



Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 14-Dec-2018 | Report No: PIDISDSA25762



BASIC INFORMATION

A. Basic Project Data

Country South Sudan	Project ID P168926	Project Name Protection of Essential Health Services Project	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 05-Dec-2018	Estimated Board Date 31-Jan-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 access to 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

Components

- Delivery of Essential Health Services
- Monitoring, Evaluation and Learning
- Emergency Preparedness and Response
- Refinancing of Project Preparation Advances

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	105.40
Total Financing	105.40
of which IBRD/IDA	105.40
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	105.40
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IDA Grant	105.40
Environmental Assessment Category	
B-Partial Assessment	
Decision	
The review did authorize the team to appraise and negotiate	

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Other Decision (as needed)

B. Introduction and Context

Country Context

Long before independence, South Sudan (known as the Southern Sudan region) has experienced significant levels of fragility, conflict and violence (FCV). There has not only been conflict with the North, which lasted close to half a century, but also significant inter- and intra-communal tensions. 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.

At independence in 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 Sudan's People's Liberation Army (SPLA) government forces and Sudan's People's Liberation Army In Opposition (SPLA-IO). While 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, open conflict escalated in Juba in July 2016 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, worsening 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.

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 and followed by a peace



celebration in Juba in October 2018. The agreement proposes a reorganization of the government with three vice-presidents and the establishment 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.

Despite an abundance of natural resources and potential oil wealth, South Sudan's economy is in crisis, with output contracting, and inflation and parallel exchange market premium soaring. South Sudan has one of the least diversified economies in the world, a result of being oil dependent. The large drop in oil prices in 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 South Sudanese Pound (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 lengthy disruptions in payments of civil service salaries over the past year.

The majority of South Sudanese have lived in poverty for generations. 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 the country, 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 nets to cushion the most vulnerable.

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 have claimed 4,289 lives between independence (2011) and 2016¹, 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 conflict². In addition, the deepening economic crisis has exacerbated 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

¹ Uppsala Conflict Database Program, 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.

² 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.



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 at 1.85 million (UNOCHA, July 2018), with many originating from the former states of Jonglei and Upper Nile

The majority of the population of South Sudan faces acute barriers to accessing basic services. 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 non-governmental organizations (NGOs), many of which have been operating in the Southern Sudan region for decades before independence.

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 row³. 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 number 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.⁴ Working conditions for aid workers remain a significant challenge, resulting in greater inaccessibility, less information on realities on the ground, and less aid reaching the most in need.

Women are highly disadvantaged, with lower levels of education relative to men and greater barriers to benefitting from economic activities. Women and girls face a disproportionate burden of violence. The roles and responsibilities of South Sudanese women have evolved throughout periods of conflict and peace, though insecurity has left many households to be 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 of intimate partner violence, as well as other harmful practices such as Female Genital Mutilation.

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

⁴ Between 2011 and 2015 there were 10 states nationwide. In 2015 they were divided into 28 states, followed by an additional division in 2017, resulting in currently 32 states in the country. The former states of Upper Nile and Jonglei now constitute seven states: Boma, Jonglei, Eastern Bieh, Western Bieh (Fangak), Latjoo, Eastern Nile, and Western Nile. These states will be referred to in this document as "former states of Upper Nile and Jonglei".



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 in conflict in South Sudan, 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 conflict⁵. While difficult to get national level estimates due to chronic underreporting, there is a consensus among actors working in the country 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 98 percent of known victims), but also men and boys⁶. 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 among SGBV survivors. Access to health and counselling services for victims of rape and other forms of gender-based violence are extremely limited.

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 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 of armed forces. 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

Health sector outcomes

In 2018 the World Bank Group has launched the Human Capital Project (HCP)⁷. It makes the case for investing in people through country engagement and analytical work, while raising awareness of the costs of inaction and bolstering demand for interventions that will build human capital. The project emphasizes the importance of sustained leadership and coordination across all levels of government—including tackling complex issues such as inadequate or inefficient spending, governance and service delivery challenges, population dynamics, fragility and conflict, and gaps in infrastructure. The first pillar of the HCP is the Human Capital Index (HCI). The index measures the human capital of the next generation, defined as the amount of human capital that a child born today can expect to achieve in view of the risks of poor health and poor education currently prevailing in the country where that child lives. Although caution should be given the quality for South Sudan, for the first year of rankings (2018), South Sudan ranked second to last globally, with an index score of 0.30 and ranking 156 out of 157 countries on the

⁵ 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

⁶ GBV Sub-Cluster Strategy South Sudan 2017

https://reliefweb.int/sites/reliefweb.int/files/resources/gbv_sub-cluster_strategy_final_1.pdf

⁷ The World Bank, The Human Capital Project (2018). Available at: <https://openknowledge.worldbank.org/handle/10986/30498>



index, ranking only higher than Chad. The results of the HCI highlight the importance and urgency to invest in health, education and overall human development outcomes in the country.

South Sudan has some of the worst health outcomes in the world (Table 1). 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 health care within a 5-km radius. Life expectancy at birth is low, being 56 years for both men and women⁸.

Table 1: Key health outcomes in South Sudan

Indicator	South Sudan (2016)	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

As highlighted above, South Sudan is one of the most dangerous places in the world to give birth; having one of the highest maternal mortality ratios globally⁹. Approximately 86 percent of deliveries occur at home. The Caesarean section rate is very low at 1 percent of deliveries, 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 country. In addition, there is a lack of trained traditional birth attendants, 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.

The survival outcomes of children in South Sudan are also among the worst in the world. Neonatal, infant mortality and under five deaths rates are very high. 39 new-born 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

⁸ UNICEF, State of the World’s Children 2016 (2016). Available at: <https://www.unicef.org/sowc2016/>

⁹UNICEF, Monitoring the Situation of Children and Women,2017 (2017)



malaria and many more will be infected but have minor symptoms¹⁰. 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.

Acute malnutrition remains a major public health emergency in South Sudan. As of August 2018, 6.1 million people, nearly 60 percent of the country's population, were estimated to be severely food insecure. Close to 50,000 people in Jonglei, Lakes, Unity and Upper Nile states, as well as in Western Bahr el Ghazal's Greater Bagarri area, are facing Catastrophe (IPC 5) levels of acute food insecurity due to poor harvests, conflicts and lack of humanitarian access (USAID, 2018). The magnitude of this is unprecedented with malnutrition a contributing factor in nearly 1 in 2 (45 percent) of all child deaths, (UNICEF, 2017)¹¹.

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 cholera became major causes of death in the country. This has especially affected displacement sites where malnutrition and poor immunity makes young children and pregnant women particularly vulnerable. Since 2011, South Sudan has experienced some of 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 World Health Organization (WHO) emergency threshold of 1 percent¹².

Health system and service delivery challenges

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 time¹³. 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. This low level of expenditure is the result of prioritizing the security sector (47 percent of total expenditure) over human development needs. 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.

Household out-of-pocket expenditures on health 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 on less than US\$3.1 a day¹⁴, high out-of-pocket health

¹⁰ Government of the Republic of South Sudan, Ministry of Health, 4th Annual HMIS Report (2015).

¹¹ UNICEF, Monitoring the Situation of Children and Women, 2017 (2017). Available at <http://data.unicef.org/topic/nutrition/malnutrition/>

¹² UNOCHA, South Sudan Humanitarian Bulletin, June 2017

¹³ World Bank, South Sudan Health Expenditure Review, May 2016.

¹⁴ World Bank 2016, "Macroeconomic and Poverty Outlook – South Sudan, n. 275, April 2016



expenditures are a significant constraint to accessing healthcare. High financial barriers to care also reinforce inequities across socioeconomic groups, increases household vulnerability to catastrophic expenditure, and undermine the principles of universal health coverage.

Service delivery for a fragile, conflict and violence affected state like South Sudan remains an important challenge. Several states, including those in the former states of Upper Nile and Jonglei, are in active conflict or experience periodic flare-ups of conflict, resulting in health systems 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 different sides in the conflict.

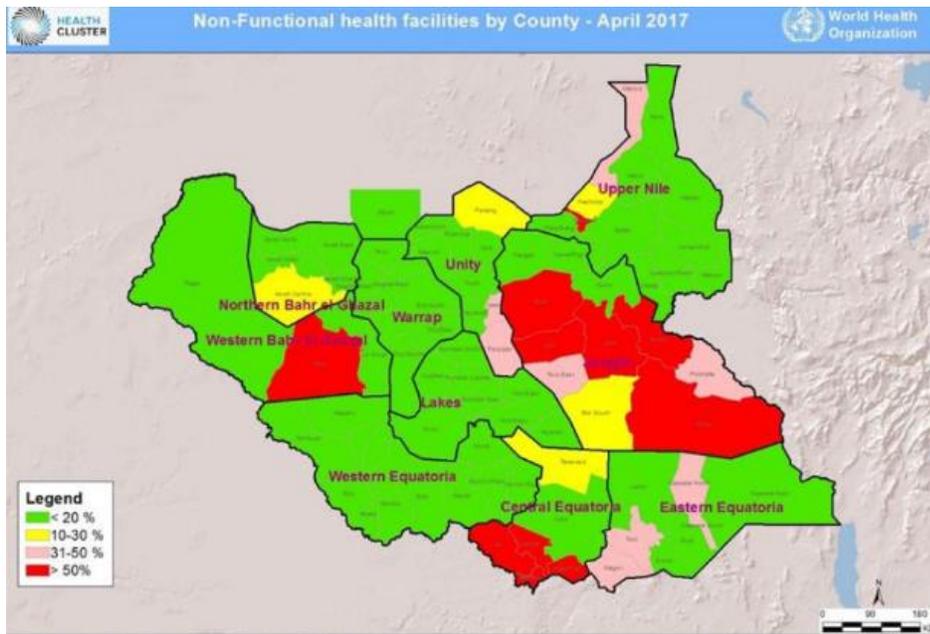
Provision of the most basic services has largely been provided by non-state actors since well before independence and continues as such today¹⁵. Although the establishment of a national health system started at Comprehensive Peace Agreement in 2005, progress has remained elusive. Whatever efforts made between 2005 and 2013 were slowed by the resumption of violence. At independence, 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, both due to ongoing conflict, as well as overall limited government capacity. 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 however some positive trends, with the number of midwives increased significantly since 2010, from only 8 in 2011 to over 600 trained with essential professional midwifery competencies (UNFPA, 2018).

High levels of insecurity have dramatically reduced the capacity of the health care system to deliver services. There are numerous reports over the past few years of health facilities being attacked, damaged and looted. Among the approximately 1,500 public 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 replacement¹⁶. In Unity state, for example, there is only one county hospital for more than one million people. Almost all facilities lack medical equipment, transport and communication, water and power supplies. The government currently does not have the capacity to deliver health services independently, and almost all health facilities are supported by NGOs/aid agencies. 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

¹⁵ 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.

¹⁶ South Sudan Health Sector Development Plan, 2016-2020.



Source: WHO, Health Cluster Bulletin, April 2018

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.

The availability of essential health services remains highly limited. As of April 2018, only 3.7 percent of the 1,332 reporting facilities provide the full-service package as per the Ministry of Health (MOH) Basic Package of Health and Nutrition Services (BPHNS)¹⁷. Furthermore, only 52.4 percent of reporting facilities were providing half the required services. For example, Outpatient Therapeutic Programs (OTP) and Targeted Supplementary Feeding Program (TSFP) for nutrition are only offered by 35.5 percent and 43.5 percent of health facilities, respectively.

Disease surveillance systems are extremely weak, leaving the population at high risk for outbreaks, epidemics and even cross-border pandemics. With the 2018 Ebola outbreaks in the North Kivu province of neighboring Democratic Republic of the Congo (DRC), the risk of severe disease outbreaks occurring in South Sudan has risen significantly higher. As of November 24th, 2018, a total of 412 cases of Ebola Virus Disease (EVD) have been reported in DRC, of which 365 are confirmed and 47 are probable. Total deaths amounted to 236. Significant efforts have been made by the government and international partners to strengthen public health preparedness and readiness of South Sudan’s health system to respond to an eventual outbreak in the country. As of November 22nd, 2018, out of the total funding requirement of US\$ 16.3 million for preparedness activities, US\$9.4 million has been mobilized, representing 57% of the total required¹⁸. Despite these efforts, the country remains on high alert, with a suspected case in Yei River

¹⁷ WHO, Health Service Functionality Bulletin, April 2018.

¹⁸ South Sudan Ministry of Health, Weekly Update on Ebola Virus Disease (EVD) Preparedness for South Sudan, November 26,



State in mid-November causing international concern. While laboratory test results for the suspected Ebola case that were conducted in Uganda concluded the case as negative for the DRC Ebola strand, the event highlighted how the porous border between South Sudan and DRC and limited capacity to respond to disease outbreaks leave South Sudan in a situation of extremely high risk. Additional efforts will be needed to support the country's efforts to be fit to respond to any potential public health emergency.

The overall response to SGBV remains inadequate in reach, quantity and quality. The availability of trained medical personnel to handle Clinical Management of Rape (CMR) 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.

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

Over the past few years, a limited number of large-scale programs were the main source of financing the delivery of health services in South Sudan, including supported provided by the Health Pooled Fund and the World Bank (WB). 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)¹⁹, 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). Critical support is also provided by UN agencies, bilaterals and NGOs, but not at the same scale as that provided by HPF and the Bank. In many parts of the country, interventions financed by HPF and the Bank are the only support available.

The Bank has been engaged and supporting the health sector since before South Sudan became independent. During the CPA period the Bank, together with other partners, was 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. Under the Multi-Donor Trust Fund (MDTF) for South Sudan, several operations were processed to support the development of the country's health sector. These include the Southern Sudan Umbrella Program for Health System development (P120464), the MDTF HIV/AIDS Project (P106927), and the first financing of HRRP. The Implementation Completion Report (ICR) rating of the HIV/AIDS project was Unsatisfactory, deemed to be due to the ambitious nature of the programs, which did not always 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

2018

¹⁹ 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.



a second AF of HRRP and the new operation proposed here. The ICR for the HRRP is currently being finalized, and several of the key lessons learned from the project have been integrated into the design of the new operation.

Experience from the health portfolio in South Sudan highlights key risks that require careful and measured approaches. These include: escalating violence limiting access to opposing sides; inability to target across warring sides; the “element of surprise” and arrival of unanticipated shocks; 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. Several of these risks, along with mitigation measures, are discussed under the Risks section.

Lessons learned from the Bank’s previous engagement in South Sudan

The proposed project takes on board over a decade of Bank experience in working South Sudan, both the health sector, supporting two of the most conflict-prone states in the country, as well as service delivery in other sectors. The Bank has been part of donor coordinated efforts to provide basic services in South Sudan since the time of the CPA. 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 South Sudan Country Engagement Note (CEN) (FY18-19) provides several key lessons from across the portfolio which have been taken in to consideration in the proposed operation. First, there is recognition that to have any significant impact on service delivery, there is need for flexibility both at the strategic and operational level; speed in delivery of services; accountability and citizen engagement; and strategic partnerships given the enormity of needs, the geographical scope and limited resources. Also, with relations between traditional donors and the government strained because of poor investment in human capital by the government, donors have shifted their focus to humanitarian relief, due to the resumption of the conflict, rather than long-term development assistance. Hence the World Bank Group is in a unique position, considering the existing complex donor relationship with the Government, to contribute to the discourse on the humanitarian-development nexus and to help articulate a path to recovery and development.

Since the launching of HRRP in 2012, 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 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.

The majority of financing for the delivery of health services to both these states has been channeled through HRRP. While the project was designed to support services in a period of conflict (mostly intra- and inter-communal clashes, 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. This violence has led to large parts of Upper Nile and Jonglei being under control of armed



forces, including both government or opposition-supported groups, resulting in significant access challenges for government and implementing partners. After two additional financings and several restructurings, the project is expected to close on March 31, 2019.

The challenging environment and security risks of where HRRP was implemented resulted in the Bank being unable to visit project sites for most of the project's duration. 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. Due to improved mobility, dry seasons have often seen upsurges in violence. Given these constraints, various third-party monitoring and verification mechanisms were put in place to ensure the results reported have been achieved. Payment to the Coordination and Service Delivery Organization (CSDO), in part depended on to the verification of results from the third-party verification agency.

The CSDO-type model, which includes an international NGO that subcontracts NGOs and county health departments (CHD) to channel resources and provide support to service providers for the delivery of a defined package of health services, is implemented across HPF and HRRP zones with similarities in the packages of services delivered and modalities for implementation. Under the HRRP implementation arrangements, the MOH entered into a performance-based contract with an international NGO contracted to be the CSDO for Upper Nile and Jonglei. The contract, signed between the MOH and the CSDO, was based on a fixed budget, calculated from the historical cost of providing services. The CSDO-contracted NGOs and county health departments (CHD) to deliver services in public facilities. Upon submission of quarterly reports, the CSDO received a lump sum payment based on satisfactory performance on specific indicators. Results were counter-verified by a third-party monitor and based on results achieved, the performance-based variable portion of the payment was made. In addition, the HRRP supports the procurement and distribution of pharmaceutical commodities in the two former states, and remains the primary source of essential health commodities, apart from those provided through humanitarian organizations providing emergency health support.

Despite providing essential support to the delivery of health services in some of the most challenging environments in South Sudan, 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 life-saving health services in a context where insecurity and instability have generated additional challenges in providing support. 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. While it has been successful in delivering basic health care to close to three million people, the ongoing conflict has resulted in the destruction of facilities, displacement of qualified health workers, shortages of essential drugs, and significant portions of the populations of Upper Nile and Jonglei becoming inaccessible to project interventions. As a result, project gains have been handicapped and the ability of the project to deliver all its anticipated benefits has been significantly curtailed.



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, contracts for procurement of pharmaceuticals, and the Third-Party Monitoring (TPM) contract. The weaknesses have been 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 have grown 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; and (iv) passive contract management leading to numerous urgent contract extensions.

The environment in which the project is being implemented has significantly deteriorated over the past year, with risks and implementation challenges continuing to grow over time. While the HRRP has surely contributed positively to providing health services in the two states, results from the project show that coverage remained 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.

In order to avoid a gap in service delivery for the approximately 3 million people residing in former Upper Nile and Jonglei, in July 2018 the MOH transitioned from the international NGO whose CSDO contract ended in June 2018 to a short-term contract with UNICEF to step in to the role to coordinate and channel resources for the delivery of health services. 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 have allowed UNICEF to continue through October 2018, with UNICEF mobilizing additional resources through DFID (United Kingdom Department for International Development) funding for the period November 2018-January 2019. This has created a situation where in February 2019 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.

In addition, 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 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 explored through country-level consultations health sector partners that were effectively able to deliver services in these challenging areas. While more than one potential entity was identified, the International Committee of the Red Cross (ICRC) was the only organization that was deemed to have the capability ensure services are delivered to these highly vulnerable populations and willing to take on the mission through the proposed operation.

Despite the challenging environment, the results from the HRRP are notable. 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. The project also contributed significantly to strengthening health information and reporting systems in the country.

Revitalizing the Bank's engagement in South Sudan's health sector through a new operation

The Government of South Sudan 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 NGOs 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 extremely negative consequences 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.

Consistent with this vision, and given the substantial health needs in the country that urgently need to be addressed, the proposed operation will entail: (i) 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; (ii) a continuation of broad support to primary health care and maternal and child health, particularly in the former states of 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.

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. The Bank's engagement going forward through the proposed operation will be in some ways a dramatic depart from previous approaches to support



South Sudan's health sector. A key departure will include implementation arrangements that engage UNICEF and ICRC directly and not through government entities such as a Project Management Unit within the Ministry of Health. The new approach will leverage the comparative advantages of ICRC and UNICEF to ensure services are delivered to target populations in neutral, flexible and rapid manner, 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.

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 at-risk populations in the country. 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). Both organizations also have expertise in supporting disease surveillance and response efforts both globally and in South Sudan, including efforts related to Ebola preparedness and response.

The proposed engagement with ICRC in South Sudan through this operation falls within the context of a broader effort between World Bank and ICRC to collaborate in fragile state and conflict-affected settings. In May 2018 the CEO of the World Bank Group and the President of the ICRC signed a Memorandum of Understanding (MOU) 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, and as needed by UN agencies and nonprofit international organizations. In August 2018, the Bank and ICRC health teams in South Sudan conducted a country-specific deep dive to identify new ways to improve effective support to harder-to-reach areas of greater Upper Nile and Jonglei states, given the challenges that arose in achieving this under the ongoing Health Rapid Results Project. The results of this collaborative process are captured in the design of the proposed Protection of Essential Health Services Project.

The proposed project will address the health challenges in the country and implementation bottlenecks witnessed in previous projects by: (i) ensuring complete geographical coverage of essential health and nutrition services in the two former states by providing direct service delivery support to health facilities; (ii) introducing flexible and dynamic approaches to service delivery such as outreach activities to high risk communities and IDPs; (iii) training and deployment of community health workers for preventive and basic curative services (and supporting the scale-up of the national Boma Health Initiative); (iv) training of lifesaving health professionals that are almost nonexistent in the country; including on counseling and treatment for SGBV victims; and (v) ensuring robust monitoring and verification measures are in place to proactively track results and monitor progress.

The value added of supporting basic health service delivery through a World Bank operation remains essential, given the Bank's ability to mobilize financing, provide higher-level technical oversight, and facilitate coordination and communication between partner agencies. In this regard, the value of providing support through the proposed operation can be seen as greater than the sum of its parts. The



proposed operation will result in the mobilization of significant resources for the provision of essential health services in a coordinated manner, bringing together diverse actors and using their comparative advantages to ensure that those with the greatest need benefit from the project's interventions.

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. These risks remain a reality for the Bank and partner agencies providing support to health services in two former states of Upper Nile and Jonglei and thus will remain so for the proposed operation, albeit potentially mitigated through the proposed project design and implementation arrangements.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The Project Development Objective is to increase access to 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

Key Results

The proposed PDO indicators, classified by project objectives, are the following:

Increase the utilization of an essential package of health services

- (a) People who have received essential health, nutrition, and population (HNP) services ²⁰;
 - a. People who have received essential health, nutrition, and population (HNP) services - Female
 - 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;
- (b) Number of curative consultations provided for under 5 children;

Increase the quality of an essential package of health services

- (c) Number of health facilities with essential medicines available;
- (d) Number of health facilities providing at least 75 percent of the essential package of health services; and
- (e) Proportion of disease outbreaks detected and responded to within 72 hours of confirmation.

D. Project Description

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

²⁰ A composite indicator with the sum of: (a) children immunized; (b) women and children who have received basic nutrition services; and (c) deliveries attended by skilled health personnel.



particular focus on the former states of Upper Nile and Jonglei for an implementation period of 24 months (calendar years 2019 and 2020). It is necessary that the project includes a level of flexibility in the geographical targeting 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 the former states of Upper Nile and Jonglei, the project will specifically target vulnerable populations, such as women, children and populations affected by conflict and violence. 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.

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, such as women, victims of violence and children. 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 former states.

Component 1: Delivery of Essential Health Services (US\$95 million)

Component 1 will support the provision of a defined package of essential health services, targeting the populations of the former states of Upper Nile and Jonglei, and other vulnerable communities affected by conflict and violence. 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 services²¹. Priority services also included in package mental health and psycho-social support services and services serving victims of SGBV, such as clinical management of rape. Component 1 will support the delivery of these services 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 communities.

Component 1 will channel resources through partner agencies ICRC and UNICEF, who will lead coordination of the delivery of the package of essential health services in the two former states and other areas in the country acutely affected by the conflict. Implementation strategies will include: (i) direct service provision of said agencies using their own staff; (ii) sub-contracting local and international NGOs (Implementation Partners, IPs) to support the coordination and delivery of health services; and (iii) strengthening the management capacity of County Health Departments and local service providers where possible.

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

²¹ The Ministry of Health's official the Basic Package of Health and Nutrition Services (draft 2011 and 2018 versions) is long and overly ambitious, covering NCDs and more. The component will support high impact essential services distilled from the comprehensive MOH BPHNS package, taking into account: (i) Consultations with stakeholders, especially with a view to alignment with Health Pooled Fund 3; (ii) Support that will be provided from other partners (e.g. OFDA, ICRC, UNFPA, WHO); (iii) Resources available; (iv) Intrinsic capacity of human resources for health available in South Sudan to deliver the services; and (v) Prioritization of services with the greatest impact, especially for women and children.



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 partners will be to mobilize all the available commodities, vehicles and human resources required to implement the outreach activities and supplement these resources where needed.

To align with other donor financing in the country such as the Health Pooled Fund and fill critical resource gaps, as with HRRP, the primary geographical focus for the operation will be the former states of Upper Nile and Jonglei. Yet as the security situation in the country remains unpredictable and the need to delivery health services in conflict-affected areas may arise outside these two former states, the component will also finance the delivery of primary and secondary care by ICRC in other areas affected by conflict and instability. To align with the financing and delivery of basic services by HPF3 in the eight former states, UNICEF's geographical coverage will remain within former Upper Nile and Jonglei, covering more accessible areas where ICRC will not be operating.

Delivery of high impact essential health services in the former Upper Nile and Jonglei States (US\$63 million)

Under this component, UNICEF will support the delivery of cost-effective, high impact essential health services to the general population living in the former Upper Nile and Jonglei States. These include areas relatively accessible and not acutely affected by conflict, where traditional support to basic service delivery can be provided. The estimated population in these areas is 1.8 million of the total population estimated by the National Bureau of Statistics (3,631,202 people). This includes: 145,248 pregnant women; 130,432 children under one; and 424,928 children under five.

The package of services and scope of activities to be supported by UNICEF includes:

Child health services: Health education; routine immunization (including via outreach); integrated management of neonatal and childhood illnesses (IMNCI) and referral for complicated cases; insecticide bed net (LLITNs) distribution; vitamin A supplementation; promotion of adequate infant and young child feeding behaviors; and nutrition screening and referral to adjacent nutrition therapeutic programs.

Maternal and neonatal health services: Health education; antenatal care (ANC4+: ANC profile will include Hb, urinalysis, rapid diagnostic testing for malaria, HIV and syphilis); antenatal care interventions (2 tetanus toxoid, deworming, iron folate supplementation, intermittent preventive treatment for malaria, and insecticide bed net distribution; skilled delivery; postnatal care of mothers and newborns; family planning; and referral (if required) for secondary health services.

Basic and comprehensive emergency obstetric and newborn care: To be delivered at the Primary Health Care Center (PHCC) and hospital level.

Sexual and gender-based violence services: Identification, counselling, management and proper referral for victims of SGBV, including rape victims;

Procurement and distribution of essential medicines and supplies: Vaccines; vitamin A; oral rehydration solution (ORS) and zinc; medicines for deworming; antibiotics; and other essential medical supplies.

Emergency preparedness and response: Building the capacity of partners to detect, assess and respond to health needs in the event of emergencies and disease outbreaks. UNICEF will integrate emergency preparedness and response into planning, capacity development, monitoring, and coordination. Kits and emergency health supplies will be prepositioned especially during the dry season (in secure warehouse



locations), and contingency plans and standby agreements will also be put in place with local partners to provide rapid surge capacity where needed.

Disease surveillance and outbreak response: In line with the nationwide Integrated Disease Surveillance Response (IDSR) and Early Warning Alert and Response (EWARS) systems, partners will collect data from health facilities; and participate in field investigations and activities to respond to outbreaks such as cholera, viral hemorrhage fever, and malaria. UNICEF South Sudan will adopt an integrated approach, combining WASH, health and Communication for Development to ensure effectiveness and efficiency of outbreak preparedness, response and control interventions. Preparedness efforts are continuously being carried out, including through training of government and partner staff as well as through timely procurement and prepositioning of supplies to all 10 field offices to enable swift access by partners. Outbreak response will aim to respond to outbreak alerts through case management, surveillance, cold chain and vaccine management for the conduct of emergency immunization campaigns, social mobilization and risk communication.

Quality improvement and supervision: in-service training (with a focus on competency-based training); continuous quality improvement activities; infection prevention activities; supportive supervision; and promotion of procedures for proper waste management and disposal of sharps and other waste.

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 weather-constrained 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 programs 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 SGBV. In summary, three main delivery strategies will be adopted:

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.

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).



Advancing community health through the Boma Health Initiative (BHI): Targeting communities far away from existing health facilities through the BHI, a network of trained community health workers (CHWs) will be responsible for delivering a standard integrated package of promotional, preventive, and selected curative health services. Delivered at the household level, these services will focus on Child Health, Safe Motherhood, and basic Community Surveillance. As such, CHWs will be trained on disease surveillance and the reporting of service delivery data and vital statistics.

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 have 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 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.

Delivery of essential health services to highly vulnerable and conflict-affected populations (US\$32 million)

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. Component 1 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. These activities will be implemented by ICRC, given the organization's proven ability to deliver both basic services and life-saving interventions, even during upsurges in violence.

The conflict and violence-affected population (resident and displaced) from the catchment areas supported by ICRC will benefit from support to primary health care services and have access to essential, quality curative and preventive health care services with functional infrastructure and management, adequate resources and trained staff providing treatment and care in line with national standards. The activities implemented by ICRC will ensure that the targeted populations are being cared for in well-functioning, equipped and staffed primary and secondary care facilities. Project support will allow for these facilities to function normally and provide effective health services to the community through trained staff, in line with national standards. Residents and/or displaced populations from the catchment areas of the facilities supported under this component will have access to preventive and curative services, in a timely manner, including referral to secondary care when needed.

The component will support both the delivery of the package of essential services, but also include capacity building efforts. Activities in supported health facilities and hospitals will include: (i) training and support in managing medical stocks, supplies and pharmaceuticals; (ii) treatment for most frequent diseases and care in line with national guidelines; (iii) training and support to antenatal care, post-natal care, safe deliveries and Basic Emergency Obstetric and Newborn Care; (iv) training and support for the Boma Health Initiative to improve community involvement/ownership in health care; (v) medical care and mental health and psychosocial support for victims of violence, including conflict related sexual violence;



(vi) support to re-establish routine expanded program on immunization (EPI) activities; and (vii) referrals to secondary/hospital care where needed.

The scope of health care activities to be supported at the primary care and community level will include:

Curative care: Patients suffering from the most frequent diseases and/or injuries and/or physical consequences of sexual violence are properly diagnosed and treated, in line with international/national standards.

Women of child bearing age: Women of child bearing age receive qualitative sexual and reproductive health care meeting national standards as a minimum, including: ante- and postnatal care, safe and clean deliveries, basic emergency obstetric and newborn care, post-abortion care, family planning and timely referral in case of complications.

Children preventive care: Children are protected against vaccine-preventable diseases, malaria and malnutrition in line with national standards.

Mental health and psychosocial support: Victims of violence (including sexual violence) have their psychological and/or psychosocial consequences of violence needs met both in health facilities and by community actors.

Mental health and psycho-social support 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 is comprised of:

- Assessing mental health and psychosocial needs and available resources and support within ICRC's supported health facilities;
- 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;
- Strengthening the technical quality of and access to psychological services and to psychosocial support activities to promote emotional well-being by improving coping mechanisms;
- 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.

To have an impact on the continuum of care, a package of secondary health services (at the county hospital level) will be developed and implemented by ICRC in conflict-affected and inaccessible areas where referral possibilities are not or insufficiently available. While currently the majority of these populations targeted by the project are located in the former states of Upper Nile and Jonglei, target populations also reside in states such as Western Bahr el Ghazal State, Greater Unity State, and Greater Equatoria State. The project will have the flexibility to respond to conflict in both known and unforeseen hotspots throughout the country. 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 adaptive in a case of a changing security situation.

Component 1 will ensure that the wounded and sick in areas affected by conflict and other emergencies, benefit from quality hospital care meeting recognized international standards. The component will aim to ensure that Health care providers, facilities, transport services are free from violence, including



obstruction of access to health care, and that patients from the catchment area of the supported hospitals in need of hospital care have access to hospital services in a timely manner. In case of an emergency and/displacement the affected population receives timely emergency hospital care. The hospital management team of supported hospitals will be tasked with assuring human resource, clinical (including infection control) and material management meeting recognized international standards. ICRC will also implement capacity building strategies so that the health authorities (or liable partner) will have the basic capacity (e.g. access, structures, organization, competencies, tools, resources, network) to handle correctly the functioning of the project-supported hospitals.

At the secondary care level, the supported hospitals will include the following package of services:

- outpatient and emergency services;
- surgical service;
- non-surgical services (including non-surgical obstetrics, pediatrics, therapeutic feeding services, physiotherapy);
- clinical support services (pharmacy, laboratory, and imaging); and
- non-clinical support services.

Component 1 will finance costs for related to (i) technical supervision, monitoring and oversight by UNICEF of sub-contracted NGO implementing partners, and (ii) cross-sectoral support and program management costs (security, transport costs, IT support, monitoring and reporting) for ICRC and UNICEF.

Component 2: Monitoring, Evaluation and Learning (US\$3 million)

The Project will ensure that independent and credible data on health service delivery are generated.

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.

Component 2 will finance costs related to a national unified monitoring approach, as well as specific monitoring of project activities in areas accessible for independent monitoring, primarily those where UNICEF will be operating. The proposed approach builds 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 third-party monitor agencies. The monitoring entities' 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.

Efforts have been made to develop a common monitoring mechanism across Health Pooled Fund and WB-supported zones for the period 2019-2020. The methodology for monitoring has been jointly designed by World Bank and HPF contributors and will launch during the first quarter of 2019, when both HPF3 and the proposed operation plan to start implementation. The task team has leveraged resources from the Global Financing Facility (GFF) and the Country Management Unit (CMU) to contribute to the design of this shared monitoring approach across HPF and WB-supported zones.



The detailed monitoring arrangements are under the Results Monitoring and Evaluation section of the PAD. As a summary, several of the key design elements will include:

- The creation of a master health service functionality database, capturing development and humanitarian health services across donors;
- Verified data within database to increase confidence in analysis and reported results and provide measures of partner data quality and reporting accuracy;
- Monthly health service functionality bulletin and implementing partner data performance reports;
- Service availability and performance indicators, including client satisfaction;
- Quarterly technical review of health service functionality data with development and humanitarian stakeholders; and
- Lots Quality Assurance Sampling (LQAS) to measure coverage of key health service delivery indicators.

Cost sharing arrangements have been made with other partners (DFID, HPF3) to finance the national monitoring model for the 2019-2020 calendar years. Component 2 will finance costs related to implementing monitoring activities (a) - (e) in the geographical areas of the former states of Upper Nile and Jonglei, as well quarterly LQAS surveys (activity (f)) nationwide (including HPF3-financed zones).

Enhanced accountability and monitoring mechanisms will be put in place to track and address project performance. Both UNICEF and ICRC will submit quarterly financial and progress reports, providing data both on the project's Results Framework indicators, as well as narratives on implementation progress and challenges, social and environmental safeguards, and fiduciary aspects. Partner agencies 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 partner agencies to review progress based on a pre-identified methodology for reporting, counter-verification and Third-Party Monitoring. Innovative technologies such as use of mobile and geotagged data through the Kobo Toolbox platform will be applied to strengthen the quality and comprehensiveness of said third-party monitoring and verification mechanisms.

Health facilities where ICRC will be supporting service delivery will be excluded from the TPM arrangements, due to a variety of reasons. These include challenges TPM agencies may have in accessing areas where ICRC operates, due to insecurity or violence, and potential sensitivities with target populations and local authorities related to confidentiality of beneficiaries. Given these challenges, a robust monitoring and reporting approach has been jointly designed with ICRC that will maximize use of data, geo-referenced where possible, to provide the clearest picture possible regarding implementation of project activities and results achieved. The detailed monitoring arrangements for ICRC are presented in the Results Monitoring and Evaluation section of the PAD.

In addition to supporting monitoring and evaluation activities, Component 2 will also support activities that aim to generate greater knowledge on service delivery in contexts such as South Sudan, where an agile mix of development and emergency strategies are needed to achieve results. To better understand the ongoing needs and to design programs on the longer term that may be more development assistance-oriented but still include elements of emergency response, the component will support several



implementation research and learning initiatives. Potential topics to be explored by ICRC and UNICEF include, but will not be limited to:

- *Psychiatry*: Status of psychiatric services and clinical health needs in South Sudan;
- *Social Inclusion*: How to optimize the social inclusion program for clients of physical rehabilitation programs in South Sudan;
- *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); and
- *Social norms and health service delivery*: Development of an adequate health system under the specific context of social systems and diverse ethnic groups in South Sudan.

Component 3: Emergency Preparedness and Response (US\$2 million)

Sub-component 3.1: Public Health Emergency Preparedness (US\$2 million). This sub-component, implemented by UNICEF, will support the national Ebola Virus Disease Preparedness and Response Plan. UNICEF is currently providing surge technical support that participate in the multi-sectoral National and State Task Forces (in high risk areas) as well as technical working groups. The technical assistance being provided by UNICEF to national and state-level partners focuses on risk communication, social mobilization and infection prevention and control through experienced health, C4D and WASH specialist.

Within this context, the following preparedness interventions will be supported through sub-component 3.1. The activities, included in the national preparedness and response plan, are budgeted at approximately US\$650,000 and to be financed through retroactive financing to UNICEF:

Increase disease risk perception and adoption of prevention and control practices among at risk and affected populations: (i) State level sensitization and technical training of religious and community leaders, civil society organizations (CSO), youth and women's groups, private sector, local authorities, and public transporters on their role in disease prevention and control; (ii) Community sensitization through IEC materials, radio, TV and mobile platforms; (iii) Community and group meetings at public points including markets, villages, towns, festivals, funerals, transit points, schools, and social service delivery points; (iv) Support risk communication using the film van-community and video shows and (v) Prepare guidance and materials.

Strengthen capacities of key stakeholders in risk communication related to prevention and control: (i) Map implementing partners and local communicators in high-risk counties; (ii) Sustain the demand and utilisation of services and positive behaviour practices; (iii) Train community leaders, religious leaders, traditional healers, and the media at state and national levels; (iv) Establish a mechanism for community surveillance as well as to collect and address rumours; and (v) Review/update training curriculum and training aids for the training of the community mobilizers.

Preposition/stockpile of critical supplies and improve identified health facilities with infection prevention and control (IPC) services: (i) Procure and prepositioning of water, sanitation and hygiene (WASH) and Personal Protection Equipment (PPE) supplies and standard operating procedures related to prevention and control of EVD outbreak; (ii) Provision of water and sanitation services including installation of hand washing facilities in screening points and EVD Isolation Units in Juba, Yei, Yambio and Nimule; (iii) Raise awareness on good hygiene practices at health facilities/Isolation Units, and key public



places around screening points and Isolation Units through installation of hand washing facilities; and (iv) Training of implementing partners, especially health and WASH personnel, on investigation of alerts and immediate outbreak response, as well as requirements for IPC associated with the preparation of disinfectants of different concentrations, excreta disposal and monitoring of water quality.

To ensure that the project is as agile and responsive as possible to emerging public health emergencies, an additional US\$1.35 million will be allocated to this sub-component as prepositioned contingency funds in the result of a disease outbreak or public health emergency, whether it be EVD or other. The funds will be used, after receiving approval from the World Bank task team, as an immediate response while additional response funds, through the sub-component 3.2 or other means, are being mobilized.

Sub-component 3.2: Contingency Emergency Response (CERC) (US\$0 million). The objective of sub-component 3.2 is to improve the country’s response capacity in the event of an emergency, following the procedures governed by OP/BP 10.00 paragraph 12 (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 areas affected by such event. In anticipation of such an event, this component will allow UNICEF and/or ICRC to receive support by reallocating funds from other project components or serving as a conduit to process additional financing from the Pandemic Emergency Facility (PEF) or other funding sources for eligible emergencies to mitigate, respond and recover from the potential harmful consequences arising from the emergency situation. Disbursements under this component will be subject to the declaration of emergency and the preparation of an “Emergency Response Operational Manual” (EROM) by UNICEF and/or ICRC, agreed upon by the Bank.

Component 4: Refinancing of Project Preparation Advances (US\$5.4 million)

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).

Table 2: Project Components Costing Table

Project Components	IDA Financing
Component 1: Delivery of Essential Health Services	95
Component 2: Monitoring, Evaluation and Learning	3
Component 3: Emergency Preparedness and Response	2
Component 4: Refinancing of Project Preparation Advances	5.4
Total Costs	105.4



C. Project Beneficiaries

The project beneficiaries are twofold. First, project beneficiaries include **the general population of the former states of Upper Nile and Jonglei, with a particular focus on women of reproductive age and children under 5**. The former states of Upper Nile and Jonglei have a population of just over 3.5 million (1,434,319 and 1,878,045 respectively), accounting for approximately 28 percent of the total population of South Sudan (13.4 million). Of those, 1,567,436 are female, 407,533 (26 percent) are of child-bearing age, 78,372 (5 percent) are pregnant women, and 313,487 (20 percent) are children under five.

The second set of project beneficiaries are **populations affected by insecurity, conflict and violence, both resident and displaced**. While currently the majority of these populations targeted by the project are located in the former states of Upper Nile and Jonglei, target populations also reside in states such as **Western Bahr el Ghazal State, Greater Unity State, and Greater Equatoria State**. Given the unpredictability of the environment in South Sudan, geographical areas affected by violence and conflict may also be targeted if the need arises, ensuring that affected populations benefit from support to primary and secondary health care services and have access to essential, quality curative and preventive health care services with functional infrastructure and management, adequate resources and trained staff providing treatment and care.

E. Implementation

Institutional and Implementation Arrangements

The IDA grant recipients for this operation are UNICEF and the International Committee of the Red Cross. Both UNICEF and ICRC 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 in South Sudan. While each organization will be responsible for a defined set activities and geographical coverage, based on the project design and their institutional comparative advantages, together they will ensure an essential package of health services is provided to the project's target populations. Both organizations have significant experience supporting health service delivery in the targeted areas. Beneficiaries will include the greater population of former Upper Nile and Jonglei, as well as specific target populations acutely affected by the conflict outside of the two priority former states. Both ICRC and UNICEF will have sufficient autonomy in implementation, allowing them to respond in a flexible manner to ever-evolving conditions in the two former states.

UNICEF, through the sub-contracting of implementing partners and use of their field offices locations in former Upper Nile and Jonglei and logistics platforms, will provide support to the approximately 200 primary health care facilities and several strategic secondary facilities in the counties of former Upper Nile and Jonglei that are currently relatively accessible. Activities to be managed by UNICEF include contracting of facilities, paying health worker incentives, procurement and delivery of essential commodities, training, coaching, supervision, and facilitating reporting at scale across contracted facilities. It should be noted that many of these health facilities also receive support from other development partners and humanitarian agencies. Coordination efforts between UNICEF, partners and MOH to avoid overlaps and redundancies will be made through meetings at the country and state health bureaus, as well



as in the health and humanitarian coordination clusters in Juba. It will also play an overall coordination function to ensure that there are no gaps in service delivery and that duplication of effort is minimized. UNICEF performance, both in terms of implementation successes as well as results in service delivery, will be measured by the Third-Party Monitoring entities.

UNICEF has existing institutional and implementation channels for the delivery of essential services and ensuring the availability of critical medicines nationwide. These implementation arrangements, which have proven successful in the past, have been able to adapt to the context and remain flexible, based on the security situation, health priorities, and strategies for negotiating access to hard to reach populations, to provide the identified package of healthcare services. Therefore, both organizations will work with the existing local health system structures at the governorate, district and community levels to preserve the national capacity and maintain the core functions of the health system.

ICRC, using its own internal service delivery mechanisms, will provide support to approximately 25 primary health centers and 2 secondary hospitals that serve highly vulnerable populations affected by conflict, primarily in Upper Nile and Jonglei. The areas that will be covered by ICRC are those that remain inaccessible to other partners due to insecurity, often being controlled by opposition and weapons-bearing parties. ICRC already has a significant presence in former Upper Nile and Jonglei, consisting of a network of sub-delegations and field offices (Figure 4, Upper Nile and Jonglei in red box). While these accessibility issues cause significant logistical challenges and high costs to guarantee appropriate services are offered, ICRC remains the only organization that has the capacity to reach these areas, and willing to scale-up support to beneficiary populations targeted by the project.

While the package of health services to be supported by ICRC and UNICEF will be similar in many ways, given the context-specific realities of South Sudan, each organization will adopt adaptive strategies to ensure these essential services are delivered. 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.

The implementation arrangements developed for the proposed project was found to represent the optimal approach for several reasons. First, the new project builds on a project that achieved results, despite significant challenges, in a highly fragile context. Lessons learned have been identified where aspects of HRRP did not work well or could be strengthened and have been integrated in to the design and implementation arrangements of new operation.

The project will use various mechanisms to target the worst off and use the comparative advantages of ICRC and UNICEF to ensure prioritized populations benefit from improved access to essential health services. Those affected by conflict, displaced or isolated due to seasonal weather will be prioritized both in terms of financing as well as content of service delivery support. The project will ensure that the same essential package of services is provided to target populations in both government- and opposition-held territories. The prioritization of support efforts by ICRC and UNICEF will be based on population health needs, beneficiary eligibility criteria, without discrimination and independent political/group affiliation. In addition to their main activities supported by the project, UNICEF and ICRC will coordinate with humanitarian agencies to identify and serve health needs for IDPs that might be in displacement camps.

The project will ensure neutrality in providing service delivery support to target populations with the



clear objective of improving access to services for all people in the target former states. Services will be delivered to populations without discrimination and independent of geographical location or political/group affiliation. The experiences from HRRP regarding how to manage this in the current context, such as the delivery of pharmaceuticals to both sides, medical airlifts from wounded on both sides, negotiating access across conflict borders, and facilitating agreements for safe passage will all be integrated into the approach to service delivery in the target zones. These lessons will be clearly outlined in the Implementation Completion Report for HRRP currently under preparation.

The project is designed to harness the comparative advantages of ICRC and UNICEF by using their proven service delivery strategies in the country to meet the development objectives of the project. UNICEF will follow its own procurement procedures as Alternative Procurement Arrangements allowed by the World Bank New Procurement Framework Policy Section III. F. For ICRC, an approach has been developed where the IDA grant will only finance salaries of ICRC staff and utilities/running costs directly related to the program defined under this project. As such, IDA financing will not be used for any procurement within the defined scope of activities implemented by ICRC. This implementation arrangement is recommended by the Project Procurement Strategy for Development (PPSD) based on the fact that the procurement procedures of UNICEF were assessed and found acceptable to the World Bank under other agreements, and project financing will not be used for any procurement under the IDA grant to ICRC. This procurement arrangement is considered a fit-for-purpose arrangement.

Closing date and implementation schedule. Given IDA resource constraints, the unpredictable setting and urgent health needs in South Sudan, the planned activities under the proposed operation have an estimated budget for 24 months but will be implementation period will be over a period of 2.5 years (February 1, 2019 to July 31, 2021). An additional six months is added to the project duration to allow for both flexibility to adjust strategies and timelines given the unpredictable environment, as well as to allow for the financial closure undertaken by the partner organizations.²² Refinancing of Project Preparation Advances from other operations will be conducted through the UNICEF Financing Agreement and processed immediately after effectiveness. Therefore, it is envisaged that the proposed US\$105.4 million IDA grant will be disbursed over the period of 24-30 months.

F. 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; difficult-to-reach areas may be targeted also in other areas of South Sudan following sufficient provision of information by the partner and no-objection by the Bank. Minor rehabilitation of existing health facilities is expected, in aggregate to constitute 5-10% of the total budget of the project. All rehabilitation will take place within the existing footprint of the health facility grounds. No new construction is envisaged due to the limited funds as well as the risk of subsequent damage to the facility and/or risk of moving to another facility based on

²² Under UNICEF rules, there is a financial closure period of twelve months during which the ongoing activities need to be wrapped up (that is, goods delivered to the country, consultants' reports submitted, all invoices to subcontractors paid, and so on).



community needs. Provision of equipment and materials includes how to acquire and dispose material medical inputs without adverse impacts on environment and public health.

G. Environmental and Social Safeguards Specialists on the Team

Tracy Hart, Environmental Specialist
Simon Sottas, Social Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Environmental Assessment OP 4.01 is applicable to the project due to delivery of essential health services, to include maternal and child health services, mental health and psychosocial support (MHPSS), expanded program immunization, and treatment for the most frequent diseases. Potential adverse environmental impacts are expected to be limited, site-specific, and reversible. These impacts are expected to fall within one or more of the following categories: (i) provision, transport, storage, use and disposal of medicines and vaccines; (ii) medical waste management; (iii) worker health and safety; (iv) community health and safety; and (v) minor rehabilitation of current public health facilities. An Environmental and Social Management Framework (ESMF) has been prepared by each of the two organizations. Social risks have been assessed and mitigation measures planned via the Social Assessment conducted along OP 4.10.
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 People is applicable. As a result, Social Assessments (SAs) have been prepared



and broad community support has been assessed for project activities. As the overwhelming majority of project beneficiaries are considered IPs per the criteria set out in OP 4.10, no separate Indigenous Peoples' Plan is required and the elements of an IPP are included in the overall project design. As such, the mitigation measures identified in the SAs will be addressed by and mainstreamed into, the overall project activities. The poor and underserved remain central to the project in prioritization, with the restoration of services in the areas most affected by 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.

Involuntary Resettlement OP/BP 4.12	No	This policy is not applicable, as the project will not require any land acquisition or use of any lands other than land currently used by health facilities. There is expected to be limited rehabilitation of existing public health facilities. All rehabilitation is expected to take place within current health facility grounds.
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.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

Environmental Assessment OP 4.01 is applicable due to the purchase and administration of medicines, including vaccines, as well as the provision of essential health services, the latter of which includes risks associated with worker health and safety, patient and community health and safety; medical waste disposal; and minor rehabilitation of existing public health facilities. No large-scale, significant, and/or irreversible impacts are expected. Two Environmental and Social Management Frameworks (ESMFs) have been prepared, each with medical waste



management details within it. The grievance redress mechanism (GRM), as well as other social risk management activities regarding targeting issues, GBV, and conflict and violence, will be based on the two Social Assessments prepared in line with provisions of OP 4.10 by the implementing partners.

Significant gender and age-related protection concerns arise in this region; high-levels of gender-based violence (GBV) in South Sudan as a result of the conflict have been well documented. In the aforementioned study; 41 percent of respondents representing all population groups said that they had experienced GBV within the last year (Oxfam, 2017). Sexual violence is thus a significant concern. According to the Commission on Human Rights in South Sudan (A/HRC/37/71), acts of rape, mutilation of sexual organs and other forms of sexual violence were perpetrated against women, girls, men and boys, often in front of relatives, in order to humiliate victims, families and entire communities, or as a form of punishment in detention settings. Displaced persons are particularly vulnerable. In 2017, UNMISS documented 196 cases of conflict-related sexual violence, affecting 128 women and 68 girls (UN SRSR report, 2018). Child abductions and child recruitment have occurred, as well as early marriage of girls. “Gendered psychosocial stress” has also been evidenced, including for men who feel they are no longer able to uphold traditional roles as family providers (Oxfam, 2017). The activities financed by this project have been designed with these particular social issues in mind.

The project will significantly scale-up attention and efforts to improve access to services for SGBV victims. Clinical Management of Rape (CMR) and basic psycho-social support services are included in the essential package of health services offered at health facilities supported by the project. This includes identification, counselling, management and proper referral for victims of SGBV. Second, the availability of trained medical personnel to provide CMR and basic psycho-social support services to SGBV victims will be increased. Health professionals at facilities supported by the project will be trained in appropriate counseling and psycho-social support. Third, specialized mental health expertise will be expanded within the health workforce, with health facilities supported by the project including Mental Health and Psycho-Social Support (MHPSS) into the package of services offered and service providers trained in the subject. Finally, Codes of Conduct will be applied and monitored for project-supported staff and included in all contracts of all Implementing Partners.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area: No potential indirect and /or long term impacts due to anticipated future activities in the project area have been identified.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts. The project will not include any new construction of public health facilities or major works. Only minor rehabilitation of existing structures, where needed, will be financed. This is due to the need to direct all available funds to essential health services, as well as the risk of damage or loss of public facilities due to conflict. The greatest needs for the population are in the realm of vaccinations, maternal and child health (MCH), treatment of frequent diseases, and mental health and psychosocial support (MHPSS), which can be provided primarily at the primary care and community levels. These essential health services have less adverse impacts than those associated with hospitals. A few strategically-located secondary hospitals will be supported in an effort to improve access to services that cannot be provided at the primary care level, as well as strengthen referrals between primary care and higher levels. The same safeguards policies will apply to hospitals as primary care centers.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described. Both partners (UNICEF and ICRC) have internal procedures in place to address safeguard policies issues. When needed,



these have been supplemented in order to comply fully with World Bank safeguards requirements. The measures taken are described more fully in the Environmental and Social Management Frameworks (ESMFs) and Social Assessments (SAs) of UNICEF and ICRC. Measures include, but are not limited to: cold chain storage and transportation systems for medical supplies; computerized inventories; medical waste management plans (MWMPs); Codes of Conduct; continuing education for both international and locally-hired medical staff; grievance redress mechanisms both internal to the implementing partner as well as to receive and address client/patient complaints. Both organizations have the capacity to implement the measures described above. The organizations must demonstrate their capacity, as well as their compliance, through monitoring and reporting documentation to be submitted to the World Bank on a quarterly basis.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

Primary stakeholders are pregnant women, new mothers and children. Secondary stakeholders are the broader communities in the catchment areas of health facilities and hospitals supported by the project.

Throughout 2018 in the former states of Jonglei and Upper Nile, the project partner organizations (UNICEF and ICRC) conducted monthly consultations with Community Health Committees (CHCs) as well as elected representatives of the local communities, in addition to cooperation on a day-to-day basis with local health staff and beneficiaries.

Where CHCs exist, they are regularly invited to participate in stakeholder consultations. Where CHCs do not exist, the organizations encourage the communities to form them and elect representatives, encouraging diverse representation. The partners may support CHC participation by providing meals for those attending meetings, as well as travel stipends for those who travel long distances to participate, in areas where public transportation is available. The meetings often take place at the health facility itself.

The CHCs are responsible for ensuring that communities are aware of ongoing activities, they also help ensure that the communities make use of the health facilities. The CHCs typically meet once per month, where they receive updates from the health facility staff on the functionality of the supported health facility and the development of health activities in the catchment area. The CHCs also update the technical teams on health concerns in their villages. Staff will regularly participate in CHC meetings to ensure functionality. Partner organizations will also ensure that proactive measures are taken to include vulnerable and marginalized groups or individuals in meaningful consultations, including women, elderly, displaced populations, ethnic minorities, etc., providing measures tailored to any specific needs. As such, separate consultations with these vulnerable groups may be necessary.

Consultations on a proportionally but equal level have also been conducted in the other states outside former Upper Nile and Jonglei at sites that will be supported by the project. Beneficiaries and CHCs have raised issues which focus on requests of further extending the support provided by ICRC and in parallel increase work opportunities for local communities. These consultations will continue throughout project implementation and partner organizations will regularly report, confidentially, to the World Bank in case outcome of consultations change risk levels and components for the Project.



B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank 29-Oct-2018	Date of submission for disclosure 27-Nov-2018	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
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"In country" Disclosure

South Sudan
13-Dec-2018

Comments

UNICEF: Public notices that summarize the Environmental and Social Management Framework and provide links to the online disclosure of the document have been posted on December 11, 2018 in central locations at main offices in Juba as well as all field offices in project locations, with hard copies available upon request in the field offices.

ICRC: Public notices that summarize the Environmental and Social Management Framework and provide links to the online disclosure of the document have been posted on December 13, 2018 in central locations at main offices in Juba as well as all field offices in project locations, with hard copies available upon request in the field offices.

Indigenous Peoples Development Plan/Framework

Date of receipt by the Bank 29-Oct-2018	Date of submission for disclosure 27-Nov-2018
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"In country" Disclosure

South Sudan
13-Dec-2018

Comments

UNICEF: Public notices that summarize the Social Assessment provide links to the online disclosure of the document have been posted on December 11, 2018 in central locations at main offices in Juba as well as all field offices in project locations, with hard copies available upon request in the field offices.

ICRC: Public notices that summarize the Social Assessment and provide links to the online disclosure of the documents have been posted on December 13, 2018 in central locations at main offices in Juba as well as all field offices in project locations, with hard copies available upon request in the field offices.

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment



Does the project require a stand-alone EA (including EMP) report?

Yes

If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?

Yes

Are the cost and the accountabilities for the EMP incorporated in the credit/loan?

Yes

OP/BP 4.10 - Indigenous Peoples

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?

No

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Yes

Have costs related to safeguard policy measures been included in the project cost?

Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

Yes

CONTACT POINT

World Bank



Paul Jacob Robyn
Senior Health Specialist

Fatimah Abubakar Mustapha
Health Specialist

Borrower/Client/Recipient

International Committee of the Red Cross
Christian Wabnitz
External Relations Manager
cwabnitz@icrc.org

UNICEF
Mahimbo Mdoe
Representative
mmdoe@unicef.org

Implementing Agencies

International Committee of the Red Cross
Christian Wabnitz
External Relations Manager
cwabnitz@icrc.org

UNICEF
Mahimbo Mdoe
Representative
mmdoe@unicef.org

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: <http://www.worldbank.org/projects>



APPROVAL

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

Safeguards Advisor:	Nathalie S. Munzberg	13-Dec-2018
Practice Manager/Manager:	Trina S. Haque	13-Dec-2018
Country Director:	Carolyn Turk	14-Dec-2018

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