party monitoring and verification was built into the design of the ongoing operation, payment to the CSDO - IMA World Health depended in part to the verification of results from the third-party verification agency (the

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<sup>16</sup> The HPF is a multi-donor trust funding managed by DFID and received financial support from the Governments of the UK, US, Canada, Sweden and the European Commission.



London School of Tropical Medicine).

35. **Despite providing essential support to ensure an essential package of services was continued to be provided in the states of Upper Nile and Jonglei, HRRP has had mixed success and provides several key lessons that have been factored in to the proposed project's design.** Although the CSDO model was designed before the December 2013 crisis to respond to the context of endemic violence, limited access and infrastructure, and population mobility, the upsurge in violence has led to an increased need for emergency health services in a context where insecurity and instability have generated additional challenges in providing support. On the one hand it has been successful in delivering basic health care inputs to many citizens of Jonglei and Upper Nile, but on the other hand the on-going conflict has resulted in the destruction of facilities, displacement of qualified health workers, and shortages of essential drugs and commodities and, as a result project gains have been rolled back and the ability of the project to deliver all anticipated benefits has been significantly curtailed.

36. **The project's implementation modalities were not always as flexible or responsive as needed to the ever-evolving security situation, and as such did not always immediately respond to the target population's changing health needs.** Yet despite these weaknesses, HRRP has remained the primary source of support for health service delivery in Upper Nile and Jonglei for the past six years. It's important to note that as violence and instability increased, project targets were adjusted downward to reflect the realities of providing support to the health sector in Upper Nile and Jonglei. Despite the evolving ambitions and implementation realities when HRRP closes there will effectively be no other large-scale donor financing providing health services in the former states of Jonglei and Upper Nile.

37. **Another significant challenge the project faced was the limited capacity of the Ministry of Health to proactively and properly manage large contracts, including both the CSDO contract and the third-party monitoring (TPM) contract.** The weaknesses are significant: (i) continual payment delays to the CSDOs and its implementing partners due to the MOH providing incomplete documentation and justification for payment; (ii) ineligible expenditures that continue to increase over time; (iii) insufficient oversight by the MOH on the performance of the CSDO and lack of clarity on the extent to which services are supported in conflict-affected and opposition held areas, leading to lack of confidence in data and reporting coming from the field; (iv) passive contract management leading to numerous contract extensions urgently done at the last second, etc.

38. **The environment in which the project is being implemented has significantly deteriorated over the past year.** While the HRRP has surely contributed positively to providing health services in the two states, results from the project show that coverage remains ineffective due to various reasons: (i) upsurge in instability and violence not allowing the CSDO to provide services in multiple localities; (ii) inability to monitor and verify results in the majority of the two states (verification and monitoring teams are often not allowed into opposition-held territory or cannot go there due to the insecurity); (iii) perceived (and probable) non-neutrality in service delivery support across areas held by the government and opposition forces; (iv) ineffective implementation and coordination between the CSDO and its implementation partners (national and international NGOs) leading to a wide variety in quality and comprehensiveness of support; and (v) limited oversight and ability of the government to provide satisfactory justification/evidence of supplies, drugs and services arriving at their intended destination; etc. Reports from the field point to extremely low levels of effective coverage under implementation arrangements. Furthermore, the Bank task team has not been allowed to visit any project sites due to insecurity.

39. **Despite the challenging environment, the results from the HRRP are significant.** As per the project's Results Framework, pulling from data reported from the MOH through the CSDO's quarterly reports, shows that as of June 2018 the project has contributed to over 107,000 children being fully vaccinated (DTP3) in their first twelve months, 180,000



pregnant women receiving antenatal care services, tripled the rate for outpatient visits per capita per year (from 0.1 contacts per year to 0.35), 524,000 children receiving Vitamin A doses, 161,000 children under five years of age receiving measles vaccinations, 16,000 birth deliveries attended by skilled personnel, and purchased and distributed over 2.5 million long-lasting insecticide treated bednets.

40. **In order to avoid a gap in service delivery for the approximately 3 million people residing in Upper Nile and Jonglei, in July 2018 the MOH transitioned from the international NGO whose contract ended in June 2018 to a short-term contract with UNICEF to step in to the role of CSDO.** Through a project restructuring processed in July 2018, an additional US\$4.5 million was allocated to Component 1 to allow for an additional three months of support to the provision of health services to approximately 220 health facilities in the two former states. UNICEF rapidly stepped in to the role of CSDO, quickly subcontracting the 17 implementation partners (mostly previously engaged by the prior CSDO), resulting in only minor disruptions in service delivery in Upper Nile and Jonglei. Current resources available in HRRP will only allow for UNICEF to continue through October 2018, creating a situation where the two former states face another risk of having essential health services interrupted. Given that the Bank has committed to continuing to support these two former states through the new operation, there is an urgent need to process the new operation as quickly as possible.

41. **In addition, in recent months it has become clear that the CSDO model has not been able to support health services to the extent necessary in inaccessible areas affected by conflict or held by the opposition.** UNICEF has also acknowledged that there are certain parts of Upper Nile and Jonglei that remain inaccessible to them. As such, an alternative approach to supporting these zones must be adopted if the Bank aims to support the entirety of the two states and not just areas that are more accessible. Only a few actors are able to reach these areas, and even fewer that can implement within the specific circumstances found there. Given their unique approach to service delivery, their mandate of neutrality and focusing on populations that no one else can reach due to violence and conflict, the Bank identified the International Committee of the Red Cross (ICRC) as the only organization that has the capability to meet the project's goals and willing to take on the mission.

42. **Within the context of a broader effort between World Bank and ICRC to collaborate in fragile state and conflict-affected settings, the Bank and ICRC health teams in South Sudan have engaged to identify new ways to improve effective support to harder-to-reach communities of Upper Nile and Jonglei states, given the challenges that arose in achieving this under the ongoing Health Rapid Results Project.** In May 2018 the CEO of the World Bank Group and the President of the ICRC signed a Memorandum of Understanding to promote cooperation between the World Bank and the ICRC. The MoU identifies three broad themes for cooperation: (1) operational collaboration; (2) knowledge and expertise exchange; and (3) coordinated efforts to shape the global humanitarian and development agenda. Furthermore, Senior Management has decided that IDA financing for all new operations under preparation through 2020 in South Sudan will be channeled through and implemented by nongovernmental entities such as UN agencies and nonprofit international organizations.

43. **The proposed operation will respond directly to the acute health challenges by rapidly improving access to essential services for the populations of former Upper Nile and Jonglei, including those that were previously inaccessible.** Without World Bank support there will be little to no resources for the provision of health services to 3 million people. The proposed project will address the dire health challenges presented above by (i) ensuring complete geographical coverage of essential health and nutrition services in the two states by providing direct service delivery support to health facilities, both emergency and non-emergency; (ii) introducing flexible and dynamic approaches to service delivery such as outreach activities to high risk communities, training and deployment of community health workers for preventive and basic curative services (and supporting the scale-up of the government's Boma Health Initiative); (iii) training of lifesaving health professionals that are almost nonexistent in the country; including on counseling



and treatment for GBV victims; and (iv) ensuring robust monitoring and verification measures are in place to proactively track results and monitor progress.

44. **The risks will be high across the board, as evidenced from the HRRP implementation.** Throughout the implementation period of HRRP, facilities have been attacked and looted with the deaths of patients and health workers as a result. Based on the data received from the CSDO, since the project began 43 out of 248 facilities have been looted or physically damaged by violence groups, several facilities have been victims of violent attacks resulting in severe injuries or even death and stealing and syphoning off of essential medicines has remained a constant problem. These risks remain a reality for actors providing support to health services in two former states of Upper Nile and Jonglei and thus will remain so for the proposed operation.

45. **GOSS has requested the World Bank in a letter dated August 14, 2018, to provide financing directly to organizations to carry out operations for the benefit of the people in South Sudan, due to capacity constraints of the government to effectively manage and implement operations.** Under these circumstances, World Bank financing will be provided directly to the UN, international non-governmental organizations (NGO) and humanitarian organizations for the benefit of affected communities. This implementation arrangement is the most feasible possibility for the WB to engage in South Sudan at this point, and the alternative of 'non-engagement' would have an extremely negative consequence for the population is not favorable. The government has experience with this approach in the health sector, as there are many similarities to the Health Pooled Fund's implementation arrangements. For this to happen, there will be a need for Board approval of waiver for IDA grants being made directly to Recipients such as ICRC and UNICEF.

46. **Consistent with this vision, and given the dire humanitarian crisis at hand, the proposed operation will entail:** a) a surge of high-impact, immediate response and early recovery interventions in areas significantly affected by the conflict that remain inaccessible to more development-oriented assistance approaches, and; b) a continuation of broad support to primary health care and maternal and child health in Upper Nile and Jonglei, in an effort to continue efforts to coordinate support to the health system between the Health Pooled Fund and the World Bank. This approach will strategically address existing gaps in service delivery and health needs for both conflict-affected and the general population, while maximizing the World Bank's comparative advantage and value addition by making resilience building a key underpinning of the interventions proposed to be financed under the operation.

47. **Based on the lessons learned from HRRP and in close consultation with health sector donors, development partners and humanitarian organizations, it is proposed that the project will support the provision of essential health services in South Sudan, with a particular focus on the former states Upper Nile and Jonglei and populations affected by the conflict.** This will be done through engaging UNICEF and ICRC and use their comparative advantages to ensure services are delivered to target populations, with a particular focus on at-risk and vulnerable populations. The importance of leveraging these actors and providing an immediate flow of funds is necessary in the context of the operation to sustain existing momentum and scale up ongoing activities while also avoiding interruption to service delivery supported by HRRP.

48. **Both organizations have a strong focus on rural populations and hard-to-access areas where vulnerability is acute, allowing the project to target some of the most vulnerable populations.** Beneficiaries will include the greater population of former Upper Nile and Jonglei (through UNICEF), including areas severely impacted by conflict (through ICRC), as well as target populations affected by the conflict outside of the two priority former states (through ICRC).

#### Relationship to CPF

49. **The proposed investments are aligned with the Country Engagement Note (CEN) FY 18-19 of November 2017**



**for South Sudan.** The Systematic Country Diagnosis (SCD) for South Sudan underscores the importance of ensuring access to basic services and the role that contracting arrangements can have in supporting service delivery in contexts of fragility. The proposed operation is in line with the government's Health Sector Development Plan and the Health Sector Strategic Plan (2015-2019) and the Boma Health Initiative, whose objectives to "increase the utilization and quality of health services, with emphasis on maternal and child health"; to "strengthen institutional functioning including governance and health system effectiveness, efficiency, and equity"; and community health system (the reform) as a means to equitably engage communities in health promotion at household level. The new CEN proposes a strategy with two pillars: (i) provision of basic social services to the most marginalized and vulnerable populations; and (ii) social protection of the most vulnerable households, supporting livelihoods and basic economic recovery.

50. **The project is well-aligned with development partners approaches and focus to support the most vulnerable populations affected by conflict.** The content of the proposed operation is in line with the World Bank's engagement in the country and approach to support in FCV contexts. The project will support a minimum level of capacity building efforts that is absolutely necessary to ensure that services are provided to the level and quality required for medical services provision and supervision.

### C. Proposed Development Objective(s)

The Project Development Objective is to increase the utilization and quality of an essential package of health services, with a particular focus on the former states of Upper Nile and Jonglei

Key Results (From PCN)

51. **The proposed PDO indicators are the following:**

- a. People who have received essential health, nutrition, and population services (cumulative number disaggregated by gender, children and IDPs);
- b. Number of children immunized;
- c. Number of women and children who have received basic nutrition services;
- d. Number of deliveries attended by skilled health personnel;
- e. Number of health facilities with at essential medicines available (definition to be determined); and
- f. Number of health facilities providing at least 75 percent of the essential package of health services (disaggregated by conflict and non-conflict affected areas).

### D. Concept Description

52. **Based on the lessons learned from the Health Rapid Results Project and in close concertation with health sector donors, development partners and humanitarian organizations, it is proposed that the project will support the delivery of a package of essential health services in South Sudan with a particular focus on the former states of Upper Nile and Jonglei.** That being said, it's necessary that the project includes a level of flexibility in the geographical targeting and covering of supported interventions, due to the ever-evolving state of the conflict and unpredictability of violent events outside of the two former states. In addition to providing general service delivery support to these areas, the project will specifically target vulnerable populations affected by the conflict. The importance of leveraging partnerships with institutions that can ensure services are provided even during surges of violence and conflict will be essential to achieving



the objectives of the operation. The immediate mobilization of resources to support the provision of essential health services is necessary in the context of the operation to sustain existing momentum and scale up ongoing activities while also avoiding interruption to service delivery supported by HRRP.

53. **The project will have a strong focus on rural populations and hard-to-access areas where vulnerability is acute, allowing the project to target some of the most vulnerable populations.** Beneficiaries will include the greater population of former Upper Nile and Jonglei, including areas severely impacted by conflict, as well as target populations affected by the conflict outside of the two priority former states.

**Component 1: Support delivery of essential package of basic health and nutrition services (BHPNS) in the former states of Upper Nile and Jonglei (US\$68 million)**

54. **Component 1 will support the provision of a defined package of essential health services in the former states of Upper Nile and Jonglei, as well as third-party monitoring and verification of results.** The main goal of this component is to support the delivery of a well-defined and costed package of essential services for the general population of the two former states. The package will include maternal and child health services such as vaccinations, prenatal care, skilled birth attendance, neonatal care and preventive and curative health and nutrition services. The package of services to be supported will primarily be provided at primary care facilities and strategically identified secondary hospitals, complemented with community outreach and mobile health services to increase and expand equitable coverage and access, especially for remote or hard to reach populations with intermittent periods of stability and access. Support to health facilities will include civil works such as minor rehabilitations of existing infrastructure within existing boundaries of supported facilities.

55. **Component 1 will finance partner agencies who will coordinate the delivery of an essential package of health and nutrition services in the two former states and other areas in the country acutely affected by the conflict.** The terms of reference of the partner agencies will include: (i) direct service provision of said agencies using their own staff; (ii) sub-contracting NGOs (Implementation Partners) to support the coordination and delivery of health services; (iii) strengthening the management capacity of County Health Departments where possible; and (iv) introducing innovations in approaches to providing health services that address some of the challenges facing the health system in South Sudan.

56. **Partner agencies will improve access to services despite seasonal accessibility challenges.** Excessive reliance on fixed health facilities will leave many people in the two states without physical access to PHC services. Thus, the project will have to strengthen outreach activities, particularly during the dry season. The dry-season campaigns are aimed at improving the coverage of basic services such as immunization, vitamin A supplementation, and anti-malaria treated bed nets. Part of the coordination role of implementing agencies will be to mobilize all the available commodities, vehicles and human resources required to implement the outreach activities and supplement these resources where needed.

**Implementation strategies**

57. **The main strategy is to support an agile mix of static primary health care services that is complimented 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 front-line interventions will be supported in specific areas with the roll-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 ensure the 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 Ministry of Health, State Ministry of Health and county health officials, UNICEF will provide implementing partners (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 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 focus on the promotion of Child Health, Safe Motherhood, and basic Community Surveillance, along with community engagement and mobilisation (e.g. to use outreach services when they are available).

58. **This component will also address the limited availability of qualified professions trained in SGBV who are offering services to victims by investing heavily in training, sensitization and monitoring.** In collaboration with other development and humanitarian partners working in South Sudan's health sector, many who already has a significant program addressing SGBV in South Sudan, the project will significantly scale-up attention and efforts to improve access to services for SGBV victims. For example, the project will support the work of Gender and Social Inclusion (GESI) experts at UNICEF to scale-up training programs of health professionals and expand the network of service providers offering SGBV counseling and treatment services in former Upper Nile and Jonglei.

59. **Accessibility to provide health services in areas acutely affected by the crisis remains a significant challenge in South Sudan, with only few actors in the country have been able to find ways to allow them to cross boundaries between government and opposition-held areas to deliver services.** The component will also support the delivery of a multidisciplinary response to urgent health needs arising out of the conflict in the country, with a particular focus on zones that remain inaccessible to other parties (sub-component 1.2). ICRC has proven its ability to do so, even during upsurges in violence. The sub-components to be implemented by ICRC as the Recipient include the following:

60. **The services targeted by the medical teams in the facilities will include:**

- (a) Training and support in managing medical stocks, supplies and pharmaceuticals;
- (b) Treatment for most frequent diseases and care in line with national guidelines;
- (c) Training and support to antenatal care, post-natal care, safe deliveries and Basic Emergency Obstetric and Newborn Care;
- (d) Training and support for the *Boma Initiative* to improve community involvement/ownership in health care;



- (e) Medical care and MHPSS support for victims of violence, including conflict related sexual violence;
- (f) Support to re-establish routine expanded program immunization (EPI); and
- (g) Referrals to secondary/hospital care.

61. **In any health system, hospitals are increasingly complex and costly organizations.** Effective health service delivery means an integration with existing primary health care services providing a continuum of care with effective linkages on all levels. It is essential that hospitals respond to the demand created from referrals of patients from the primary level of care and supported health workers at primary level.

62. **To have an impact on the continuum of care, a package of secondary health services (level at the county hospital) will be developed and implemented by ICRC in conflict-affected and inaccessible areas where referral possibilities are not or insufficiently available.** While many of these areas are in former Jonglei and Upper Nile, the specific locations and numbers are still to be determined giving the evolving context. Given the complex situation in South Sudan and especially in the non-governmental controlled areas, the approach at the hospital level will remain agile and quick to adapt in a case of a changing security situation.

63. **In the current situation of volatility, the support to any county hospital should be agile in a way it increases the access and referral to secondary hospital services to provide the best quality of care possible.** The following clinical services should be supported: maternity, pediatrics, adult inpatients service, outpatient department and initial stabilization of surgical emergency cases. Aside the outpatient department, inpatients will be admitted in a maternity ward (including other female inpatients), pediatric ward and adult male ward. The average catchment population for a county hospital in South Sudan should be around 200,000.

64. **Mental health and psycho-social support (MHPSS) and medical care will be provided to victims of violence and conflict-related sexual violence in a safe environment.** Linkages will be developed between a primary point of contact from the community to referral services, to ensure effective awareness raising and referral pathway for victims of conflict related sexual violence. The inclusive mental health services package comprises:

- (a) Assessing mental health and psychosocial needs and available resources and support within ICRC's supported health facilities;
- (b) MHPSS capacity-building: training and follow-up supervision for community key actors, health staffs (identified as focal points), on issues such as identification of symptoms, strategies for potential responses and referrals when possible;
- (c) Strengthening the technical quality of and access to psychological services and to psychosocial support activities to promote emotional well-being by improving coping mechanisms;
- (d) Sensitization and community mobilization through the ICRC supported health facilities to provide information and promote knowledge on MHPSS issues through awareness-raising campaigns and community outreach.

65. **This subcomponent will also finance costs related to overall implementation, overhead and programmatic costs for implementing agencies.**

## **Component 2: Monitoring, Evaluation and learning (US\$2 million)**

66. **The Project will ensure that there is a steady stream of independent and credible data on health service delivery in the two former states.** This is critical to enable the World Bank, government and development partners to have a clear



line of sight that resources are reaching the intended beneficiaries and are not being used to cause harm. The enhanced monitoring and verification mechanisms that are proposed to be put in place to collect evidence of sustained service delivery will hopefully minimize the need for a “stop/go” financing situation even if the levels of conflict and violence increase.

67. **Sub-component 2.1: Third Party Monitoring (US\$1.5 million):** This sub-component will build on experience from HRRP’s third-party monitoring (which included Lot Quality Assurance Surveys (LQAS), Quarterly Verification Visits and health information system assessments) and will include contracting of a third-party monitor. The Third-Party monitor roles will include supportive supervision and monitoring to identify challenges and propose context-appropriate solutions, as well as ex-post fact verification of results provided by project reporting mechanisms. Where necessary, the TPM will only collect population-level data on service coverage and not collect data directly from health facilities.

68. **As there are efforts to develop a common TPM mechanism across HPF and WB-supported zones for which significant consultative efforts are needed, the exact methodology will be defined and implemented in 2019.** The task team has leveraged resources from the Global Financing Facility (GFF) and the CMU (ASA FY19) to contribute to the design of this shared TPM approach across HPF and WB zones.

69. **Enhanced accountability and monitoring mechanisms will be put in place to track and address partners’ performance.** Engaged institutions will be held accountable for improving the quantity and quality of health services based on a specific set of measurable indicators that also reflect the project’s results framework. The World Bank will conduct quarterly meetings with implementing agencies to review progress based on a pre-identified methodology for reporting, counter-verification and third-party monitoring. Mechanisms will include quarterly bulletins analyzing data from the health management information system (HMIS), from quantitative supervisory checklists (QSC), and Lot Quality Assurance Surveys (LQAS). Innovative technologies such as use of mobile and geotagged data will be applied to strengthen the quality and comprehensiveness of said third-party monitoring and verification mechanisms.

70. **Sub-component 2.2 – Knowledge and learning (US\$0.5 million):** To better understand the ongoing needs and to design programs on the longer term, the sub-component will support several implementation research initiatives. Three potential topics will be analyzed further:

- (a) Psychiatry: the status of psychiatric services and clinical health needs in South Sudan (consultancy);
- (b) Social Inclusion: how to optimize the social inclusion program for clients of the physical rehabilitation program in South Sudan (consultancy); and
- (c) Service delivery in conflict situations: attacks on medical facilities and the impact on the health status of the population of South Sudan (research in collaboration with the Juba University, Department of Public Health).

### **Component 3: Refinancing of Project Preparation Advances (US\$4.5 million)**

71. **The financing processed through this project will also support the repayment of Project Preparation Advances from other projects that were disbursed but for which the project was never delivered.** The projects include the South Sudan Institutional Development and Capacity Building Project (P143975, Loan number Q9090), the Energy Sector Technical Assistance Project (P145581, Loan number Q9320), and the Agricultural Development and Food Security Project (P130119, Loan number Q9460).

### **Component 4: Contingency Emergency Response (US\$0 million)**



72. **The objective of this component is to improve the country’s response capacity in the event of an emergency, following the procedures governed by OP/BP 10.00 paragraph 13 (Rapid Response to Crisis and Emergencies).** There is a moderate to high probability that during the life of the project that South Sudan will experience an epidemic or outbreak of public health importance or other health emergency with the potential to cause a major adverse economic and/or social impact which would result in a request to the Bank to support mitigation, response, and recovery in the region(s) affected by such an emergency. In anticipation of such an event, this contingent emergency response component (CERC) provides a mechanism for the project to support mitigation, response, and recovery in the district(s) affected by such event. This Program provides an important opportunity for clients to stop epidemics from spreading within and across borders through early intervention, without the need to set financing aside in a conventional contingency fund.

## SAFEGUARDS

### A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The Project will primarily be implemented in the former states of Upper Nile and Jonglei. Civil works, such as minor rehabilitation and/or repair of damaged health facilities, will be included where needed. These minor civil works will be limited to within existing perimeters of facilities. Provision of equipment and materials will need to take into consideration ways on how to acquire and dispose material medical inputs without adverse impacts on environment and public health. As the project is financing Project Preparation Advances (PPA) for past operations, appropriate modalities for screening E&S impacts, compliance of safeguards policies, and risks will be conducted prior to disbursing on repayments of these PPAs.

### B. Borrower’s Institutional Capacity for Safeguard Policies

Both implementation partners have demonstrated capacity for applying international safeguards best practices as highlighted by many years of positive contributions in the health sector in South Sudan. However, as the project implementation must comply with World Bank safeguards policies, the World Bank team will provide the necessary support to ensure that such standards are being followed in design, implementation, and monitoring. This applies specifically to questions of long-term engagement with communities and continuing community consultations and implementation of a responsive Grievance Redress Service.

### C. Environmental and Social Safeguards Specialists on the Team

Tracy Hart, Environmental Specialist  
Simon Sottsas, Social Specialist

### D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Environmental Assessment OP 4.01 is applicable due to minor rehabilitation of existing health facility infrastructure, the purchase and administration of vaccines, and the provision of essential health



services. It is expected that two Environmental and Social Management Frameworks (ESMFs) will be prepared -- once for each implementation partner -- based on the components and activities, as well as the standard modalities for mitigating and monitoring safeguards compliance specific to each. Each ESMF will also include environmental and social screening, eligibility criteria, and management of social issues such as Gender-Based Violence, codes of conduct, and inclusion. Design of these social aspects are guided by two Social Assessments (SAs).

Performance Standards for Private Sector Activities OP/BP 4.03	No	No private sector activities are envisaged.
Natural Habitats OP/BP 4.04	No	This policy is not applicable.
Forests OP/BP 4.36	No	This policy is not applicable.
Pest Management OP 4.09	No	This policy is not applicable.
Physical Cultural Resources OP/BP 4.11	No	This policy is not applicable.
Indigenous Peoples OP/BP 4.10	Yes	OP 4.10 on Indigenous Peoples is triggered as analysis by the World Bank confirms that most people in the proposed project areas are expected to meet the requirements of OP 4.10. Per OP 4.10, when the vast majority of people in the project are Indigenous Peoples, a Social Assessment (SA) is prepared and, OP 4.10 elements are mainstreamed into project design. Therefore, a SA will be prepared by each implementation partner and disclosed before or on appraisal.
Involuntary Resettlement OP/BP 4.12	No	This policy is not applicable, as the project will only support rehabilitation of damaged infrastructure, within the physical boundaries of health facilities. There will be no expansion or new construction of health facilities.
Safety of Dams OP/BP 4.37	No	This policy is not applicable.
Projects on International Waterways OP/BP 7.50	No	This policy is not applicable.
Projects in Disputed Areas OP/BP 7.60	No	This policy is not applicable.

**E. Safeguard Preparation Plan**

Tentative target date for preparing the Appraisal Stage PID/ISDS

Nov 19, 2018



Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

While the proposed operation meets the emergency provisions of OP 10.00 Paragraph 12 (Projects in Situations of Urgent Need of Assistance or Capacity Constraints) of the World Bank's Operational Manual and Guidelines and will be processed through condensed procedures provided therein, the proposed operation is not requesting deferral of social and environmental safeguards requirements to the implementation phase, and will have them processed during preparation.

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**APPROVAL**

Task Team Leader(s):	Paul Jacob Robyn, Fatimah Abubakar Mustapha
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**Approved By**

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Practice Manager/Manager:	Trina S. Haque	05-Nov-2018
Country Director:	Sahr Kpundeh	26-Nov-2018

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