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COMBINED PROJECT INFORMATION DOCUMENTS / INTEGRATED SAFEGUARDS DATA SHEET (PID/ISDS)
ADDITIONAL FINANCING

Report No.: PIDISDSA17265

Date Prepared/Updated: 08-Jun-2016

I. BASIC INFORMATION

A. Basic Project Data

Country:	South Sudan	**Project ID:**	P156917
		Parent Project ID (if any):	P127187
Project Name:	South Sudan Health Rapid Results Project AF (P156917)		
Parent Project Name:	South Sudan Health Rapid Results Project (P127187)		
Region:	AFRICA		
Estimated Appraisal Date:	06-May-2016	**Estimated Board Date:**	27-Jun-2016
Practice Area (Lead):	Health, Nutrition & Population	**Lending Instrument:**	Investment Project Financing
Sector(s):	Health (80%), Public administration- Health (20%)		
Theme(s):	Child health (30%), Health system performance (30%), Population and reproductive health (20%), Nutrition and food security (10%), Ma laria (10%)		
Borrower(s):	Ministry of Finance and Economic Planning		
Implementing Agency:	Ministry of Health		
Is this project processed under OP 8.50 (Emergency Recovery) or OP 8.00 (Rapid Response to Crises and Emergencies)?			

Financing (in USD Million)

Financing Source	Amount
BORROWER/RECIPIENT	0.00
IDA Grant	40.00
Total Project Cost	40.00

Environmental Category:	B - Partial Assessment
Appraisal Review Decision (from Decision Note):	The review did authorize to proceed with Negotiations, in principle
Other Decision:	Approval was received to apply OP10.00 paragraph 12 for the deferral of

	safeguards instruments to the implementation phase of the proposed second AF to enable the Ministry of Health to provide urgent care to the target population between the end date of the current AF (30 June 2016) and the second AF effectiveness.
Is this a Repeater project?	No

B. Introduction and Context

Country Context

In July 2011, after decades of civil war, South Sudan celebrated its independence from Sudan. Since the Comprehensive Peace Agreement signed with Sudan in 2005, the population has grown from 8 to 12 million. The total fertility rate is estimated at 6.7 children per woman, while the average life expectancy at birth for both sexes is 42 years. South Sudan is still characterized by high incidence of poverty, inadequate access to basic services, very limited access to economic opportunities, poor infrastructure, high mortality and morbidity rates and food insecurity. More than half of the population of South Sudan (51%) lives below the poverty line and income disparity is high. More than 90% of the population lives in rural areas.

The population is ethnically, linguistically, socially, and culturally rich and diverse. An estimated 70 languages are spoken, providing an illustrative example of the country's diversity. It has been estimated that there are about 65 South Sudanese ethnic groups with distinctive histories, traditions, and beliefs.

Since independence in 2011, South Sudan has experienced volatile macroeconomic performance due to conflict and oil-related shocks. South Sudan's economy is oil-dependent. Around 80% of its GDP is driven by petroleum-based activities. Until July 2014, oil exports represented more than 85% of the government's revenue. Due to the fall of global oil prices and lower production resulting from the conflict in the two oil producing states (Unity and Upper Nile State), the government's monthly revenue shrank by 75% - from over 800 million South Sudanese Pound (SSP) in July 2014 to 200 million SSP in August 2015. Outside of the oil sector, livelihoods are concentrated on low-productivity activities, subsistence agriculture and pastoralism, which account for less than 15% of GDP but engage about 78% of the population.

In December 2015, the government moved from a fixed exchange rate to a managed floating exchange rate regime, which has brought the parallel market exchange rate closer to the official one. However, the new regime has not prevented the continuing depreciation of the SSP against the dollar. Since December 2013, conflict and diminishing oil-based revenue have pushed the government to fund its deficit through an expansionary monetary policy. This has led to further depreciation of the SSP against the dollar. As most of the goods are imported, the combination of depreciation, lower foreign exchange reserves and growing money supply has been fueling inflation. In December 2015, the annual inflation reached 109.9 percent. Increasing food prices are particularly affecting poor households and contributing to widespread malnutrition.

The macroeconomic and fiscal situation remains extremely fragile. Despite the government's efforts to cut public spending and realign the exchange rate with the market rate, depreciatory and inflationary trends remain. With global forecasts estimating average oil prices at US$37 per barrel

in 2016, the government has sought to renegotiate the Transitional Financial Agreement with Sudan (currently fixed at US$26.5 per barrel that transits through Sudan's pipelines). Discussions are still ongoing but in the short term, an agreement with Sudan would create some fiscal space for the government of South Sudan.

Since December 2013, South Sudan has been affected by political instability and renewed conflict. The past two and a half years have seen several unfulfilled peace agreements between the Government and the opposition (Sudan People's Liberation Movement-in-Opposition [SPLM-IO]). The latest peace agreement was signed in August 2015, and a Transitional Government of National Unity (TGoNU) was formed on April 29, 2016. Even though the opposition returned to Juba and the political environment appears calm, the implementation of the peace process and consolidation of the TGoNU remains a challenge given the difficult fiscal and macroeconomic context. In line with the peace process, the UN Security Council passed Resolution 2252 extending and expanding the mandate of the UN peacekeeping mission. There will now be some 15,000 UN uniformed military and police personnel for the mission, w ith protection of citizens as its top priority. A key instrument of mediation support, created in the Agreement, is the Joint Monitoring and Evaluation Commission (JMEC), led by the former President of Botswana, Festus Mogae, charged with shepherding the peace process during the transition.

Sectoral and institutional Context

Decades of conflict, massive displacement of the population, widespread insecurity, and the consistent underinvestment had led to the collapse of the health care system resulting in poor health status of the population by the time of the Comprehensive Peace Agreement in 2005. South Sudan had one of the highest Maternal Mortality Ratio (MMR) in the world, estimated at 2054/100,000 live births in 2006. Although close to 69.0% of pregnant women attend at least one Antenatal Care (ANC) visit, only 27.5% of deliveries are attended by skilled health professionals. Institutional deliveries account for just 27.2% of births, while the contraceptive prevalence rate (CPR) is 5.0%. The Infant Mortality Rate (IMR) and Under-five Mortality Rate (U5MR) were very high at 102 per 1000 live births and 135 per 1,000 live births, respectively. South Sudan is also home to most of the world's neglected tropical diseases (NTD); 13 of the 17 prioritized NTDs are endemic in South Sudan. Malnutrition remains high with 31% stunting under 5 years of age and general acute malnutrition at 23% despite very fertile land and adequate rainfall mainly due to the impact of war.

The crisis has impacted the health system in the three most conflict-affected states - Unity, Jonglei, and Upper Nile - more strongly than in the rest of the country. Insecurity, destruction of facilities, access constraints for personnel and medical supplies, rampant malnutrition and massive population displacements have put a significant stress on an already weak health system. In the two states supported by the World Bank, the number of fully functional facilities was more than halved during the first year of conflict. Consequently, health outputs such as vaccination coverage (DPT3 and measles) declined. In the other eight states covered by USAID and the Health Pooled Fund (HPF), service delivery was less affected by the conflict (with the notable exception of Unity).

While health services were almost entirely interrupted in the state of Unity, the World Bank supported project enabled the Ministry of Health (MOH) and the contracted Coordination and Service Delivery Organization (CSDO) financed through the project to maintain health care in Jonglei and Upper Nile and put the health system on the tracks of early - though slow - recovery. Continuing conflict in Upper Nile (where most of the fighting between the government and the

opposition forces takes place) has increased the difficulty and cost of ensuring the delivery of services. In Jonglei, health outputs have recovered to their pre-conflict levels. However, new sources of violence are hindering the gradual recovery process.

The availability of medicines in the country is a major concern for the MOH and health partners. The lack of medicines in health facilities not only affects the capacity to treat patients but also reduces their care-seeking behaviors, independent of whether the pathology requires drugs-based treatment. Thus, lower availability of drugs affects the utilization of health services.

C. Proposed Development Objective(s)

Original Project Development Objective(s) - Parent

The project development objectives (PDOs) are(i) to improve the delivery of high impact primary health care services in Recipient'sstates of Jonglei and Upper Nile; and (ii) to strengthen coordination and monitoring and evaluation capacities of the Ministry of Health.

Key Results

Component 1: Delivery of high impact Primary Health Care services. The primary health care services are supported in the two states of Jonglei and Upper Nile and include maternal and child health services such as vaccination, prenatal care, skilled birth attendance, etc. Under the supervision of the MOH and State MOHs, the CSDO supervises service delivery, mobilizes human resources, procures and distributes pharmaceuticals and other inputs, and helps determine the need for additional health facilities.

Progress under Component 1 is satisfactory. The MOH has reviewed and approved the latest progress reports (for the period of January-September 2015) on services delivered by the CSDO. These have been verified by the M&E firm contracted by the MOH for this purpose under Component 2 of the Project. The CSDO services both Jonglei and Upper Nile States. a) Jonglei: Under the supervision of the CSDO, services are delivered through 151 primary health care facilities. In addition, the CSDO has undertaken activities to strengthen the capacity and function of CHDs in 11 counties across the state. Services are delivered by sub-contracted NGO partners in each of the 11 counties through CHDs, all Primary Health Care Centers (PHCCs) and Primary Health Care Units (PHCUs). In addition, the CSDO also supports three NGOs that support county hospitals in Boma, Akobo, and Duk.
b) Upper Nile: Under the supervision of the CSDO, services are delivered through 132 primary health care facilities. In addition, the CSDO supports the strengthening of the capacity and function of the CHDs in 13 counties across Upper Nile. As in Jonglei, the CSDO directly supports five counties (Malakal, Akoka, Manyo, Melut, and Renk) in collaboration with the State Ministry of Health (SMOH) by direct subcontracting of the CHDs. The CSDO provides materials and funding to carry out essential functions such as monitoring and reporting, supply of materials and drugs, and supervision. In the other eight counties, the CSDO subcontracts NGO partners to support CHDs, all PHCCs, PHCUs, and County Hospitals. The CSDO Reports indicate that continuous engagement with the communities through CHDs and NGOs have taken place to increase community involvement in project activities and discuss potential issues related to service delivery.

After the flare up of fighting in November 2013, of the 283 health facilities that were covered by the HRRP, the number of functioning facilities went down. This was mainly due to looting of

commodities, destruction of the facilities and cold chain systems along with displacement of the populations and health care providers as a result of insecurity. However, even throughout the conflict, 65% of the facilities in the affected areas continued to provide services to the population of South Sudan as compared to 80-90% before the conflict.

Component 2: Strengthening implementation capacity of MOH at the national level has two sub-components as follows: (i) strengthening Grant and Contract Management: this sub-component supports the strengthening of the MOH capacity to plan, manage, and monitor grants and contracts; and (ii) bolstering the M&E function: this sub-component ensures that there is a steady stream of independent and credible data on health and sector performance.

Progress under Component 2 is satisfactory. Working with the consultant independent monitoring and evaluation firm, the MOH has already undertaken a District Health Information System (DHIS) initiation and refresher course for 30 SMoH M&E Coordinators and other MOH staff. A Health Facility survey as well as a Household Survey on a state by state basis were conducted in the last quarter of 2015. The HMIS 2014 report was finalized. A Lot Quality Assurance Sampling (LQAS) survey was undertaken in March-June 2015 and the draft report has been submitted to the MoH. The M&E firm has also provided assistance to the MOH and SMOHs to verify implementation progress and ensure results and targets are achieved by the CSDO in Jonglei and Upper Nile. The firm has verified that the targets reported by the CSDO have been met and surpassed in certain areas. The MTR mission found that it was challenging to monitor progress of the second component on strengthening implementation capacity and coordination of the MOH and hence the proposed AF will include new indicators to ensure effective tracking of this PDO.

The Project is also supporting a Performance Based Contracting pilot for county hospitals, CHDs and facilities and results are promising. All 24 CHDs and approximately half of the 283 MOH supported health facilities have the opportunity to earn monthly incentives based on the attainment of 5-6 key project indicators. Incentives are given as block grants to institutions (not to personnel) and paid out monthly on a sliding scale based on performance. MTR recommended that the PBF mechanism, though functioning well, will need to be re-evaluated especially the area of Quarterly Verification Visits (QVV) which is critical for data verification used to initiate payment. In view of the conflict and fragility affecting the states supported by the projects, undertaking QVV missions is quite a challenge.

D. Project Description

The original grant for the South Sudan Health Rapid Results Project (HRRP) of US$28 million was approved on April 2, 2012, and became effective on August 2, 2012, with an original closing date of October 31, 2014. The first Additional Financing (AF), of US$25 million in IDA grant and US$10 million in IDA credit, was approved on March 13, 2014 and became effective on September 9, 2014. The current closing date is June 30, 2016. The proposed second AF of US$40 million would help continue the activities initiated under the Project to ensure sustainability and continue with maximizing the health development impact. This includes activities under component one which focus on improving the delivery of high impact primary health care services in Upper Nile and Jonglei states. For implementation of this component, the Ministry of Health (MOH) performance-based contract with a Coordination and Service Delivery Organization (CSDO) will be signed. The CSDO will continue to play an overall coordination function to ensure that there are no gaps in service delivery and to minimize duplication of efforts.

Under Component two, the proposed AF would continue to support the MOH and State Ministries of Health in their management and stewardship roles. This would include strengthening (i) MOH grant and contract management and (ii) monitoring and evaluation (M&E) functions by improving routine data collection through the Health Management Information System (HMIS) and Quantitative Supervisory Checklists, and ensuring timely health facility surveys and household surveys. A new third component has been added that will primarily focus on the procurement and distribution of pharmaceutical commodities in the country. The financing of pharmaceuticals following the MDTF (2011 to 2013) was done through the Emergency Medicines Fund (EMF) from 2013 to 2014 for South Sudan. The EMF financed a one-year supply of essential medicines and health commodities. This program ended in June 2015. A stopgap measure was constituted with financing from DFID ($12 million) and USAID ($4 million) as "a mini-EMF" for emergency pharmaceutical supplies to cover up to June 2016 through the Health Pooled Fund (HPF). The pharmaceuticals procured through the mini-EMF will be distributed countrywide. Subsequently, the HPF will only procure medicines for the states it serves hence the importance of having a strong component on pharmaceuticals for Upper Nile and Jonglei, the states supported by the project.

Component Name

Component 1: Delivery of High Impact Health Services in Jonglei and Upper Nile States.

Comments (optional)

Support the MOH's performance-based contract with a Coordination and Service Delivery Organization (CSDO) to improve the delivery of high impact primary health care services in Upper Nile and Jonglei. The primary health care services to be supported include maternal and child health services such as vaccination, prenatal care, skilled birth attendance, etc. The extent of coverage of the current design of the performance based contracting model which basically covers all geographical areas within Jonglei and Upper Nile states will remain unchanged.

Component Name

Component 2: Strengthen Implementation capacity of MOH at the National Level.

Comments (optional)

The component has two sub-components as follows:

Sub-component 2.1 (US$1.0 million) supports the strengthening of the MOH's capacity to plan, manage, and monitor grants and contracts under this AF. With the positive performance of the PMU under the project, the MOH plans to expand its role with a view to support and coordinate all donor supported programs and financing.

Sub-component 2.2 (US$3.0 million) aims to ensure that there is a steady stream of independent and credible data on health and sector performance. Following the findings of the MTR, new indicators would be included to fully monitor progress of M&E and capacity building of the MoH for contract management and coordination.

Component Name

Component 3 (new): Procurement of Pharmaceutical Commodities and logistics.

Comments (optional)

This will support the financing of pharmaceutical commodities and logistics to deliver to the beneficiaries following dynamics on ground as regard procurement and distribution of

pharmaceuticals by the three principle Primary Health Care providers.

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

The project is being implemented in the two states of Jonglei and Upper Nile. The geographical terrain is swampy lowlands, part of the Nile basin. This makes implementation of the project extremely difficult in the rainy season when most areas are cut off due to floods. Issues of medical waste and safe water management become relevant.

F. Environmental and Social Safeguards Specialists

Anton Karel George Baare (GSU07)

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II. Implementation

Institutional and Implementation Arrangements

South Sudan has a decentralized system of governance. In health the implementing entities are the states receiving support from the central government. However, due to low levels of human capacity and infrastructure, service delivery is mostly led by both national and international NGOs. In addition, the overall financing from both the central and the local governments is low. This makes implementation by the existing County Health Departments (CHDs) challenging. For the other Primary Health Care (PHC) programs, implementation is also through NGOs as implementing partners.

The Project Management Unit (PMU) in place comprises the Project Manager, Financial Management Specialist, Procurement Assistant, Health Planner, and M&E Specialist. To strengthen the implementation capacity of the State MOHs, the project is supporting a Planning Officer for Jonglei. It has been challenging to recruit for a similar position in Upper Nile due to insecurity. Given the successful project implementation under the PMU, the MOH sees itself in a stronger stewardship role whereby it will support and coordinate all donor-supported programs and financing. In addition, over the past 2.5 years, some County Health Departments (CHDs) contracted-in by the CSDO have demonstrated capacity for continued engagement and delivery of health services. For the proposed AF, increasing the number of contracted-in CHDs with complementary support from implementing partners (IP) will be explored as part of the overall implementation capacity strengthening for the CHDs. Over time, this would lead to a more sustainable model of service delivery given the significant role that the counties play in managing and providing services. The CSDO has continuously carried community meetings to promote community involvement in the project activities and discuss potential issues with health facilities. Moreover, some communities have established Village Health Committees composed of community members that discuss with facilities and local authorities issues related to service delivery. The second AF will provide support for scaling up this community engagement mechanism.
The financial management (FM) arrangements under the project will remain the same. The project's FM has been assessed to be satisfactory. FM risk is high given that the project is implemented in Jonglei and Upper Nile States which are two of the most affected states by the current conflict.

The arrangements for procurement management under the original project will remain unchanged. Procurement for the proposed second AF will be carried out in accordance with the Bank's Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers, dated January 2011 and revised in 2014 and Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers, dated January 2011 and revised in 2014. The flexibilities in the procedures described in OP 10.00 will be used. The MOH developed a Procurement Plan (PP), dated June 7, 2016, which will cover the duration of implementation of the proposed second AF. The PP for the use of the PPA amount of US$4.0 million has already been prepared by the MOH and reviewed and cleared by the Bank. The PP will be updated in agreement with the Bank project team on an annual basis or as needed to reflect the actual project implementation needs. For the period covered by the PPA (April 1, 2016, until effectiveness of the AF expected by August 31, 2016), the current contracts with the CSDO, which expired on March 31, 2016, will be extended in the amount of US$2,113,692 million for Jonglei and US$1,886,308 for Upper Nile contracts, respectively.

For the proposed second AF, the current CSDO contracts will have expired and will leave gaps in service delivery in the two states. Given the emergency situation, a CSDO must be operational by effectiveness of the proposed additional financing, in both states. In this regard, clearance was received from the Operational Procurement Review Committee (OPRC) to extend the current contracts. The estimated contract value for each state is US$10.5 million for service delivery until September 2017.

Similarly, concerning the supply and distribution of medicines for the two states, clearance was provided by the OPRC to the direct contracting of an agent, Crown Agents/International Procurement Agency (CAIPA). The agent will be responsible for the purchase, storage, and distribution of pharmaceutical commodities under the proposed second AF by August 2016 given that the stock of the drugs is estimated to last until August 2016. The agent will be contracted under a supplier contract based on the Bank's standard contract form of Health Sector Goods. This contract would be developed and finalized with inputs and clearance from the Africa Region Procurement Manager. The estimated value for this procurement is US$15 million.

Due to limited procurement capacity, the support of the procurement officer will continue during the proposed second AF period. Keeping in view the overall country procurement environment due to the security condition in the country, the overall procurement risk is rated as High.

III. Safeguard Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Due to the procurement of pharmaceuticals and disposal of medical waste
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP	Yes	Providing emergency support to populations in states

4.10		mostly affected by civil conflict. Special priority is placed on women and children (Maternal and Child Health interventions) and also serving internally displaced people.
Involuntary Resettlement OP/ BP 4.12	No	
Safety of Dams OP/BP 4.37	No	
Projects on International Waterways OP/BP 7.50	No	
Projects in Disputed Areas OP/ BP 7.60	No	

IV. 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:

The proposed second Additional Financing (AF2) is a continuation of the ongoing HRRP. There are no changes to either the PDO or the EA Screening Category, which is B. Like the original project, AF2 triggers OP 4.01 Environmental Assessment. The main environmental issues relate to health care waste management, in view of the risks associated with the handling and disposal of medical waste. Other issues that are expected include those pertaining to safe water supply, sanitation, and waste disposal that might arise due to minor renovation of existing functioning health facilities and health care activities.

The first Additional Financing (AF1) triggered OP/BP 4.10 on Indigenous Peoples, which is applicable to AF2. Analysis by World Bank and other experts confirmed, at the time of processing AF1, that the overwhelming majority of people in the project area are expected to meet the requirements of OP 4.10. These considerations were consistent with a national level ESSAF in place at the time (2012 - 2014) and that was informed by an at the time ongoing and comprehensive study on South Sudan's ethnic composition and indigenous populations.

The implementation period of AF1 coincided with an intensification of internal conflict in the country that hindered a planned social assessment and consultations. While the situation on the ground is improving, the Jonglei and Upper Nile States are among still affected states. For these reasons the team requested and was granted deferral of safeguards under OP10, para 12

During the AF1 implementation period comprehensive ethnographic research continued in order to better understand the specific vulnerabilities South Sudan's ethnic groups. It combined an extensive desk review with new field research to gather additional information on informal and formal institutions, the status of women and girls, youth aspirations and opportunities, livelihood strategies, economic opportunities, and traditional arbitration and grievance redress systems. This body of work also covers the mix of ethnic groups in Jonglei and Upper Nile states were the health project is implemented.

The approach and implementation process of the proposed Project embeds the basic principles of OP 4.10 and ensures that (i) benefits will flow to all households, and (ii) outreach and citizen

engagement activities under component 2 enable support for the project and participation of the entire community.

The preparation of a project social assessment and Environmental and Social Management Framework (ESMF) began under AF1, but the Ministry of Health (MOH) was unable to fully engage in the states of Upper Nile and Jonglei as some areas were partially controlled by the opposition during the conflict. The formation of the Transitional Government of National Unity, which was materialized in April 2016, provides a new window of opportunity to conduct a social assessment. With the approved safeguards deferral, the team and the borrower will finalize the project social assessment and update the ESMF no later than one month after the effectiveness date of AF2.

To avoid/offset the anticipated environmental impacts, AF2 will use the updated project specific ESSAF that explains the OPs triggered, safeguard screening and mitigation based on the possible types of sub-projects, responsibilities for safeguards screening and mitigation, capacity-building and monitoring of safeguards framework implementation, and consultation and disclosure.

The ESSAF was first disclosed as part of the parent project (P127187). As indicated in the parent project's ISDS, the ESSAF was updated to include the National Medical Waste Plan (see below). The updated ESSAF along with the Medical Waste Plan will be redisclosed as part of this proposed second Additional Financing (P156917). As part of the ESSAF framework, training and capacity building activities have been held targeted to the MOH Environmental Health Directorate (EHD) in order to strengthen their capacity for managing the environmental and health issues. To date the implementation of the ESSAF has been satisfactory.

The Medical Waste Management Plan (MWMP), prepared, finalized and disclosed in the Bank's InfoShop on February 10, 2014, will also guide AF2 implementation. The MWMP focuses on existing waste generation, as well as segregation, storage, collection, transport, and final disposal practices; technologies for waste disposal; public awareness programs; and relevant national legislation. The South Sudan Ministry of Health will continue to use this Plan as a guideline to avoid or minimize the potential impacts that could be generated due to the implementation of the project, particularly lack of proper hygiene and sanitation facilities and mismanagement of medical wastes.

During the implementation of the original project and first Additional Finance, no significant environmental or social impacts were identified; no instances of safeguards non-compliance were recorded; and all safeguards issues were managed by the best practice methods described in the ESSAF and Medical waste management plan.

OP 4.12 on Involuntary Resettlement is not triggered since minor renovations and upgrades are expected to be undertaken in existing facilities and there will be no taking of land under the project. Social impacts of proposed activities under the project will be addressed in accordance with the updated ESSAF that was prepared for the original project.

The Bank's safeguards team will work closely with the government to confirm the technical assistance and capacity building required at central, state and local government levels to ensure effective implementation of the ESSAF, MWMP, and Environmental and Social Management Plans (ESMPs).

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

There are no long term impacts or risks associated with the project in the project-supported states of Jonglei and Upper Nile.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

No project alternatives were identified in the implementation of both the parent project (P127187) and the first additional financing (P146413).

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.

The ongoing project and the proposed second AF trigger World Bank Safeguard Policy OP/BP 4.01 on Environmental Assessment similar to the original project. To offset the potential adverse impacts of the project, the Borrower has begun to mitigate the impacts that may be generated due to the distribution and use of medical supplies based on the ESSAF and the MWMP. Based on the screening process outlined in the ESSAF, the client will continue to conduct an environmental impact assessment for specific activities as needed and develop appropriate ESMPs and other safeguards instruments before the commencement of the activities during implementation, as and when required.

The MWMP is valid for a five year period (2011- 2016) and is therefore valid for supporting implementation under the propped 2nd AF. During the implementation of the second AF, the team will revisit MWMP to assess updates and subsequent redisclosure may be needed.

The Environmental and Occupational Health Department (EOHD) under the MOH which is responsible in conducting follow-up and implementation safeguard within the Ministry has a limited capacity to take care of environmental and social safeguards issues. However, the MOH, particularly the EOHD has been supported through training and capacity building activities to strengthen available capacity for managing the environmental and health issues. The EOHD has received and will continue to receive required technical expertise from the project for implementing the MWMP and preparation of ESMPs, as required. This capacity building for the EOHD will help the team to identify the potential impacts, monitor the recommended Environmental and Social mitigation measures and carry out all health service activities in an environmental sound manner.

The MOH has provided a draft EMSF, which has been disclosed as a living document in the Bank's InfoShop on May 25, 2016. The borrower will update and disclose a comprehensive ESMF engaging all stakeholders no later than one month after the effectiveness date of the AF2.

OP/BP 4.10 on Indigenous Peoples was triggered in the first additional financing in 2014 and in continuation also AF2 triggers OP4.10 and is applicable to the project as analysis by World Bank and other experts confirms that the overwhelming majority of people in the project area are expected to meet the requirements of OP 4.10. No Indigenous Peoples' Plan (IPP) is required. The team and the borrower will finalize the social assessment no later than one month after the effectiveness date of the AF2.

The project in compliance with the principles of OP4.10 has procedures for consultations and implementation processes that employ extensive community outreach activities to ensure

participation and access to essential health services by all communities including the most vulnerable groups in the project area. The project has added additional citizen engagement procedures and safeguards related indicators. The project communication and outreach activity is conducted with field personnel familiar with local cultural norms and language skills. A review of the project implementation manual will be conducted by the PMU to strengthen the implementation of community outreach and citizens' participation and feedback activities. The PMU will ensure that subsequent training of relevant personnel at various levels is conducted based on the revised Project Implementation Manual (PIM). Progress towards reaching the most vulnerable groups will be captured through indicators incorporated in the results framework.
5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
Key stakeholders include the MOH, SMOHs, CHDs, health care workers and local communities in target states, international/national NGOs/FBOs and development partners. All stakeholders receive guidelines on inclusion of potentially affected people in decision making on matters that might affect them.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other	
Date of receipt by the Bank	24-May-2016
Date of submission to InfoShop	25-May-2016
For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	
"In country" Disclosure	
Comments:	
Indigenous Peoples Development Plan/Framework	
Date of receipt by the Bank	13-Apr-2100
Date of submission to InfoShop	13-Apr-2100
"In country" Disclosure	
Comments:	
If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/ Audit/or EMP.	
If in-country disclosure of any of the above documents is not expected, please explain why:	

C. Compliance Monitoring Indicators at the Corporate Level

OP/BP/GP 4.01 - Environment Assessment	
Does the project require a stand-alone EA (including EMP) report?	Yes [ ] No [×] NA [ ]

OP/BP 4.10 - Indigenous Peoples	
Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?	Yes [ ] No [ ] NA [×]
The World Bank Policy on Disclosure of Information	
Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes [ ] No [×] NA [ ]
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 [ ] No [×] NA [ ]
All Safeguard Policies	
Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have costs related to safeguard policy measures been included in the project cost?	Yes [×] No [ ] NA [ ]
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes [×] No [ ] NA [ ]

V. Contact point

World Bank

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Borrower/Client/Recipient

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Implementing Agencies

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