Environmental and Social Management Framework

Provision of Essential Health Services Project

South Sudan – 2019

Version December 3, 2019
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## Acronyms

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<th>Description</th>
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<tbody>
<tr>
<td>AAP</td>
<td>Accountability to Affected People</td>
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<tr>
<td>CBP</td>
<td>Community-based Protection</td>
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<tr>
<td>CERC</td>
<td>Contingency Emergency Response Mechanism</td>
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<tr>
<td>FI</td>
<td>Financial Intermediary</td>
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<tr>
<td>GBV</td>
<td>Gender-based Violence</td>
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<tr>
<td>GoSS</td>
<td>Government of South Sudan</td>
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<tr>
<td>HCID</td>
<td>Healthcare in Danger</td>
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<tr>
<td>ICRC</td>
<td>International Committee of the Red Cross</td>
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<tr>
<td>IDMC</td>
<td>Internal Displacement Monitoring Center</td>
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<tr>
<td>IDP</td>
<td>Internally Displaced Person</td>
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<tr>
<td>IHL</td>
<td>International Humanitarian Law</td>
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<tr>
<td>IPC</td>
<td>Integrated Food Security Phase Classification</td>
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<tr>
<td>MHPSS</td>
<td>Mental Health and Psychosocial Support</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
</tr>
<tr>
<td>NIIHA</td>
<td>Neutral, Impartial, Independent Humanitarian Action</td>
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<tr>
<td>OCHA</td>
<td>Office for the Coordination of Humanitarian Affairs</td>
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<tr>
<td>OSV</td>
<td>Other Situations of Violence</td>
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<tr>
<td>PfR</td>
<td>Planning for Results</td>
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<tr>
<td>PHC</td>
<td>Primary Healthcare</td>
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<tr>
<td>PMT</td>
<td>Planning and Monitoring Tool</td>
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<tr>
<td>POM</td>
<td>Project Operational Manual</td>
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<tr>
<td>PoC</td>
<td>Protection of Civilians</td>
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<tr>
<td>SA</td>
<td>Social Assessment</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
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<tr>
<td>UNHCR</td>
<td>Office of the United Nations High Commissioner for Refugees</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNMISS</td>
<td>United Nations Mission in South Sudan</td>
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<td>WB</td>
<td>World Bank</td>
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1 Executive Summary

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 having been able to find ways allowing them to cross boundaries between government and opposition-held areas to deliver services. This intervention will 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 actors.

The conflict and violence-affected population (resident and displaced) from the catchment areas supported under this intervention 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. This sub-component will ensure that the targeted populations are being cared for in well-functioning, equipped and staffed primary (25 PHC facilities) and secondary care facilities (2 hospitals). 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 sub-component will have access to preventive and curative services, in a timely manner, including referral to secondary care when needed.

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

(a) **Curative care**: patients suffering from the most frequent diseases and/or injuries and/or physical consequences of sexual violence are properly diagnosed and treated (early risk detection and referral if necessary), in line with international/national standards.

(b) **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.

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

(d) **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 (MHPSS) and medical care will be provided to victims of violence and conflict-related sexual violence in a safe environment. Linkages will be developed between
primary points of contact communities to referral services, to ensure effective awareness raising and referral pathway for victims of conflict related sexual violence. The inclusive mental health services package comprises:

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

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

Lastly, this intervention 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 sub-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 official counterparts) can develop 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:

(a) outpatient and emergency services;
(b) surgical services including obstetric emergencies
(c) non-surgical services (including non-surgical obstetrics, pediatrics, therapeutic feeding services, physiotherapy);
(d) clinical support services (pharmacy, laboratory, and imaging); and
(e) non-clinical support services.

Potential negative environmental impacts of some project activities, including (i) provision, storage, handling, and disposal of essential drugs, supplies and equipment; (ii) delivery of basic health services; (iii) basic facility repair and the anticipated increase in medical waste due to improved coverage and quality health services across the country. These activities are low risk and the initial evaluation assigns the project as Category B - Partial Assessment for OP 4.01 Environmental Assessment (EA) purposes. Through the ESMF, the project also considers the World Bank Group’s Environmental, Health, and Safety

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Guidelines for Health Care Facilities, in so far as they are relevant for rural primary health care centres in conflict settings.

Minor repair of health clinics will not involve significant structural rehabilitation and will not involve new construction or extension (i.e. major environmental impacts in this regard). Rather, all repair activities will be implemented within existing facilities.

Meanwhile OP 4.10 on Indigenous People (IP) has been triggered. Because IPs are indeed the overwhelming majority in the project area, elements of an Indigenous Plan have been integrated into project design. These cultural characteristics and issues will be critically examined, identified and factored into local planning during the start of the project. More generally, benefits and the approach by which they will be provided will be culturally appropriate and adapted to the respective needs and structures of the vulnerable groups involved.

A summary of risk, impacts, mitigating measures and policies, procedures, practices is attached on the next page.

Before beginning support to any health facility, a health needs assessment is conducted. Like any of its health activities as per normal modus operandi, in designing the activities proposed above, the ICRC in South Sudan met with relevant authorities and community representatives to discuss and assess needs. Together, they discussed the areas of responsibility of the ICRC and those of the community and health authorities (County Health Department/ director).

Where Community Health Committees exist, the ICRC regularly invites their participation in the same meetings. Where CHCs do not exist, the ICRC encourages the communities to form them and elect representatives, encouraging diverse representation. (The ICRC also supports CHCs 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 take place at the health facility itself.

The CHCs are responsible for ensuring that communities are aware of the ICRC’s activities and providing feedback to the ICRC, they also help ensure that the communities make use of the health facilities. The CHCs meet once per month, where they receive updates from the technical team working in the health facility- 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 the health status in their villages.

The ICRC also ensures that for all input provided by the ICRC to the community health centers (drugs, materials, and equipment - also any kind of renovation of the health facility), a community representative receives and signs off on the donations.

Grievances may be addressed directly following the direct contact beneficiaries and communities have with ICRC staff, given the proximity sought, or through more formal channels via the ICRC head of the field structure, depending on their nature. Regular exchanges with traditional and official authorities, as well as CHCs of the given project catchment areas, allow for other structured opportunities for grievance expression, redress and monitoring by those involved.

The ICRC’s CBP workshops in South Sudan often address grievances as part of the concerns raised by the community members the Delegation interacts and discusses with; the ICRC in South Sudan also collects broader feedback (including grievances) through community-based activities, such as needs assessments for health or economic security, or water and sanitation. The ICRC does its best to respond to complaints and concerns in a timely and comprehensive manner, being sensitive to confidentiality and data privacy as the situation requires.
<table>
<thead>
<tr>
<th>S/N</th>
<th>ENVIRONMENTAL / SOCIAL IMPACT</th>
<th>DESCRIPTIONS</th>
<th>SUGGESTED MITIGATION MEASURES AND RELATED PROTOCOLS/SOP</th>
<th>MONITORING AND REPORTING ROLES AND INDICATORS</th>
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<tbody>
<tr>
<td>1</td>
<td>OCCUPATIONAL HEALTH &amp; SAFETY</td>
<td>B. Medical personnel and waste handlers are exposed to dangerous and infectious HCW (health care waste) as they collect and transport HCW. B. Staff incur on-the-job injuries due to improper clinical techniques, use of equipment, etc.</td>
<td>B. Medical staff is medically screened, briefed and trained on risks (cf. Annex on ICRC medical standards for deployment). B. Primary and secondary measures are followed (cf. ICRC’s Medical Waste Management Manual). B. Exposure protocols are known and implemented (cf. Annex on ICRC PEP guidelines). B. Juba and Geneva staff health colleagues are available if need be.</td>
<td>B. HQ HR Staff Health and Region B. Juba Health program coordination team B. Suggested indicators: o Indicator (PEP): Number of cases having required use of PEP kits o Indicator (PEP): Number of helpers receiving follow-up support (MHPSS).</td>
</tr>
<tr>
<td>2</td>
<td>COMMUNITY HEALTH AND SAFETY</td>
<td>B. Lapse of confidentiality. B. Assault by medical staff worker. B. Unrealistic expectation of level of care and/or recovery. B. Sub-par quality/inefficacy of medical goods procured (drugs, supplies, equipment). B. Expiration of goods. B. Unnecessary and/or improper disposal of goods.</td>
<td>B. Medical staff hired is experienced, professional and trained (cf. Annexes on ICRC staff hiring requirements, code of conduct (see Annex 9.1) and of some of the training available to health staff). B. Patients and/or care-takers are told and aware of the services available and understand procedures offered as well as their consequences. B. Complaints and grievances can be aired and processed. B. All waste storage and disposal sites is adequately cordoned off from the public (cf. ICRC’s medical waste management manual). B. Procurement system (cf. Annex on ICRC’s on Procurement guidelines below). B. Cold chain / storage and transport management system (cf. Annex on ICRC’s medical logistics below). B. Computerized and manual inventory system as well as disposal SOP (cf. Annex on ICRC’s medical logistics below).</td>
<td>B. HQ HR Talent Management and Global Compliance Office B. Juba Health program coordination team B. Field site Health delegates and Community Health Committees B. Suggested indicators: o Indicator (PHC): Working days per month. o Indicator (PHC): Number of MOH/DOH/Health authorities visits. o Indicator (PHC): Number of days of shortages of drugs. o Indicator (PHC): Indicator on whether the monthly health committee meetings took place. o Indicator (PHC): Number of ICRC visits. o Indicator (2nd HC): Indicator on whether there is a monthly functioning hospital community board. o Indicator (2nd HC): Number of qualified staff doing consultations. o Indicator (2nd HC): Number of days per months with storage for the ten main drugs. o Indicator (2nd HC): Total number of laboratory tests done. o Indicator (2nd HC): Availability 24h/day of water. o Indicator (2nd HC): Availability 24h/day of electricity. o Indicator (2nd HC): Follow-up and implementation of a regular maintenance schedule plan for hospital equipment. o Indicator (2nd HC): Follow-up and implementation of a regular maintenance schedule plan for infrastructure. o Indicator (MHPSS): Number of practitioners trained.</td>
</tr>
</tbody>
</table>

1 All to be reported on a quarterly basis
| 3 | **MEDICAL WASTE MANAGEMENT** | B. Medical waste and other potentially dangerous by-products of health care activities (e.g. expired medication) are an ineludible side product of any HC facility that represents potential hazard to public safety  
B. Public access to HC waste could be a hazard to communities and individuals  
B. Improper waste management could lead to leachate produced flowing into surface waters and contamination could occur  
B. A medical waste management plan for each HCF exists (based on ICRC Medical Waste Management Manual), including elements on:  
  o The proper handling, and disposal of wastes  
  o The establishment/upgrade of secured on-site waste collection and storage points  
  o Clear roles and responsibilities |  
| 4 | **MINOR FACILITY REPAIR AND REHABILITATION (within existing footprint of facility only)** | B. Construction worker first-aid  
B. Community health and safety  
B. Construction equipment handing  
B. Construction debris management  
B. Poor quality construction leading to harm to workers and/or patients  
B. ICRC’s engineering teams deploy best efforts to follow apply ILO health and safety recommendations to any works undertaken, including when it comes to access to and use of personal protective equipment; cordon-off of areas under active construction, or safe storage of construction equipment, f.e.. |  
|  |  | B. Juba Health program coordination team  
B. Suggested indicators:  
  o Indicator (PHC): Presence of waste disposals in the health structure  
  o Indicator (PHC): Presence of safety boxes for used needles/sharps  
  o Indicator (2nd HC): Indicator on whether the waste management guidelines are implemented  
  o Indicator (2nd HC): Existence of a cleaning schedule/plan |  
|  |  | B. Juba Water and Habitat program coordination team  
B. Suggested indicators:  
  o Indicator (MHPSS): Number of training sessions with practitioners  
  B. Medical Logistics and/or Pharmacists in Juba, Nairobi and Geneva  
  B. Suggested indicator:  
    o Indicator: Juba central warehouse quarterly cold Cloud data log (tbc) |  

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2 Note that no rehabilitation/renovation works of health-care facilities will be supported by means made available in the frame of this project – resources required will be drawn independently on by the ICRC to this end.
2 Introduction

Present in Juba since 1980, the International Committee of the Red-Cross (ICRC) opened a delegation in newly independent South Sudan in mid-2011. It works to ensure that people affected by non-international and international armed conflicts are protected in accordance with International Humanitarian Law (IHL), have access to medical care, physical rehabilitation and safe water, receive emergency relief and livelihood support, and can restore contact with relatives. It visits detainees and seeks to increase knowledge of IHL among the authorities, armed forces and other weapon bearers. It works with and supports the South Sudan Red Cross.

The envisaged backing of the current project will allow the ICRC to expand its operational footprint in the provision of, and inter-alia, greater and safer access to primary and secondary health-care services, including Mental Health and Psychosocial Support (MHPSS) at both levels. Succinctly put, the foreseen support will contribute to ICRC’s efforts in South Sudan to ensure that:

- The conflict and violence-affected population (resident and displaced) from the catchment areas of ICRC operations benefit from support to primary health care services and have access to essential, quality curative and preventive health care services with functional management, adequate resources and trained staff providing treatment and care in line with national standards, and
- The wounded and sick in areas affected by conflict and other emergencies, benefit from quality hospital care meeting recognized international standards.

The project takes place during a period of conflict, violence, and significant displacement, a product of the civil war that began in December 2013, two years after South Sudan achieved independence. Humanitarian needs are significant, with OCHA estimating 7 million people in need in 2018 alone. More than 4.4 million people have been displaced, almost half of whom are displaced internally. The protracted conflict has caused a major public health emergency affecting a system that was already struggling, which this project will seek to ameliorate. This context, alongside key socio-cultural, institutional, political, and historical factors, forms the key backdrop of this project.

The ICRC employs an operational approach to its assistance (and protection) programs that puts the benefiting population at the heart of its response in South Sudan and globally. Its neutral, impartial, and independent humanitarian action (NIIHA) allows it to access and gain acceptance with some of the most vulnerable and affected populations in South Sudan. The organization’s centennial practice in the domain of medical emergency response and decade long presence in South Sudan provide a robust backbone to manage environmental and social risks associated with the program under consideration. Although exact apppellations and angles might differ between organizations, analogous reference frameworks to take into account the dimensions under consideration and ensuing standard operating procedures (SOP) exist at the institutional level and are reflected in the field practice of the South Sudan delegation.

Risks identified center on pollution prevention and management (i.e. essentially medical waste management considerations); on minor rehabilitation and petty rehabilitation works, as well as on community health and safety. They remain negligible given the type, location, sensitivity, and scale of the proposed project, the nature and magnitude of its potential impacts and scope, the mitigating measures available, and the relative benefits of the live-saving impact of the program catering to a basic human need.

ICRC’s SOP will adequately cater to ensure they are managed suitably and professionally in the realities of the South Sudanese environment.
3  Project Description

3.1  Background Considerations
Treating and caring for the wounded and sick in armed conflict, other major violence and natural disasters has always been bound-up with the history, identity, values and reputation of the ICRC. In an increasingly unstable and violent world, and extremely challenging humanitarian environment, the organization continues to address the main issues affecting people’s health. Whilst ICRC’s traditional health activities (first aid, war surgery, physical rehabilitation and health care in detention) have lost none of their relevance, other disciplines (primary health care, comprehensive hospital care, and mental health and psychosocial support) are increasingly proving their worth.
The ICRC has made a clear commitment to providing high-quality and accountable health programs, designed to meet professional standards. It often works in partnership with other organizations to bring together experts from different fields.

The protracted conflict in South Sudan has caused a major public health emergency affecting a system that was already in crisis. The country hosts some 2 million internally displaced persons (IDPs), one of the largest IDP populations in the world. In 2017 alone, there were approximately 857,000 new displacements – the fourth largest set of new displacements in Africa for 2017 – much of which was due to conflict and consequent food insecurity (IDMC, 2018). Movements of people can place additional stress on already-struggling communities and systems, including healthcare. In South Sudan, influxes of IDPs or returnees (whether IDPs or refugees) to their homes can create surges in need for primary and secondary healthcare. Trauma of flight and separation from loved ones also can increase need for mental and psychosocial support. Some of the most pressing issues leading to unmet needs include: the closure of or damage to many health facilities (sometimes due to attacks), unpaid or displaced staff members, and the scarcity of medications. Throughout the country, the condition of the health care infrastructures is rudimentary at best, with generally a dire lack of access to basic utilities. Authorities have neither the capacity nor the resources to deliver health services independently. Despite efforts, access to quality health care remains starkly limited by insecurity and logistical constraints. In hard to reach conflict affected areas, the situation is even direr.

Basic primary health care (PHC) services such as routine vaccinations, malnutrition screenings and antenatal care have been severely disrupted. Immunization coverage continues to decline. Stakeholders are implementing mass immunization campaigns (measles / polio) where possible, but these do not routinely include other antigens. Statistics are sparse and outdated, rates of illness have likely deteriorated further. There are few midwives in rural areas–mostly replaced by traditional birth attendants with little training. There is usually no referral to comprehensive emergency obstetric / medical care.

Mental health services for trauma, stress, depression and other psychological issues are virtually non-existent in the country. Among communities, awareness and understanding of mental health issues remain low and are compounded by the stigma associated with mental health issues, making the likelihood of seeking care low.

Victims of sexual violence continue to have little or no access to appropriate medical and psycho-social care. The main causes are difficulties of access linked to the social cost of disclosure for victims.

2018 has shown the volatility of the current situation with health care facilities becoming dysfunctional to various degrees. ICRC has developed a light and flexible footprint, adapting to the ever-changing situation while continuing to provide basic healthcare for the most vulnerable.

The programmatic support considered to the ICRC will allow for the delivery of a comprehensive package of health services to highly vulnerable and conflict-affected communities. It will support and allow the scale-up of the ICRC’s ongoing multidisciplinary response to urgent health needs arising out of the conflict in South Sudan. This will help the organization in continuing the pace and momentum of its ongoing health programs as well as further expand them, especially in hard-to-reach areas. The proposed program for 2019 would support the below health-care delivery activities, prioritizing areas affected by conflict or inaccessible to other actors supporting the health sector.

Of note, the project financial support envisaged will not be channeled towards any minor repairs or rehabilitation. Other financial sources of support will ensure health-care infrastructure are adequately rehabilitated/renovated where needed to ensure both the best possible care for patients and safe working conditions for ICRC staff. However, for the purposes of this ESMF, any minor repairs or rehabilitation is considered an associated work and is covered as a part of this ESMF.
The following three sections describe the activities funded by the project in the context of ICRC’s work program in South Sudan.

3.2 Delivery of High Impact Primary Health Care Services in South Sudan for the Most Vulnerable and Affected Communities

The ICRC’s goal is to guarantee a first point of access to health care for victims of armed conflict.

The objective of ICRC health interventions at the first level of care is to reduce the mortality and morbidity of the population and to alleviate their suffering. The first level of care is the place where individuals, their family and the community have their first contact with a health system. It is as close as possible to where people live and work.

The aim is to have primary health-care services with professionally trained staff to provide care and treatment for the diseases most commonly contracted by victims of conflict in a safe environment. Staff can also recognize and stabilize more complex cases, where necessary transferring them to nearby hospitals for further tests and treatment. Typical minimum services provided are: curative care for the most frequent diseases; sexual violence management; antenatal, deliveries and postnatal care for women of child bearing age; vaccination activities, from mass vaccination campaign to Expanded Program of Immunization (EPI); protection and treatment of the population against epidemics threats and major communicable diseases; etc.

In South Sudan, a scale-up of support to some 25 primary health care (PHC) centers and related community health activities is envisaged, focusing on areas heavily affected by conflict and inaccessible to others, including in, but not limited to, former Upper Nile and Jonglei. In addition to professional service delivery, provided support will encompass drugs, equipment, dressing materials and vaccines, etc., including consideration linked to the safe delivery of the medical mission. The services supported, targeted by the medical teams in the facilities will include:

a) Training and support in managing medical stocks, supplies and pharmaceuticals;
b) Treatment for most frequent diseases and care in line with national guidelines;
c) Training and support to antenatal care, post-natal care, safe deliveries and Basic Emergency Obstetric and Newborn Care;
d) Training and support for the Boma Initiative to improve community involvement/ownership in health care;
e) Medical care and mental health and psychosocial support (MHPSS) for victims of violence, including conflict-related sexual violence;
f) Support to re-establish routine expanded program immunization (EPI);
g) Referrals to secondary/hospital care.

3.3 Delivery of Mental Health and Psycho-Social Support in all ICRC Supported Health Facilities

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

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

Mental health and psychosocial support (MHPSS) frequently requires special consideration during armed conflicts, other situations of violence (OSV) and emergencies. Violence, fear, and uncertainty can create an environment of chaos and reduce community resources, producing psychological distress and other MHPSS consequences for affected populations. Severe mental health disorders often pre-date an emergency but also may exacerbated or newly induced by the crisis. People with such disorders are extremely vulnerable and are often abandoned in such situations.

At the same time, conflict and violence lead as well to the breakdown of local systems, infrastructure and coping mechanisms. As a result, adequate assistance is often unavailable when people need it the most.

MHPS Services provided by the ICRC accordingly cover a wide range of activities to address psychosocial, psychological and psychiatric problems caused or exacerbated by conflict. Its programs aim to stabilize and improve patients’ mental health and to ensure the emotional well-being of individuals and communities affected by armed conflict and other situations of violence. The ICRC focusses on providing mental health and psychosocial support to families of missing people, victims of sexual violence, detainees, other victims of violence, such as unaccompanied minors and first-aiders. Further elements of background to its approach to approach as well as guidelines have been developed by the organization based on its extensive practice in conflict zones.

### 3.4 Delivery of High Impact Secondary Health Care Services as a Continuum of Care at Community Level

To have an impact on the continuum of care, a package of secondary health services (level at the county hospital) will be developed and implemented by ICRC in conflict-affected and inaccessible areas where referral possibilities are not or insufficiently available. While many of these areas are in former Jonglei and Upper Nile, the specific locations and numbers are still to be determined giving the evolving context.

Given the complex situation in South Sudan and especially in the non-governmental controlled areas, the approach at the hospital level will remain agile and adapt in a case of a changing security situation. This 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 sub-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 will develop the basic capacity (e.g. access, structures, organization, competencies, tools, resources, network) to handle correctly the functioning of the project-supported hospitals.

Providing health care is a challenge in times of armed conflict, when the infrastructure of a society collapses and violence leads to increased demands for care. The objective of an ICRC hospital intervention
is to provide, maintain or restore safe access of the population to quality secondary health care in order to save lives and alleviate suffering. Adequate hospital care – close to where people live, and with good links to primary health care, first aid and physical rehabilitation services – ensures an essential continuum of care.

The ICRC has developed expertise in the field of war surgery, and its role often goes further than providing direct patient care. The ICRC also recognizes the need for broader hospital help. Standing in for, or supporting, services that can no longer be provided (e.g., internal medicine, pediatrics, gynecology and obstetrics) is an important part of what the organization does in times of conflict.

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

In South Sudan, to have an impact on the continuum of care, the ICRC is developing a package of secondary health services (level county hospital) in areas where it is supporting a number of primary healthcare centers and where referral possibilities are not or insufficient available.

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

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

In the current situation of volatility, the support to any county hospital will be agile in a way it increases the access and referral to secondary hospital services to provide the best quality of care possible. Services considered for support will include, amongst others emergency room services maternities, pediatrics, adult inpatients service, outpatient department and initial stabilization of surgical emergency cases as well as essential hospital support services. Weapon wounded patients or other trauma cases will be transferred to the ICRC hospitals in Ganyiel or Juba. Aside the outpatient department, inpatients will be admitted in a maternity ward (including other female inpatients), pediatric ward and adult male ward.

ICRC investments on the existing and within the defined perimeter of medical facilities are mainly a mix of light rehabilitation and larger renovations works on current infrastructure, to ensure a safe and sanitary environment for both patients and health staff. From past experience, these are typically the like of rehabilitating roofs, increasing of ventilation capacity of premises, refurbishing of sanitary facilities, perimeter fencing, drainage systems improvements, etc.

Any extension work typically takes the form of temporary or semi-temporary structures and always remain within the initial perimeter of the health facilities. This work is completed by ICRC staff.
3.5 Geographical Setting

The Project will support interventions in the following areas (see Table starting next page).

The assessments outlined below are therefore valid for all areas of intervention and ICRC will ensure that mitigation measures shall be applied uniformly throughout the project intervention areas.

Project-supported interventions in any additional or new area identified throughout the project lifecycle require a no-objection by the World Bank. In preparation, ICRC would provide an addendum to this ESM, if needed, together with the request for a no-objection. That addendum would need to describe consultations held, as well as note any change in risk levels or risk characteristics; in case of any change and/or additional risks, adapted and/or additional measures will be included which will be considered equally part of this ESMF and its overall setup.
### Supported primary health care facilities in former Upper Nile and Jonglei

<table>
<thead>
<tr>
<th>№</th>
<th>State</th>
<th>Place</th>
<th>County</th>
<th>Type of Health Care Facility</th>
<th>Within boundaries of former Upper Nile and Jonglei</th>
<th>ICRC Sub-delegation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fashoda State (Western Nile)</td>
<td>Lul</td>
<td>Fashoda</td>
<td>Primary Health Care Unit</td>
<td>Yes (Upper Nile)</td>
<td>Malakal</td>
</tr>
<tr>
<td>2</td>
<td>Fashoda State (Western Nile)</td>
<td>Kodok</td>
<td>Fashoda</td>
<td>Primary Health Care Centre</td>
<td>Yes (Upper Nile)</td>
<td>Malakal</td>
</tr>
<tr>
<td>3</td>
<td>Central Upper Nile State (Fashoda)</td>
<td>Akoka</td>
<td>Akoka</td>
<td>Primary Health Care Unit</td>
<td>Yes (Upper Nile)</td>
<td>Malakal</td>
</tr>
<tr>
<td>4</td>
<td>Northern Upper Nile State (Eastern Nile)</td>
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<td>Maban</td>
<td>Primary Health Care Unit</td>
<td>Yes (Upper Nile)</td>
<td>Malakal</td>
</tr>
<tr>
<td>5</td>
<td>Bieh State</td>
<td>Karam</td>
<td>Uror</td>
<td>Primary Health Care Unit</td>
<td>Yes (Jonglei)</td>
<td>Bor</td>
</tr>
<tr>
<td>6</td>
<td>Bieh State</td>
<td>Buong</td>
<td>Akobo West</td>
<td>Primary Health Care Unit</td>
<td>Yes (Jonglei)</td>
<td>Bor</td>
</tr>
<tr>
<td>7</td>
<td>Jonglei State</td>
<td>Duk Padiet</td>
<td>Duk</td>
<td>Primary Health Care Centre</td>
<td>Yes (Jonglei)</td>
<td>Bor</td>
</tr>
<tr>
<td>8</td>
<td>Phow State</td>
<td>Toch</td>
<td>Fangak</td>
<td>Primary Health Care Unit</td>
<td>Yes (Jonglei)</td>
<td>Bor</td>
</tr>
</tbody>
</table>

### Primary health care facilities, support to be resumed (suspended) in former Upper Nile and Jonglei

<table>
<thead>
<tr>
<th>№</th>
<th>State</th>
<th>Place</th>
<th>County</th>
<th>Type of Health Care Facility</th>
<th>Within boundaries of former Upper Nile and Jonglei</th>
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<tbody>
<tr>
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<td>Waat Nyrol</td>
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</tr>
<tr>
<td>2</td>
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<td>Nyrol</td>
<td>Primary Health Care Unit</td>
<td>Yes (Jonglei)</td>
<td>Bor</td>
</tr>
</tbody>
</table>

### Primary health care facilities assessed or under-assessment (no ICRC support for the moment)

<table>
<thead>
<tr>
<th>№</th>
<th>State</th>
<th>Place</th>
<th>County</th>
<th>Type of Health Care Facility</th>
<th>Within boundaries of former Upper Nile and Jonglei</th>
<th>ICRC Sub-delegation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Central Upper Nile State</td>
<td>Tonga</td>
<td>Panikng</td>
<td>Primary Health Care Centre</td>
<td>Yes (Upper Nile)</td>
<td>Malakal</td>
</tr>
<tr>
<td>2</td>
<td>Latjor State</td>
<td>Yomding</td>
<td>Ulang</td>
<td>Primary Health Care Centre</td>
<td>Yes (Upper Nile)</td>
<td>Malakal</td>
</tr>
<tr>
<td>3</td>
<td>Latjor State</td>
<td>Doma</td>
<td>Ulang</td>
<td>Primary Health Care Unit</td>
<td>Yes (Upper Nile)</td>
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</tr>
<tr>
<td>4</td>
<td>Northern Upper Nile State</td>
<td>Jamam</td>
<td>Jamam</td>
<td>Primary Health Care Unit</td>
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### Latjor State

<table>
<thead>
<tr>
<th>No.</th>
<th>State</th>
<th>Place</th>
<th>County</th>
<th>Type of Health Care Facility</th>
<th>Within boundaries of former Upper Nile and Jonglei</th>
<th>ICRC Sub-delegation</th>
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<tbody>
<tr>
<td>5</td>
<td>Latjor</td>
<td>Makak</td>
<td>Nassir</td>
<td>Primary Health Care Unit</td>
<td>Yes (Upper Nile)</td>
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</tr>
<tr>
<td>6</td>
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<td>Mandeng</td>
<td>Nassir</td>
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<tr>
<td>7</td>
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<td>Ulang</td>
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<td>Latjor</td>
<td>Jikmir</td>
<td>Nassir</td>
<td>Primary Health Care Centre</td>
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<tr>
<td>9</td>
<td>Phow</td>
<td>Pagil</td>
<td>Ayod</td>
<td>Primary Health Care Centre</td>
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<td>Bor</td>
</tr>
<tr>
<td>10</td>
<td>Jonglei</td>
<td>Baidit</td>
<td>Greater North Bor</td>
<td>Primary Health Care Centre</td>
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### Jonglei State

<table>
<thead>
<tr>
<th>No.</th>
<th>State</th>
<th>Place</th>
<th>County</th>
<th>Type of Health Care Facility</th>
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<th>ICRC Sub-delegation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bieh</td>
<td>Akobo</td>
<td>Akobo East</td>
<td>County Hospital</td>
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</table>

**Supported secondary health care facilities**

<table>
<thead>
<tr>
<th>No.</th>
<th>State</th>
<th>Place</th>
<th>County</th>
<th>Type of Health Care Facility</th>
<th>Within boundaries of former Upper Nile and Jonglei</th>
<th>ICRC Sub-delegation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bieh State</td>
<td>Akobo</td>
<td>Akobo East</td>
<td>County Hospital</td>
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<td>Bor</td>
</tr>
</tbody>
</table>

In addition to the main support for Jonglei and Upper Nile, the Project will support interventions also in the following areas:

<table>
<thead>
<tr>
<th>ICRC Sub-delegation</th>
<th>State</th>
<th>County</th>
<th>Place</th>
<th>Type of Health Care Facility</th>
<th></th>
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<tbody>
<tr>
<td>Bentiu</td>
<td>Northern Liech State</td>
<td>Bentiu</td>
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<tr>
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<td>Mayong</td>
<td>Wang Kai</td>
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<td>Leer</td>
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<td>Primary Health Care Unit</td>
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<td>Nyrol</td>
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<td></td>
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<td>Yambio</td>
<td>Out Patients Department</td>
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<tr>
<td>ICRC Sub-delegation</td>
<td>State</td>
<td>County</td>
<td>Place</td>
<td>Type of Health Care Facility</td>
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<td>Nassir</td>
<td>Yomding</td>
<td>Primary Health Care Centre</td>
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<td>Ngo Dakala</td>
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<td></td>
<td>Jur River</td>
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<td>Primary Health Care Unit</td>
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<tr>
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<td></td>
<td>Wad Allel</td>
<td>Primary Health Care Unit</td>
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</tr>
</tbody>
</table>
3.6 Contingency Emergency Response Mechanism (CERC)

There is an additional, non-compulsory mechanism provided within the financed which improve the country’s response capacity in the event of an emergency, called a Contingency Emergency Response Mechanism (CERC). 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 ICRC to receive support by reallocating funds from other project components or serving as a conduit to process additional financing from funding sources for eligible emergencies to mitigate, respond and recover from the potential harmful consequences arising from the emergency situation.

In order to ensure that the CERC emergency subproject activities comply with environmental and social safeguards, the activities identified in the action plan for financing under the CERC will be subject to a review in order to determine if they are eligible under the safeguard policies and compliance procedures used for the Protection of Essential Health Project. The screening and environmental management procedures described in the Project Operational Manual (POM) will then be utilized. This will allow the possibility to exclude certain activities if the environmental or social impacts are too great, or to include appropriate mitigation measures for a proposed activity if feasible. Having the existing safeguards screening process in place will also allow a certain degree of flexibility and efficiency in processing potential subprojects or activities. The screening process would be based on the existing ESMF. If warranted, a CERC-ESMF would be created, to include indicative CERC-related activities, CERC positive list, negative list, impact mitigation measures, institutional arrangements, and grievance redress mechanism.

4 Legal and Institutional Framework

A range of applicable policy frameworks, whether international treaties or national laws and regulations specific to South Sudan exist, relating to environment and social issues. Governmental institutional capabilities, including for implementation remains variable though generally could benefit from support.

The WB’s environmental and social policies are equally representing key frameworks of reference in the overall design of this project. A Social Assessment serves as a companion piece for this ESMF, and supports social risks, impacts and mitigation measures in more detail.

ICRC’s own regulatory institutional framework relating to environmental and social considerations for its part is robust, honed by both its wider organizations expertise and decade long experience operating in South Sudan. They thus provide a useful complement to South Sudan current capacities in the domains under consideration.

4.1 Legal International and National Frameworks

4.1.1 Basel Convention, 1989

The United Nations Environment Program (UNEP) coordinates the Basel Convention. It controls transboundary movements of hazardous waste including medical and pharmaceutical waste. Hazardous waste exports from most developed countries to the developing world are banned by the convention.
4.1.2 Stockholm Convention, 2001
The Stockholm Convention is a global treaty to protect human health and the environment from persistent organic pollutants (POPs), that is chemicals which: remain intact in the environment for long periods; become widely distributed geographically; accumulate in the fatty tissue of living organisms and are toxic to humans and wildlife. Parties are required to take measures to eliminate or minimize the production, unintentional production, use, and release of POPs, including dioxins and furans.

4.1.3 Environment Policy of South Sudan, 2010
The Environment policy of South Sudan provides a wide range of guidance in response to emerging environmental management challenges to enable decision makers and resource users to make development choices that are economically efficient, socially equitable and environmentally friendly to ensure realization of sustainable development. The goal of the South Sudan National Environment Policy is to ensure protection and conservation of the environment and sustainable management of renewable natural resources in order to meet the needs of its present population and future generations.

Of note, the Transitional Constitution of the Republic of South Sudan of 2011 incorporates numerous provisions that have a bearing on the environment.

4.1.4 Environment Protection Bill of South Sudan, 2010
Section 32 of the Draft Environment Protection Bill of South Sudan, 2010 Cap 7 intends to introduce the requirement for Environmental Audits. An Environmental Audit, according to this Bill, is defined as systematic, documented, periodic and objective evaluation of how well Environmental organization, management and equipment are performing in conserving the Environment and its resources.

4.1.5 Environmental Protection Act, 2001
The Sudan Environmental Protection Act of 2001 (enacted prior to South Sudan’s statehood) has the following objectives: i) to protect the environment in its holistic definition for the realization of sustainable development; ii) to improve the environment and the sustainable exploitation of natural resources; and iii) to create a link between environmental and developmental issues, and to empower concerned national authorities and organs to assume an effective role in environmental protection.

Section III of the Act outlines general policies and principles for the protection of the environment. It is worth noting that these policies and principles are not legally binding but are guidelines to be observed by the authorities concerned when setting development policies.

4.1.6 Environment Health Act, 1975
The Environment Health Act (enacted prior to South Sudan’s statehood) covers prevention of water pollution, inspection of drinking water, disposal of waste and sewage, inspection of industrial areas and bakeries, prevention of air pollution and inspection of waste dumping places and brick kilns.

4.1.7 Public Health (Water and Sanitation) Acts of South Sudan, 2008
The Public Health Act emphasizes the prevention of pollution of air, water and encourages sanitation. Some of the key areas of emphasis include measure to prevent and regulate the pollution of water and air and regulations and measure to combat atmospheric pollution.
4.1.8 Policy on Medical Waste Management for South Sudan, 2012
In 2012 a draft guideline for the future management of medical waste was developed. The Policy on Medical Waste Management sets out to ensure that patients, health workers, communities and the environment are protected from risks associated with unsafe medical waste handling, treatment and disposal.

4.1.9 Guideline on MWM for South Sudan, 2011
Based on the draft Medical Waste Management Policy, the draft Guidelines for the Safe Management of Medical Waste in South Sudan were developed. The purpose of this guideline is to ensure the proper and harmonized management of medical waste in South Sudan, including segregation, collection, transportation, treatment and disposal of wastes which is complied with hygienic principles. The guideline applies to all Health Care facilities in the South Sudan.

4.2 World Bank Environmental and Social Policies
When providing financial support to projects, the World Bank aims to ensure that the people and the environment are protected from potential adverse impacts. The Bank does this through policies that identify, avoid, and minimize harm to people and the environment. These policies require its partners to address to the best of their availabilities provided given circumstances, certain environmental and social risks in order to receive World Bank support for investment projects.

For the EHSP, OP 4.01 is applicable due to the potential negative environmental impacts of some project activities, including (i) provision, storage, handling, and disposal of essential drugs, supplies and equipment; (ii) delivery of basic health services; (iii) basic facility repair and the anticipated increase in medical waste due to improved coverage and quality health services across the country. These activities are low risk and the initial evaluation assigns the project as Category B - Partial Assessment for Environmental Assessment (EA) purposes. Through the ESMF, the project also considers the World Bank Group’s Environmental, Health, and Safety Guidelines for Health Care Facilities, in so far as they are relevant for rural primary health care centres in conflict settings. No impacts related to the World Bank’s Operational Policy on Involuntary Resettlement (OP 4.12) are anticipated under any of the project activities proposed for implementation. Moreover, with respect to OP 4.12, minor repair of health clinics will not involve structural rehabilitation and will not involve new construction or extension (i.e. major environmental impacts in this regard). Rather, all repair activities will be implemented within existing facilities.

Meanwhile OP 4.10 on Indigenous People has been triggered. Because IPs are indeed the overwhelming majority in the project area, elements of an Indigenous Plan have been integrated into project design. Cultural characteristics and issues will be critically examined, identified and factored into local planning during the start of the project. More generally, benefits and the approach by which they will be provided will be culturally appropriate and adapted to the respective needs and structures of the vulnerable groups involved.

4.3 Institutional ICRC Environmental and Social Frameworks
4.3.1 Framework for Sustainable Development at the ICRC
The ICRC, by its very nature as a humanitarian organization, has a moral duty to take into consideration future generations when designing and implementing its relief actions.
Looking into the future, sustainable development is a fundamental guiding principle for how the organization delivers aid to victims of armed conflict and other violence, with a view to reduce the potentially negative impact of the ICRC’s activities on the environment. The health and well-being of beneficiaries and local communities in countries in which it operates is intrinsically linked to the state of the natural environment. This is why the ICRC strive to incorporate sustainability into all activities to maximize the positive impact of humanitarian aid and accountability through suitable, sustainable and effective action.

In November 2011, the ICRC Directorate validated a framework for sustainable development at the ICRC. Rooting a strategic vision, this key document formalizes the ICRC’s commitment to integrate in a progressive and realistic manner principles of sustainable development – reducing the potentially negative impact of its activities on the environment, making optimal use of financial resources and acting as a socially-responsible humanitarian actor and interlocutor – into its humanitarian work.

Guided by the framework for sustainable development, operations take into account three dimensions, supported by the following commitments:

a) Social sustainability
   - Reduce the impact of environmental degradation and climate change on the victims of conflict and violence.
   - Be a socially responsible partner in our interactions with all stakeholders (beneficiaries, staff, suppliers, State and non-State entities, donors).

b) Environmental sustainability
   - Monitor and reduce the environmental footprint of the ICRC’s operational and support activities.

c) Economic sustainability
   - Manage financial resources ethically and optimally.

Accordingly, the ICRC:

- Systematically examines the economic, social and environmental consequences of its policies and activities and reports on it annually at an institutional level
- Incorporates sustainability principles into the design and implementation of assistance programs
- Ensures that the ICRC staff support sustainable development and integrate it in their work
- Optimize the logistics chain to be able to deliver quality assistance needed by our beneficiaries on time and in the right place
- Uses new technologies and solutions to reduce the ICRC’s ecological footprint
- Applies rules and principles of responsible people-management strategy to address the diverse needs of all staff
- Applies an ethical purchasing policy to ensure that procured products were manufactured under acceptable conditions in terms of both social and environmental compliance
- Adheres to the rules and principles of ethical conduct in the management of financial resources
4.3.2 ICRC Framework for Environmental Management in Assistance Programs

ICRC Assistance Programs aim to preserve or restore acceptable living conditions for people affected by armed conflict and other situations of violence. As in South Sudan, these victims can be highly vulnerable and are in most contexts highly dependent on their local environment for their livelihoods, health and security. AHuman health, livelihood and survival are intertwined with environmental concerns. Environmental concerns are thus directly relevant to ICRC assistance activities and must be part of them.

As a leading humanitarian organization, the ICRC has a key role to play in issuing a clear message that allows for consideration of environmental issues that affect the victims of armed conflict while ensuring that the affected populations themselves remain central to its Assistance programs.

The ICRC framework for environmental management in assistance programs defines environmental issues in the context of ICRC’s operations. It provides useful and practical guidance on several levels:

- How to understand the relationship between Assistance activities (Health programs included) and the environment upon which victims of armed conflicts depend;
- How to consider the potential positive or negative impacts of Assistance activities, without in any way compromising the rapidity and effectiveness of ICRC action;
- How to continue to develop an environmentally alert mindset and to enable environmental issues to be systematically integrated into the balance of factors that need to be considered to produce an efficient, effective and rapid ICRC response.

The framework fits into the broader environmental concern of the ICRC as a whole. It encourages field operations to systematically assess, identify and understand the potential environmental impacts and implications of their activities and to take reasonable and feasible initiatives to reduce these impacts and enhance the efficiency, appropriateness and quality of Assistance Programs.

4.3.3 Medical Waste Management

The health needs of people in armed conflict or other situations of violence are met according to defined minimum packages of health services/care. Curative and preventative health actions remain at the heart of ICRC’s projects. Saving lives and alleviating suffering is the central objective of health assistance.

Health activities can also have direct negative impacts on the environment, health workers and communities. Although the risks associated with hazardous medical waste and the ways and means of managing that waste are relatively well known and described in manuals and other literature, the treatment and elimination methods advocated require considerable technical and financial resources and a legal framework, which are often lacking in the contexts in which the ICRC works.

Poor waste management can jeopardize care staff, employees who handle medical waste, patients and their families, and the neighboring population. In addition, the inappropriate treatment or disposal of that waste can lead to environmental contamination or pollution.

In unfavorable contexts, the risks associated with hazardous medical waste can be significantly reduced through simple and appropriate measures. The ICRC has therefore established a Medical Waste Management manual intended as a practical and pragmatic tool for the routine management of dangerous medical wastes in its operations. It does not under any circumstances replace any existing national waste management legislation and plans.

The manual covers the general framework for waste management, safety requirements, and has carefully detailed illustrations to explain practicalities required. ICRC’s medical waste management guide is designed for application in areas requiring emergency aid delivery where waste-related resources and infrastructure are compromised or non-existent; i.e. the guide contains much compromise in approaches
to waste management; however, these compromises result from decades of experience working in conflict environments and balance carefully safety and environmental concerns with practicality and need.

The below diagram provides an example of the guidance/decision tree used by the ICRC for deciding on the treatment/disposal methods to be used in the absence of appropriate regional infrastructures:

4.3.4 Acceptance of the ICRC (Social Considerations) and Security Management

Acceptance is the main pillar, the vital component in the ICRC’s field security concept. Acceptance is fundamental and indispensable in situations of armed conflict and internal violence.

To be able to operate, the ICRC must first ensure that it is accepted by the parties to a conflict as well as the communities it sets out to serve. They will accept its presence and working procedures if they understand its role as an exclusively humanitarian (independent and impartial) organization and the purpose of its activities, and if a relationship of trust has been established. The ICRC has no means of exerting pressure to impose its activities. Persuasion, influence and credibility are its only means of action.

It is crucial to ensure that the ICRC is accepted at least by all those who influence the course of events. However, globally, the fragmentation of society has led to the rise of players such as warlords,
transnational terrorist or mafia networks, armed resistance groups, mercenaries and paramilitary forces, whose degree of acceptance of the ICRC is at times hard to assess.

In order to be able to contact all the various parties during a conflict situation, the ICRC seeks to establish channels of communication to all those likely to misunderstand or reject its work. It may be difficult or impossible to have direct access to certain extremists; such alternative channels are therefore a necessary additional means of reinforcing a sound, widespread and diversified networking process.

Within the framework of its integrated operational and mobilization strategies, the ICRC gains acceptance by the relevance of its operational choices, through dialogue, negotiation and communication, by projecting a coherent image and by spreading knowledge of international humanitarian law and the Fundamental Principles of the International Red Cross and Red Crescent Movement at all levels.

Acceptance is built up over time through action and dialogue; some degree of fragility and vulnerability is inevitable. Public communication approaches and messages are conceived and developed within an integrated strategy that takes account of the security parameters applying to local, regional and global communication.

As in other operational contexts, ICRC’s decade long presence in South Sudan in deep field locations and the centrality of the principle of acceptance are a testimony of the close network it strives to maintain with all the different facets of society. Given the fluidity of patterns of violence in context, the strict preservation of the ICRC’s neutral, impartial and independent humanitarian action is central and a constant compass to its action. Perceptions that might taint this understanding, e.g. through partnerships that are considered biased in favor of one of the party to the conflict, can have direct and direct repercussions on both the organization’s access to victims and security. Accordingly, the careful management of acceptance is at the center of any delegation’s efforts to ensure the ICRC’s ability to deliver on its mandate.

More generally, the ICRC strives at all times to reconcile its operational goal to stand by the victims and vulnerable persons with the responsibility it has towards its personnel. It therefore weighs every operation and its humanitarian impact against the risks involved. It is the responsibility of those directing ICRC operations to manage security; the ICRC makes no distinction between security management and the conduct of operations. The South Sudan delegation exercises extensive autonomy within a clearly defined institutional framework that has three components: the ICRC’s mandate, its principles, and its security concept. Each delegation assesses its security environment in the light of the context and on the basis of the institution’s indicators, the “pillars of security”. Danger is a part of every delegate’s routine; risks are inherent in the discharge of the ICRC’s mandate, including in a context such as South Sudan.

The Security and Crisis Management Support Unit (SCMS) at ICRC Headquarters, which reports to the Department of Operations, has a watchdog function and bears chief responsibility for drawing up general policy and for providing follow-up and operational support, in the form of training and field security missions. SCMS has developed a Security and Safety Risk Management Methodology (SRRM) methodology that provides a common procedure that is relatively light and flexible while at the same time relying on the personal experience, contextual knowledge, analytical skills, reactivity and common sense of staff members. It provide an institutional systematized standard used by all sites across contexts.

The key pillar of ICRC security and safety management have proven their value over time i.e.:

- security management is integrated in operations management;
- security management is decentralized closest to the actual risk environment;
- risk is inherent to humanitarian action and that a certain level of risk is accepted by the Institution;
- "acceptance" remains the main pillar of field security management.
4.3.5 Accountability to Affected People Institutional Framework

The ICRC’s Accountability to Affected People Institutional Framework is currently being finalized (estimated November 2018), following a recent evaluation.

Accountability to Affected People (AAP) is an approach (cf. infographic Error! Reference source not found.) that seeks to preserve the dignity of people affected by armed conflict and other situations of violence. It focuses on giving people a voice in determining their own needs and designing their own solutions, acknowledging the diversity of people forming a community and the fact they have different needs and capacities. In other words, it seeks to ensure that affected people have the power to effectively contribute to shaping humanitarian response.

Beyond recognizing the need to be accountable to individuals and communities affected by armed conflict and other situations of violence, the ICRC also acknowledges the importance of taking into account their specific and diverse needs, vulnerabilities and capacities, which are often linked to factors such as gender, age and disability. As such, it strives to engage directly with people and communities, in order to involve them in planning and implementing its activities. Listening to the people it seeks to help is also crucial to fostering acceptance for the ICRC’s mandate and activities.

Guided by an institutional framework for improving its accountability to the people it works to assist, the ICRC seeks to help people and communities mitigate their exposure to risks and back their efforts to strengthen their resilience to the effects of conflict and other violence, for instance by helping them build upon their existing coping mechanisms. In line with this, the ICRC takes steps to identify the potential adverse consequences of its activities or of its lack of response, and does its best to avoid these.

The ICRC seeks to ensure that its policies, approaches and practices are sensitive to gender, age and disability and that beneficiaries can access its services in an equitable manner. Through an ongoing process to develop an operational approach for addressing gender, age, disability and other diversity factors, the ICRC is strengthening its understanding of these issues and how they compound people’s vulnerabilities, as well as how to better integrate them in its operations, and ensure that its processes are inclusive and participatory. In terms of addressing the needs of people with disabilities, the ICRC has widened its scope of activities for people with physical disabilities to include not only support for their physical rehabilitation but also efforts to promote their social inclusion.

The diagram below summarizes how the ICRC aims to work in humanitarian response: a strong ethical foundation with the objective to ensure the quality and accountability of our programs; a set of guiding principles and good practice that enhance our ability to achieve program results; as well as support functions and systems that enable staff to turn these principles in action.
4.3.6 Guidelines and Information on How to Do Business with ICRC
The ICRC requires its suppliers to ensure social compliance, environmental and quality management match with international standards such as ISO 26000, ISO 14001, ISO 9001 and SA 8000. Furthermore, neutrality towards conflicting parties is a must.

When working with trading companies, the ICRC assesses their sources. In order to optimize the product’s performance, a life cycle analysis is developed in partnership with the supplier and all the stakeholders in the supply chain.

The Guidelines and information on how to do business with the ICRC document provides procurement policy related information on:

- Fundamental principles for doing business with the ICRC
- ICRC long-term relationships strategy
- ICRC active sourcing policy
- ”QSE” requirements: Quality, social & environmental audits

4.3.7 Code of Ethics for Purchasing (Goods and Services)
ICRC’s code of ethics for purchasing insist on ethical standards from our suppliers. The ICRC commits not only to be fair and above board in its dealings, but to avoid any conduct which is capable of having an adverse interpretation put on it.

4.3.8 General Conditions for Purchasing
The ICRC has a General Conditions of Purchasing (GCP) document applicable for all procurements. Purchase orders or contracts shall become effective, subject to a written confirmation of the seller that he accepts
the ICRC general conditions on purchasing. Acceptance of the ICRC purchase order entails waiving by the seller of his general sales conditions.

The General Conditions of Purchasing document refers to and incorporates the Universal Declaration of Human Rights, the Convention on the Rights of the Child and the ILO’s Declaration on Fundamental Principles and Rights at Work, to which sellers must abide. By virtue of these documents, the Seller must respect the following:

- prohibition on the use of child labor;
- prohibition on the use of forced labor;
- national laws regarding hygiene, safety and labor rights.

The application of these principles is based on the laws of the country in which the items are produced. Should those laws fail to be observed by the Seller and/or its suppliers, the Buyer may make recommendations. If these recommendations are not followed, the Buyer is entitled to suspend or cancel the contract. Already rendered Services that cannot be returned, or goods and services that the Buyer keeps, must be paid but no compensation for the cancellation of the contract is due.

Similarly, considerations on environmental protection are included in the GCP (Article 23), as such, environmental protection is to be taken into consideration in the complete production process and distribution chain, from the raw materials production to the point of sale, and is not limited to the ICRC’s own activities and suppliers - local, regional and global environmental concerns are considered. Whenever possible, the Buyer has to seek to procure goods and services that lessen the burden on the environment.

4.3.9 Reference of Manufacturing Standards for Relief Items Production

The Reference of manufacturing standards for relief items production document applies to relief items purchased by the ICRC. It has also been proposed to the Quality Social Environment working group members (IFRC, UNHCR, UNICEF, IOM and MSF) to become an interagency standard.

The document contains the most important references to existing international standards for requirements in:

- Quality Management Systems (QMS) and associated Quality Controls (QC)
- Environmental Management Systems (EMS)
- Corporate Social Responsibility (CSR)

The ICRC is not a normative organization and has therefore no intention to elaborate international standards. The document merely provides references to existing international standards whenever possible.

4.3.10 Internal ICRC Logistics’ SOP

In addition to the above considerations, the ICRC has furthermore a range of rules and guidelines when it comes to procurement guidelines, transport and import/export of goods, the sustainability and responsibility of the logistical services provided, and specific standards required by medical items (cf. Annexes below).

4.3.11 Rules on Personal Data Protection

Safeguarding the personal data of individuals, particularly in testing conditions, such as armed conflicts and other humanitarian emergencies, is an essential aspect of protecting people’s lives, their physical and mental integrity, and their dignity – which makes it a matter of fundamental importance for the ICRC. ICRC’s set of rules for protecting personal data have therefore been codified in its Rules on Personal Data Protection according to which it processes personal data.
4.3.12 ICRC’s Approach to Protection
In order to preserve the lives, security, dignity and physical and mental well-being of people adversely affected by armed conflict and other violence, the ICRC has adopted a protection approach that aims to ensure that the authorities and other stakeholders involved fulfil their obligations and uphold the rights of individuals protected by law. It also tries to prevent and/or end actual or probable violations of IHL and of other bodies of law protecting people in such situations. Protection focuses on the causes, circumstances and consequences of violations, targeting those responsible and those who can influence them.

The beneficiaries include, inter alia, resident and displaced civilians, vulnerable migrants, people deprived of their freedom (in particular prisoners of war, security detainees, internees and other people at risk of being subject to ill-treatment or substandard living conditions), people separated from their relatives because of conflict, violence or other circumstances, such as natural disasters or migration, and missing persons and their families. Fighters and other persons participating in the hostilities also indirectly benefit from the ICRC’s work in this domain, particularly in relation to the organization’s advocacy on prohibiting certain weapons and tactics of warfare.

As a neutral, impartial and independent humanitarian organization, the ICRC seeks to ensure that all the parties to a conflict and all authorities provide individuals and groups with the full respect and protection that are due to them under IHL and other fundamental rules protecting persons in armed conflict or other situations of violence. In response to violations of these rules, the ICRC endeavors, through constructive and confidential dialogue, to encourage the authorities concerned to take corrective action and to prevent any recurrence. Delegations monitor the situation and the treatment of the civilian population
and people deprived of their freedom, discuss their findings with the authorities concerned, recommend measures, support the authorities in implementing them, and conduct follow-up activities.

The ICRC has developed a set of minimum but essential standards aimed at ensuring that protection work carried out by human rights and humanitarian actors in armed conflict and other situations of violence is safe and effective. The standards reflect shared thinking and common agreement among humanitarian and human rights practitioners (UN, NGOs, and components of the International Red Cross and Red Crescent Movement). The Professional Standards for Protection Work (third edition) were adopted following an ICRC-led consultation process.

Beyond these overarching considerations, a further set of principles guide the ICRC’s efforts to deliver the necessary standard of care in armed conflict and other situations of violence in its health-care programs, including the like of complying with recognized professional standards, abiding by medical ethics, particularly impartiality of care and patient confidentiality, and remaining accountable to beneficiaries.

4.3.13 Headquarters Agreement
The ICRC has been present in Juba since 1980 and established an office in the newly-independent Republic of South Sudan in mid-2011. The ICRC has a headquarters agreement with the GoSS, which provides the necessary privileges and immunities for ICRC to conduct its activities in the country, facilitating the ICRC’s humanitarian mission. This provides the wider frame for cooperation agreements with certain ministries or agencies (e.g. the Ministry of Health or municipal water boards) to interacting with communities and negotiating access with non-state armed groups.

5 Baseline data
5.1 Situation Overview
The Republic of South Sudan faces considerable humanitarian challenges, which have increased substantially since the start of the conflict in December 2013. The legacy of civil war and chronic underdevelopment impact heavily on the ability of the still-new nation to provide basic services and respond to humanitarian needs, rendering communities vulnerable to the effects of insecurity, displacement, food shortages and outbreaks of disease.

As the conflict in South Sudan enters its seventh year in 2019, the humanitarian crisis has continued and expanded on a costly trajectory for the country’s people and their outlook on the future. The compounding effects of widespread violence and sustained economic hardship have further diminished the capacity of people to face threats to their health, safety and livelihoods.

Fighting and surges of violence have forced people to flee their homes, many of them multiple times. The number of people uprooted since the start of the conflict in 2013 has reached more than 4 million, including 1.9 million internally displaced people, with up to 85 per cent estimated to be children and women (OCHA, 2018).

Violence continues and has become a persistent reality for civilians. Internally displaced people’s access to services has eroded with insecurity and economic decline. Rape and other types of gender-based violence (GBV) are pervasive but go largely unreported. Particularly vulnerable groups such as children, people with disabilities and older people, suffer the most intense consequences of sustained displacement, violence and lack of access to services.
Continued economic decline has undermined people’s access to basic resources. The cost of living has continued to escalate markedly. The effects are particularly acute in urban areas, with increasing inflation. Fuel shortages have constrained activity and hobbled public services provision, compounded by irregular salary payments to public sector employees.

Children continue to suffer the brunt of conflict and economic pressures, and the situation has deteriorated, with continued incidents of recruitment, abuse, exploitation and other issues since the beginning of the conflict. Destruction of schools and the departure of teachers from many affected areas severely impacts access to education (OCHA, 2018).

Hunger and malnutrition have escalated, with about 1.1 million children under age 5 estimated to be acutely malnourished and in need of lifesaving services (OCHA, 2018). Severe food insecurity continues to increase for the sixth consecutive year and a record-high number of people are severely food insecure. Insecurity and related displacement have undermined already compromised agricultural production, destroying the livelihoods of farmers and herders and causing food shortages. Severe food insecurity is expected to rise again and deteriorate further in the lean season.

Conflict and economic crisis have taken a significant toll on health. Disease outbreaks have lasted longer and reached previously unaffected areas, weakening already vulnerable people’s ability to cope with multiple shocks. In 2017, South Sudan had the longest-running cholera outbreak in its history, which began in June 2016 and continued into 2018. Destruction of health-care facilities, attacks on health workers, and shortages of drugs and skilled professionals mean access to health care is increasingly sparse. Preventable diseases like measles spread unchecked, and cases of kala-azar and meningitis are on the rise. With only 22 per cent of health facilities fully operational, the absence of services means that cases of emergency obstetric care, as well as tuberculosis, HIV/AIDS and mental health issues go largely untreated, causing increased morbidity and mortality.

5.2 Problem Analysis

Nearly 5 million South Sudanese people need humanitarian health services (OCHA, 2018). The population is highly susceptible to disease and war-related injuries. Communicable diseases continue to spread, and disease outbreaks plague the country. The mental health and psychosocial burden increases each day that the conflict is prolonged. Access to health care is increasingly limited due to destruction or occupation of health facilities by parties to the conflict, attacks on health workers, and shortages of drugs and skilled professionals. Close to a quarter of health facilities out of the overstretched total are not functional, while those which are operational face challenges of delivering the complete basic package of health-care services due to a combination of extensive looting, critical loss of human resources, frequent stock outs of drugs and pharmaceuticals, and fiscal delays. The absence of services means that cases needing emergency obstetric care, as well as tuberculosis, HIV/AIDS and mental health issues go largely untreated, causing increased morbidity and mortality.

Displaced people face the most complex challenges in accessing health care, particularly those who have fled to remote areas. Children under age 5 are particularly vulnerable to disease, including due to the low level of routine immunization and poor nutrition status. Survivors of gender-based violence have inadequate access to services and women do not have adequate access to skilled personnel during pregnancy and childbirth. People living with HIV/AIDS or tuberculosis, mental health and disabilities have often been cut-off from life-saving treatment by the conflict and the lack of resources due to the economic crisis.

The conflict has taken a major toll on the health care system, with the Equatorias, Jonglei and Upper Nile being the hardest hit. Humanitarians have continued to provide up to 80 per cent of health care services in South Sudan, with continuity of services relying on availability of funding. There is also a lack of
infection control, health-care waste management, water quality control and monitoring to mitigate risks of diseases spreading.

According to WHO, the population of South Sudan is highly susceptible to disease and conflict-related injuries. Disease outbreaks have lasted longer than ever and reached previously unaffected areas, weakening already vulnerable people’s ability to cope with multiple shocks. Preventable diseases like measles spread unchecked. The mental health and psychosocial burden increases each day that the conflict is prolonged.

Based on the main findings of a 2017 third party external evaluation of South Sudan International Health Regulations core capacities, a range of wider systemic challenges prevail, some of them usefully mentioned to provide the backdrop of the program. For example:

- South Sudan has legislation and several regulations and administrative documents that govern public health surveillance and response. However, many of the documents are in draft and therefore cannot be put into operation.
- Generally, there is no formalized structure for coordination and communication between relevant ministries and other stakeholders on events of national and international interest. This often leads to duplication of efforts and delays in response.
- There is no national plan for the detection and reporting of antimicrobial resistance (AMR) pathogens and no healthcare associated infection (HCAI) sentinel sites have been set up. South Sudan currently has no AMR reference laboratory.
- Immunization coverage remains low at 34%, as the country is faced with the challenge of nonfunctioning health facilities due to ongoing conflict, inadequate funds and a high rate of attrition of trained immunization staff due to poor motivation. The presence of difficult terrain and conflict also means that certain parts of the country are left out for significant periods of time without vaccines.
- The local health workforce capacity of South Sudan is quite low at all the levels in terms of numbers and skills required. No mechanism is in place to train and track field epidemiology capacity and general staff attrition is high.

5.3 Analysis of Alternatives

ICRC’s approach to programming Health Care delivery in South Sudan rests on an intimate knowledge of the South Sudanese context stretching back several decades and building on an institution emergency health emergency response practice dating back to the 19th century. It is rooted in the organization’s expertise to operate and adjust its programs in conflict-affected, fluid and volatile environments thanks to its neutral, independent and impartial humanitarian action, anchored in the acceptance by affected communities and parties to the conflict. The ICRC institutional social and environmental frameworks mentioned above, which its South Sudan programs integrate, are the product of years of expertise operating in disadvantaged, conflict-affected and fluid environments. They prioritize principled pragmatism, responsiveness to acute and immediate needs, a human-centered focus, as well as flexibility and adaptiveness.

The appropriateness and impact of ICRC’s approach and methodology is evidenced by its track record in this sector in the South Sudanese context as documented in its past annual reports. The sought support will allow to build and expand on these precedents, learning as well from the South Sudan Rapid Results Health Project.
6 Environmental Risks, Impacts and Mitigation Measures

The ICRC Health program will increase the safe access to health care to conflict affected communities and internally displaced people through augmented outreach and expansion of basic health services via functional structures and professional services. These services are expected to contribute amongst others to reduction of child mortality, maternal mortality, reduce spread of vector diseases and general improvement in the quality of health service delivery.

The response will target the most vulnerable people in need of humanitarian health care. IDPs require particular consideration, given their vulnerability and susceptibility to disease. Levels of displacement, disease burden, outbreak potential, need of reproductive health care, morbidity from AIDS and tuberculosis, IPC status and levels of severe malnutrition among children with medical complications will be taken into account. Geographical locations considered include epidemic-prone, conflict-affected and seasonally hard-to-reach areas. Contextual analysis includes issues related to water and sanitation provision in health facilities, attacks on healthcare services, ICRC-related practical considerations (e.g. pluri-disciplinary approach, security, access, etc.), and other actors’ response plan in the Health sector.

Mental health and psychosocial support services will be strengthened to enhance people’s capacity to use their coping mechanisms. Integrated services along the continuum of care will be taken into account via enhanced referral mechanisms where available.

The response will promote a dignified, people centered approach, guided by the needs of the most vulnerable and the ICRC’s AAP framework. Feedback loops with people in need of health care, monitoring complaints, adjusting services as needed, and sharing best health-care practices will be considered. Regular supervision and monitoring visits by the ICRC management, in-country health coordination and health experts from the Health Unit at the ICRC HQ will ensure quality of care and service delivery. Throughout the health response, the needs of women and children will be addressed, including in relation to conflict-related sexual violence.

In general, the negative environmental and social impacts associated with the Health program (detailed in the sub-sections below) will be localized, temporary, and easily mitigated, in light of the type, location, sensitivity, and scale of the proposed project, the nature and magnitude of its potential impact and scope, as well as the mitigating measures that are part of the ICRC’s standard practice.

Looking more closely, a potential adverse impact of the ICRC Health program pertains to risk linked to the management of medical products and/or the generation of medical and healthcare waste. The organization’s stringent medical procurement, transport and warehousing procedures as applied in South Sudan as well as its medical waste management protocols will ensure the identification, prevention and mitigation of these risks at each Health facility being supported (cf. 6.3 and 6.4 below for greater detail).

Not supported in the frame of this project though ensured by other financial means, the program will support rehabilitation, maintenance and renovation works to existing health facilities, as might be needed to provide a safe and sanitary environment for both patients and personnel. No social threat and no significant environmental risks can be linked to these minor, site specific, time-bound works given the size and number of facilities to be refurbished over the life of the project. No land acquisition is expected from the renovations as they will be confined within the compounds of existing premises (cf. 6.5 below for greater detail).

ICRC’s approach integrates its AAP protocols, ensuring continuous community consultation, participation and accountability throughout the project cycle. Particular attention will be given to ensure the inclusion of vulnerable beneficiaries and households, whether stemming from host or IDP communities. These input and exchanges will be continuous, both through patient-health care staff contact opportunities
provided daily, the ready accessibility by all to ICRC personnel on site, as well as the interface of the Community Health Committees (cf. 6.4 and 6.10 below for greater detail).

Accordingly, no serious adverse impacts to people or the environment are expected, whilst worker and community health and safety will benefit from the exposure to and related training of ICRC best practices. ICRC’s core principles of neutral, impartial, independent humanitarian action driving all its programs will ensure that there is no prejudice or discrimination toward individuals or communities, with particular attention given to minority groups, and those disadvantaged or vulnerable, whether they might be in areas held by the government or armed opposition. Regular analysis as per ICRC practice will ensure that human security considerations are taken into account in the Health services provided, notably through the conduit of its integrated Health Care in Danger project.

6.1 Introduction to Assessment and Management of Environmental and Social Risks and Impacts

The ICRC’s operational security rests amongst other on its acceptance by all parties to a conflict and the communities that it intends to serve. As exposed Error! Reference source not found., this continuous consultation process is an integral part played by each and every staff in South Sudan, whether formally or informally. It constitutes a constant feedback loop provided by the multi-disciplinary teams of the various field sites whether through bilateral exchanges with their immediate hierarchy at the sub-delegation/field office level, during weekly staff meetings, or in reports. It ensures views, grievances and needs of a variety of stakeholders ranging from the voiceless to traditional leaders to armed groups calibrate its operational practice.

Additionally and more formally, in the framework of the Error! Reference source not found. mentioned AAP approach, taking a people centered, inclusive approach to programing, providing communities affected by conflict a way to be involved in decisions that affect their lives is more than ever at the center of the ICRC’s efforts. It also enables them to determine their own needs and co-design solutions, preserving the dignity of people assisted as a result. Putting people at the center also means being inclusive and acknowledging possible diversity within a community, and the resulting differences in needs, vulnerabilities and capacities. As all ICRC delegations, the South Sudan team is guided in this endeavor by a yearly (starting 2019) self-assessment tool offering a practical way to document practices and consolidate approaches, ensuring social considerations remain anchored in every delegates’ practice.

Environmental considerations, for their part are taken into account mainly through the prism of medical waste management on each of the supported primary and secondary health-care centers as exposed Error! Reference source not found. under Pollution Prevention and Management.

Furthermore and although not supported by this project, minor rehabilitation/renovation works will only be done in the perimeter of existing communal health-care facilities.

Cf. Section 6.2 below for a Summary Table of Main Risks, Mitigation Measures, and Indicators. Following Section 6.2 are Sections which give a more thorough explanation of ICRC’s related protocols and standards of procedures related to each of the five noted potential environmental and social impacts.
6.2 Summary Table of Main Risks, Mitigating Measures and Indicators

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<thead>
<tr>
<th>S/N</th>
<th>ENVIRONMENTAL / SOCIAL IMPACT</th>
<th>DESCRIPTIONS</th>
<th>SUGGESTED MITIGATION MEASURES AND RELATED PROTOCOLS/SOP</th>
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</thead>
</table>
| 1   | OCCUPATIONAL HEALTH & SAFETY  | B. Medical personnel and waste handlers are exposed to dangerous and infectious HCW (health care waste) as they collect and transport HCW  
B. Staff incur on-the-job injuries due to improper clinical techniques, use of equipment, etc. | B. Medical staff is medically screened, briefed and trained on risks (cf. Annex on ICRC medical standards for deployment)  
B. Primary and secondary measures are followed (cf. ICRC's Medical Waste Management Manual)  
B. Exposure protocols are known and implemented (cf. Annex on ICRC PEP guidelines)  
B. Juba and Geneva staff health colleagues are available if need be. | B. HQ HR Staff Health and Region  
B. Juba Health program coordination team  
B. Suggested indicators:  
  - Indicator: Number of cases having required use of PEP kits  
  - Indicator: Number of helpers receiving follow-up support (MHPSS) |
| 2   | COMMUNITY HEALTH AND SAFETY   | B. Lapse of confidentiality  
B. Assault by medical staff worker  
B. Unrealistic expectation of level of care and/or recovery  
B. Sub-par quality/inefficacy of medical goods procured (drugs, supplies, equipment)  
B. Expiration of goods  
B. Unnecessary and/or improper disposal of goods  
B. Medical staff hired is experienced, professional and trained (cf. Annexes on ICRC staff hiring requirements, code of conduct (see Annex 9.1) and of some of the training available to health staff)  
B. Patients and/or care-takers are told and aware of the services available and understand procedures offered as well as their consequences  
B. Complaints and grievances can be aired and processed  
B. All waste storage and disposal sites is adequately cordoned off from the public (cf. ICRC's medical waste management handbook)  
B. Procurement system (cf. Annex on ICRC's on Procurement guidelines below)  
B. Cold chain / storage and transport management system (cf. Annex on ICRC's medical logistics below)  
B. Computerized and manual inventory system as well as disposal SOL (cf. Annex on ICRC's medical logistics below) | B. HQ HR Talent Management and Global Compliance Office  
B. Juba Health program coordination team  
B. Field site Health delegates and Community Health Committees  
B. Suggested indicators:  
  - Indicator (PHC): Working days per month  
  - Indicator (PHC): Number of MoH/DOH/Health authorities visits  
  - Indicator (PHC): number of days of shortages of drugs  
  - Indicator (PHC): Indicator on whether the monthly health committee meetings took place.  
  - Indicator (PHC): Number of ICRC visits  
  - Indicator (2nd HC): Indicator on whether there is a functionally hospital community board  
  - Indicator (2nd HC): Number of qualified staff doing consultations  
  - Indicator (2nd HC): Number of days per months with storage for the ten main drugs  
  - Indicator (2nd HC): Total number of laboratory tests done  
  - Indicator (2nd HC): Availability 24h/day of water  
  - Indicator (2nd HC): Availability 24h/day of electricity  
  - Indicator (2nd HC): Follow-up and implementation of a regular maintenance schedule plan for hospital equipment  
  - Indicator (2nd HC):Follow-up and implementation of a regular maintenance schedule plan for infrastructure |

*All to be reported on a quarterly basis*
| 3 | **MEDICAL WASTE MANAGEMENT** | B. Medical waste and other potentially dangerous by-products of health care activities (e.g. expired medication) are an ineludible side product of any HC facility that represents potential hazard to public safety  
B. Public access to HC waste could be a hazard to communities and individuals  
B. Improper waste management could lead to leachate produced flowing into surface waters and contamination could occur  
B. A medical waste management plan for each HCF exists (based on ICRC Medical Waste Management Manual), including elements on:  
- The proper handling, and disposal of wastes  
- The establishment/upgrade of secured on-site waste collection and storage points  
- Clear roles and responsibilities | B. Juba Health program coordination team  
B. Suggested indicators:  
- Indicator (PHC): Presence of waste disposals in the health structure  
- Indicator (PHC): Presence of safety boxes for used needles/sharps  
- Indicator (2nd HC): Indicator on whether the waste management guidelines are implemented  
- Indicator (2nd HC): Existence of a cleaning schedule/plan |}

| 4 | **MINOR FACILITY REPAIR AND REHABILITATION (within existing footprint of facility only)** | B. Construction worker first-aid  
B. Community health and safety  
B. Construction equipment handing  
B. Construction debris management  
B. Poor quality construction leading to harm to workers and/or patients  
B. ICRC’s engineering teams deploy best efforts to follow apply ILO health and safety recommendations to any works undertaken, including when it comes to access to and use of personal protective equipment; cordoning-off of areas under active construction, or safe storage of construction equipment, f.e.. | B. Juba Water and Habitat program coordination team  
B. NB: no rehabilitation/renovation works of health-care facilities will be supported by means made available in the frame of this project |}

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4 Note that no rehabilitation/renovation works of health-care facilities will be supported by means made available in the frame of this project – resources required will be drawn independently on by the ICRC to this end.
6.3 Occupational Health and Safety

As a responsible employer, the ICRC promotes and integrates sound worker-management relationships, treating its staff fairly and providing safe and healthy working conditions as per its staff rules, which, where applicable, follow the South Sudan Labor Laws.

Furthermore, particular medical precautionary steps are taken to ensure the physical (e.g. required immunizations and prophylaxis) and psychological readiness of deployed staff, as well as suitable knowledge of (e.g. through trainings, cf. Annex) and care in terms of any undue health hazard exposure (cf. annexes below on Medical Standard for Deployment and PEP guidelines, as well as ICRC’s Medical Waste Management Manual). To that end, primary prevention considerations are taken into account, notably regarding the elimination of hazards; collective and technical prevention (e.g. using needle receptacles); organizational prevention (e.g. clearly assigned duties and responsibilities to all team members); and individual prevention (e.g. the use of personal protective equipment). Standard secondary prevention measures in the event of an accident are as well applied in South Sudan, with ICRC’s standard exposure control plan for blood-borne pathogens being followed for the main risk identified as being linked to the handling of needles/sharps. Should such incidents occur, these are reported to the ICRC hierarchy as per requirements linked to the use of PEP kits.

For both physical and psychological needs of its staff, in addition to a central, HQ based Health service, a staff-health officer is as well available in Juba.

The contract between local authorities and ICRC specific to occupational health and safety usually contains the following elements:

- The local relevant authorities are usually responsible for:
  - Forming a hygiene committee to ensure safety precautions are adhered to and a high standard of hygiene are maintained within the structure;

- ICRC is usually responsible for:
  - Providing materials for maintenance and cleaning of the facility;
  - Training cleaning staff in hygiene standards;
  - Providing sanitation facilities for the use of inpatients;
  - Supporting the establishment of a kitchen facility to provide food for inpatients and their caretakers; and
  - Supporting the establishment of a laundry facility to provide clean linen for the inpatients.

6.4 Community Health and Safety

For the implementation of this intervention, the health facility, including ICRC and local staff, will adhere to and observe the South Sudan Ministry of Health clinical guidelines, World Health Organization guidelines and the ICRC’s Health Programs guidelines.

Community health will benefit from the ICRC’s envisaged program to increase its access to basic health services, with a particular attention provided to the most vulnerable through dedicated community engagement (cf. Social Assessment document provided in parallel for the same program). The professionalism of the ICRC’s health staff and of its management of other inputs (cf. ICRC’s Code of Conduct; Annex 9.1 and the Section below on Staffing and Hiring) and outputs will guarantee the safety and security of its beneficiaries.

Patients and/or their caretakers are informed upon admission and treatment by health care staff (generally national ICRC employees given language barriers) of the services they are being provided with
and the possibility for them to choose to opt-out from these or express any concern. In addition, Community Health Committees act as an additional relay to channel any such grievances if need be, f.e. in their monthly meetings with the ICRC. Should such be aired via either means, they are discussed on the spot with the team and addressed if possible; if not, the issue is taken up the ICRC hierarchy in order to identify the best way forward with the parties concerned.

6.5 Medical Waste Management

ICRC’s medical inputs to the South Sudan health programs will be procured internationally, arbitrating its global footprint and leveraging economies of scale for maximum efficiency, effectiveness and economy. Institutional considerations regarding its Code of Ethics for Purchasing (goods and services) as well as General Conditions for Purchasing (cf. Error! Reference source not found.) which take into account environmental (and social) considerations, are directly applicable when it comes to concerns of efficiency and pollution related matters of used inputs.

Output related prevention and management considerations center on medical waste and will respect the ICRC’s guidelines on the matter (detailed Error! Reference source not found., as well as in Annex 2). More specifically, in South Sudan the following specificities can be mentioned.

In secondary hospital and large scale PHC centers in South Sudan, the ICRC (i.e. its Water/Habitat engineering teams) has built incinerators with high temperature dual combustion chambers (the De Montfort models are being used as blueprints, cf. Annex), using available materials in-country as well as importing refractory bricks in order to improve burning efficiency. In these structures, ICRC has incorporated the strengthening of the health facilities’ operation and maintenance as well as general waste management teams, whether through the provision of essential input as well as training (cf. Annex on the minutes of such a training) and mentoring. Medical waste plans are as well established for such facilities together with the Community Health Committees, an example of which is provided in the Annexes.

In smaller scale PHCC/U, typically the ones closer to front lines where greater agility of response is required, lighter incinerators are set-up. Though waste management is always part of the ICRC’s approach when considering rehabilitation needs of health infrastructure, delays in building incinerator until they are functional are frequent. In the interim, medical waste is burnt in dedicated barrels as provisional arrangements, ensuring sufficient air intake below the combustion flame and protecting the top with fine wire mesh (to contain the ash). Beyond incinerators, waste management practice in ICRC supported PHC in South Sudan furthermore include placenta pits (though culturally in some locations these are taken back home for burial; pits are therefore not always needed), ashes pits, and safety contained for disposal of sharps to be incinerated/buried.

In all health facilities, the waste management area is secured by a fence. ICRC staff as well works closely with local health staff, training them on waste segregation, with different type of disposal areas as per the typology of waste being generated. Non-hazardous refuse is collected and disposed of separately from infectious and hazardous wastes, collected and disposed on site either by incineration or in secured pits as mentioned above.

In order to ensure the quality of the procurement, storage and transport of the medical items, ICRC’s standard operating procedures (cf. Internal ICRC Logistics’ SOP Error! Reference source not found.) are applied by the ICRC Juba delegation. In practical terms for ICRC’s South Sudan operations, this will signify the following to ensure the quality of the goods distributed.

Three levels of risk of impacting the patient’s health are identified, and therefore Item category and applicable rules for procurement of medical inputs:
**Item 1:** Products at low risk and thus if the quality is of acceptable standard they can be bought locally without Geneva validation (mainly non-sterile Medical Devices)
   - Non-applicable for South Sudan though procurable via the regional logistics center in Nairobi.

**Item 2:** Products at medium risk (mainly sterile medical devices) can potentially be procured through Logistics Supply Centers if Geneva Technical advisers could source the right products, after conferring with either the Geneva Head Pharmacist or the Regional Pharmacist
   - Partially applicable for items not safely procurable via the regional logistics center in Nairobi.

**Item 3:** Products at high risk for the patients (mainly pharmaceuticals) have to be procured through Geneva Logistic center. A separate Quality Assurance policy for qualifying products and suppliers exists at the ICRC, the main points to guarantee the quality of pharmaceuticals being based on audits of manufacturers and marketing authorization of pharmaceuticals in highly regulated countries
   - Applicable to the South Sudan operations.

When receiving medical items at the Juba warehouse and secondary field sites, the manufacturer, batch number and expiry date of each original manufacturer carton (secondary or tertiary packaging) with the respective information on the packing list is done, all the while checking for signs of tampering.

Regarding storage realities, the South Sudan delegation has a medical facilities network composed as follows: a climate controlled central medical warehouse in Juba and dedicated pharmacies in ICRC supported hospitals in Juba, Wau, Ganyiel, Akobo and in PHCU/PHCCs of currently thirteen settlements.

The management of the cold chain equipment is guaranteed by ensuring at minimum eight hours of electricity during 24 hours for cold room, ice-lined refrigerators and fridges, with available spare capacity in case any equipment become faulty. The cold room, ice-lined refrigerators and freezers are usually kitted with temperature sensors connected to ICE3/Extra remote temperature monitoring system as well as a mains electricity supply monitoring system. Internal temperature of the main warehouse is monitored with ICE3/Extra temperature data loggers, which are checked by the Medical Logistician and the Pharmacist over the Cold Cloud on a daily basis. Any variance and undertaken remedial action are logged in a Cold Cloud report at the Juba level and alarms are sent via e-mail and sms.

On considerations pertaining to transport of medical items, when receiving cold chain consignments from Geneva, the "Arrived" / "Stop" button on the "Libero" or "Q-tag" (temperature data logger) is pressed upon arrival at the Juba medical warehouse, with the issuance and saving of an automatically generated pdf report on the temperature data log of the consignment. For onwards shipping to field sites, standard cold boxes and water-packs are used for transportation of cold chain items via ICRC’s own airlift capacity in South Sudan.

When it comes to the management of unwanted medical items, the following steps are taken:

- The unwanted health care goods are recorded and collected in a dedicated place in the medical store and kept under quarantine both in Juba’s main medical warehouse and field sites.

- Solids, semisolids and powders are incinerated with the coordination of the local Pharmacist cooperating with Juba Medical Logistics.

The contract between local authorities and ICRC specific to medical waste management usually contains the following elements:

- The local relevant authorities are usually responsible for:
  - Identifying a site for waste disposal, including sharps, within the boundaries of the compound;
Forming a hygiene committee to ensure safety precautions are adhered to and a high standard of hygiene are maintained within the structure.

- ICRC is usually responsible for:
  - Ensuring ongoing maintenance of the hospital infrastructure.
  - Building an incinerator to safely treat waste generated from the hospital activities.
  - Training staff to operate and maintain the incinerator and to provide maintenance of the hospital.

Please refer to Section 9 for the following Annexes:

- Annex 9.3: Sample Hospital Medical Waste Plan;
- Annex 9.4: Sample Montfort Incinerator Design Plan;

Annex 9.5 contains the following information:

- Example of a Form for Quantifying Waste Generation (labelled as Annex 3.1);
- Checklist for Describing Current Situation (labelled as Annex 3.2);
- Example of a Waste Flow Diagram (labelled as Annex 3.3); and
- Audit Checklist (labelled as Annex 3.4).

6.6 Minor Facility Repair and Rehabilitation

ICRC’s efforts to increase access to essential health services will be provided from existing communal and MoH health infrastructures. There will thus be no involuntary resettlement caused by the project; rather it will itself take careful account of displacement generated by conflict and violence to respond to the basic needs of those affected.

For all ICRC Health projects, discussions with the local authorities are led to ensure that the land on which the project is implemented is communal property under their responsibility and ownership. ICRC investments on the existing and within the defined perimeter of medical facilities are mainly a mix of light rehabilitation and larger renovations works on current infrastructure, to ensure a safe and sanitary environment for both patients and health staff. From past experience, these are typically the like of rehabilitating roofs, increasing of ventilation capacity of premises, refurbishing of sanitary facilities, perimeter fencing, drainage systems improvements, etc.

Any extension work typically takes the form of temporary or semi-temporary structures and always remain within the initial perimeter of the health facilities.

ICRC has and will conduct the assessment and supervision of any renovation/rehabilitation works through its in-house Water and Habitat program engineers. Within the organization, they provide support in all engineering aspects and have expertise in water production and distribution, sanitation and hygiene, environmental health, hydraulic engineering, hydrogeology, electricity, civil, chemical and environmental engineering, architecture, etc. With due considerations and realism provided for context based realities and limitations as found in South Sudan, the Water and Habitat department aims to apply ILO health and safety recommendations to any works undertaken.

Of note, the support to be provided via the means of this project is not sought to fund any of the above-mentioned rehabilitation/renovation works financed by alternative streams of income.

The contract between local authorities and ICRC specific to minor facility repair and rehabilitation usually contains the following elements:

- All the rehabilitation, renovation, expansion and maintenance works shall be conducted according to the national guidelines, the ICRC health priorities and within the capacity of the ICRC budget;
• All engineering activities will be formalized through a dedicated Letter of Agreement, added to the MoU with the local health-care authorities;

• The local relevant authorities are usually responsible for:
  o Ensuring necessary clearance and authorization for any rehabilitation, renovation and expansion works;
  o Giving final agreement to any plans for rehabilitation, renovation and expansion of the current structure.
  o Identifying a site for waste disposal, including sharps, within the boundaries of the compound;
  o Forming a hygiene committee to ensure safety precautions are adhered to and a high standard of hygiene are maintained within the structure.

• ICRC is usually responsible for:
  o Rehabilitating, renovating and expanding a facility to enable a safe and hygienic environment in order to improve the quality of health service provision.
  o Working closely with local authorities in the planning of the rehabilitation and expansion of the health facility; and
  o Ensuring ongoing maintenance of the hospital infrastructure.
# 7 Social Risks and Mitigation Measures

Main risks stem from affecting variables of the ongoing conflict which continues to divide segments of society, and from leaving some more vulnerable (whether physically, mentally, or economically).

Based on the assessments and consultations undertaken, the specific risks that could arise from the ICRC’s health programs as described above have been identified as the following:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigating Measures</th>
<th>Who is responsible</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intimidation of staff due to ethnicity</td>
<td>• Maintaining balance of background when hiring&lt;br&gt;• Strict control of deployment of staff of certain ethnicities to the field&lt;br&gt;• Transparency with authorities&lt;br&gt;• Flexibility to make adjustments as needed</td>
<td>Hospital management committee and ICRC</td>
<td>During the recruitment process</td>
</tr>
<tr>
<td>Sexual favors requested by staff</td>
<td>• Ensure all staff have read and signed the Code of Conduct (see Annex 1)&lt;br&gt;• Strong hiring procedures and background checks, as well as diligent performance appraisals</td>
<td>ICRC</td>
<td>Immediate</td>
</tr>
<tr>
<td>Targeting of health institutions by parties to the conflict</td>
<td>• Dialogue with all parties to the conflict on IHL&lt;br&gt;• ICRC’s HCD initiative&lt;br&gt;• ICRC Juba Delegation’s security framework is in place and applied</td>
<td>ICRC to address authorities/weapon bearers and community members</td>
<td>Ongoing through operational communication</td>
</tr>
<tr>
<td>Perception of targeting only a certain group among beneficiaries/potential for unrest</td>
<td>• Use of clear vulnerability criteria&lt;br&gt;• Wide consultations with stakeholders through the AAP and CBP approaches&lt;br&gt;• ICRC logo and insignia/NIIHA approach</td>
<td>Hospital management committee and ICRC</td>
<td>Immediate</td>
</tr>
<tr>
<td>Nepotism by community leaders among population benefiting from programs</td>
<td>• Wide consultations with stakeholders through the AAP and CBP approaches</td>
<td>ICRC to engage with communities</td>
<td>As soon as concern is raised</td>
</tr>
<tr>
<td>Criminality/looting</td>
<td>• Engage with law enforcement forces to remind authorities of their responsibilities to protect humanitarian structures and essential services&lt;br&gt;• Engage with communities to identify and approach actors of influence</td>
<td>ICRC to engage with law enforcement operations and communities</td>
<td>Immediate</td>
</tr>
<tr>
<td>Revenge killing between the clans, sub clans and families</td>
<td>• CBP workshops to identify positive coping strategies&lt;br&gt;• PCP documentation and ICRC intervention&lt;br&gt;• Operational communications sessions to engage with actors of influence/weapon bearers&lt;br&gt;• Anthropological/cultural study conducted and results integrated in our approach/action</td>
<td>ICRC to engage with communities, actors of influence</td>
<td>Immediate</td>
</tr>
</tbody>
</table>
Key project approaches and activities themselves seek to mitigate these risks. Careful analysis taking into account external perspectives and local knowledge, blended with the ICRC’s neutral, impartial, and independent (NIIHA) approach ensure the ‘do not harm’ ethos. Access to primary and secondary healthcare, as well as psychosocial support, and by the most vulnerable regardless of age, gender, ethnicity, disability, sexual orientation, or other identity markers is maximized by the permanent presence of diverse field staff on project locations, attuned to the socio-political realities of the country and connected through various forms of engagement to the different segments of the population.

The ICRC’s program will build on its acceptance as a neutral, impartial, independent and humanitarian actor, focusing on ensuring the functionality of health provision structures and steering away from institutional/political agendas into which ethnicity is often intertwined, which could represent liabilities to its humanitarian action. The ‘do no harm’ principle imbues all considerations in the planning and project cycle as exposed above.

Regular analysis as per ICRC practice will ensure that human security considerations are taken into account in the health services provided.

7.1 Grievance Redress

Grievances are addressed directly following the direct contact beneficiaries and communities have with ICRC staff, given the proximity sought, or through more formal channels via the ICRC head of the field structure, depending on their nature. Regular exchanges with traditional and official authorities, as well as CHCs of the given project catchment areas, allow for other structured opportunities for filing of project-related grievances.

The ICRC’s CBP workshops in South Sudan often equally address grievances as part of the concerns raised by the community members the Delegation interacts and discusses with (see above section on CBP); the ICRC in South Sudan also collects broader feedback (including grievances) through community-based activities, such as needs assessments for health or economic security, or water and sanitation.

In terms of secondary care, in almost all cases, the ICRC operates in support mode of the local hospital structures, i.e. it does not operate its own hospitals (the exception being one weapon-wounded trauma center in Lebanon), so in this sense its hospital patients are also Ministry of Health patients. The ICRC therefore considers the MoH empowered to determine their own grievance redress mechanisms that make sense. Nonetheless, there are also informal grievance structures in place, whereby the Hospital Project Manager or Head Nurse listens to complaints and take necessary measures to resolve the issues related to ICRC services.

In case of specific grievances raised in the wider project activities, ICRC will record these. If such grievances cannot be resolved positively on the spot, ICRC will consult with the respective CHC, and the CHC will provide guidance. If the grievance cannot be resolved amicably, ICRC will forward it to a mandated officer in the Delegation in Juba for a second opinion. Grievances are generally addressed within 30 days or the aggrieved party has to be informed about a necessary extension of time. A quarterly technical report, which will flag the number and type of grievances should they occur, will inform the project on any trends on grievances, remaining sensitive to confidentiality and data privacy as the situation requires. As per need and through such internal reporting, ways to calibrate the program are discussed with ICRC headquarters.

Due to the poor telephone coverage in South Sudan, the ICRC does not have a telephone hotline in place to collect feedback/complaints. High levels of illiteracy means that comment boxes are also not ideal means of inviting and submitting feedback. Therefore, ICRC will ensure regular personal contact with communities to ensure early identification of grievances as well as disclosure of procedures how communities can raise grievances as noted above.
The focal points for grievances will be ICRC health delegates covering support provided to PHCs. Information about grievance redress mechanisms will be relayed through the CHCs. Certain grievances will be fast-tracked due to their nature (e.g. sexual exploitation and abuse, fraud) and will be treated confidentially.

The ICRC’s Investigation Unit (responsible for investigating breaches of the ICRC’s Code of Conduct – see Annex 1) may also receive complaints through one of the following channels: employee, a line manager, HR, logistics, or finance and administration manager; head of delegation or director, general counsel, or a member of the ICRC’s Global Compliance Office. For external parties, grievances can be made through an ICRC employee or the Integrity Line (https://icrc.integrityplatform.org/) – which is independently managed in close cooperation with the ICRC’s Global Compliance office. These cases are then submitted to the Investigation Unit.

The Investigation Unit’s complaint-handling process begins with the acknowledgement of receipt of the complaint. All complaints of possible misconduct are logged in a confidential case management system and are assigned an identification number.

The case is the pre-assessed, and will be triaged along with other complaints based on the severity and risk. For issues outside the scope of the Code of Conduct (Category A), the Investigation Unit will inform the complainant or reporter about the determination and provide them with information about the possible support mechanisms existing within the organization, e.g. the Ombuds Office, the Staff Health Centre of Expertise, the diversity and inclusion adviser, etc. The Investigation Unit may also, in consultation with the complainant or reporter, decide to refer the case to management for follow-up.

For Category B\(^5\) and C\(^6\) cases, which fall within the scope of the CoC, an inquiry\(^7\) or investigation\(^8\) will be opened, based on the severity of the case. For Category C cases, the Investigation Unit completes a risk assessment questionnaire to determine the risk of the potential misconduct to the individual and/or the ICRC from a reputational, operational, financial and legal perspective. Category C lower-risk cases may be assigned to the Internal Control, Compliance and Fraud Investigation Unit, the Logistics Unit, HR, the Code of Conduct facilitator, or other subject matter experts.

Category C higher-risk cases are immediately assigned for investigation to the Investigation Unit. Similarly, the Investigation Unit may delegate investigative tasks to individuals outside the Investigation Unit who are suitably skilled or positioned to assist the investigation and perform the task. Any investigative tasks thus delegated will be considered to be conducted by persons authorized by the Investigation Unit and under the guidance and monitoring of the head of the Investigation Unit.

Upon completion of the investigation/inquiry, the investigator or inquiry lead will draft an investigation/inquiry report, a closure note or a closure report. If the allegations are substantiated during the inquiry/investigation, an Investigation or Inquiry Report will be written. Upon review and approval of the investigation/inquiry report, the Investigation Unit sends the report to the designated sanction owner. The sanction owner is the manager two levels above the subject of the investigation/inquiry. The ICRC’s general counsel can be consulted on disciplinary sanctions by the sanction owner where deemed necessary to ensure compliance. In exceptional cases, for example where an actual or perceived conflict of interest is raised by the Investigation Unit or the sanction owner himself/herself, and is confirmed by the Investigation Unit, the manager three levels above the subject of the investigation/inquiry (at the time of the conclusion of the investigation/inquiry) is the sanction owner.

The investigation/inquiry report will be shared with the manager of the subject of the investigation/inquiry except in those cases where they may be implicated. In harassment cases, the victim will be notified about the completion of the investigation and the key findings, but the report itself will not be shared.

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\(^5\) Cases where the reported allegations involve potential improper behavior that is linked to administrative and behavioral rules

\(^6\) Cases where the reported allegations involve improper behavior that may be the result of a criminal act, such as fraud, theft, harassment, abuse of power or sexual exploitation.

\(^7\) An inquiry is a fact-finding exercise which serves to examine and determine the veracity of allegations of lower-risk CoC violations, including with respect to, but not limited to, projects financed by the ICRC, and allegations of misconduct on the part of the organization’s staff members.

\(^8\) An investigation is a fact-finding exercise which serves to examine and determine the veracity of allegations of higher-risk Code of Conduct violations, including with respect to, but not limited to, projects financed by the ICRC, and allegations of misconduct on the part of the organization’s staff members.
It is the responsibility of the sanction owner to ensure compliance with the sanction Guidelines outlined in the ICRC’s Code of Conduct Operational Guidelines in taking appropriate action. The sanction is subject to appeal. Where an investigation reveals credible evidence of a crime, the Investigation Unit may, as appropriate, recommend that the general counsel, with the approval of the director-general, refer the case to the competent national law enforcement authorities for criminal investigation, and will prepare a summary of evidence to transmit to the authorities. In cases of vendor sanction or debarment, a notification will be send to the Logistics purchasing team in accordance with the Procurement Manual to initiate a sanction/debarment of any vendor implicated in fraudulent activities.

The Global Compliance Office retains a monitoring role with regard to sanctioning the subject of inquiry/investigation for category C cases. The Global Compliance Office will include the relevant director to whom the function reports in a quarterly review of the sanctions recorded in order to work towards consistent sanctioning and identify training in this regard.

If the allegation is found to be unsubstantiated, the investigation/inquiry is closed without the involvement of the sanction owner, and a closure note (issued when it is found that the inquiry/investigation cannot be completed to a satisfactory standard) or a closure report (outlining the facts established through the investigation/inquiry process and has determined the allegation(s) to be unfounded or unable to be substantiated.

The ICRC produces a quarterly report that discloses the results of measures taken with regard to cases of violation of the ICRC’s Code of Conduct and related policies by employees. The report also summarizes cases in which action has been taken to recover money owed to the organization in connection with disciplinary cases involving sanctions and other measures, as well as cases of potentially criminal behavior that were transmitted to the general counsel to consider referring them to national law enforcement authorities. The quarterly report is issued by the Investigation Unit to coincide with the quarterly Code of Conduct Steering Committee meetings. Upon approval by the Code of Conduct Steering Committee, the report can be made available on the ICRC extranet for donors (at the level of the Donor Support Group), with due regard for protecting the privacy of the individuals or entities concerned.

Confidentiality
Activities by the Investigation Unit or any other individual, delegation or function with respect to inquiries and investigations will be conducted in a confidential manner. The requirement for confidentiality extends to any employee who is involved with or has knowledge of the inquiry or investigation. Information will only be disclosed by the investigator or inquiry lead as required by the legitimate needs of the investigation or inquiry, in order to:

- allow for the subject of an investigation or inquiry to fully respond to the allegations and evidence
- facilitate witness testimony
- enable management or others to assist an investigation or inquiry or to mitigate potential risks to individuals or the organization
- protect the alleged victim or address security concerns.

Any violation of the confidentiality requirements for employees involved in inquiries and investigations may itself constitute misconduct.

Unlike other types of misconduct, the aggrieved individual in harassment cases is not obliged to report harassment, including sexual harassment. Before filing a complaint, the aggrieved may consult with the head of the Investigation Unit about the process that would apply should they decide to report an allegation.
7.2 Stakeholder Consultations

The ICRC’s operational approach, in which teams are physically embedded in the communities in which it works, is one that facilitates an ongoing process of participation and feedback from the communities. Moreover, the ICRC’s multi-sectoral approach to assistance – integrating elements of its Health, Water and Habitat (WatHab), and Economic Security (EcoSec), all the while ensuring Protection needs and concerns, ensures that needs across sectors are taken into consideration and programs are adapted accordingly, and that population feedback is integrated and communicated across sectors to be reflected into activities when pertinent and feasible.

Throughout 2018 in South Sudan, including in Jonglei and Upper Nile, ICRC has conducted monthly consultations with 12 Community Health Committees, elected representatives of the local communities; in addition to cooperation on a day-to-day basis with local health staff as well as beneficiaries. Consultations comparable level have also been conducted in the other states. 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. The feedback underlines backing for the project, considered as broad community support. The ICRC follows the principle that consultations need to be inclusive of all social/economic groups, gender, youth, and vulnerable groups. The aim of consultations is to inform communities about the project, obtain their feedback, obtain broad ownership of project activities and discuss how negative impacts (if any) will be mitigated. Throughout the Project lifecycle, ICRC will continue to assess environmental and social risks and mitigation measures to react adaptively to the volatile situation in South Sudan.

8 Institutional Arrangements of the ESMF

To ensure effectiveness, efficiency, and accountability, the ICRC employs a structured approach – known as results-based management – to planning, implementing and evaluating its activities. The approach calls on each delegation and program to focus on the expected results for the beneficiaries as per needs assessed by multidisciplinary teams, throughout the management cycle, and not simply during project implementation or budget control. Results-based management links activities from one stage to the next; requires the collection of information at each stage, which is used for management and reporting purposes; and ensures that resources are used to best effect.

The ICRC’s management cycle aims to maximize the benefits of programs for the beneficiaries, ensuring that efforts are relevant, feasible, and, whenever appropriate, sustainable. Guiding frameworks such as those relating to environmental management in assistance programs and accountability to affected population detailed above, are transversally integrated to this approach. The cycle starts with an assessment, which, after analysis, may lead to the formulation/planning, implementation and monitoring, and evaluation and learning. The entire sequence and the decisions taken therein are consistent with the ICRC’s mandate and its legal and policy framework.

The phases of the cycle are progressive, each needs to be completed for the next to be tackled successfully, with the exception of monitoring and evaluation, which are continuous and can be conducted at any stage. On the basis of its monitoring, the ICRC can recalibrate activities to ensure it remains focused on the expected result and to verify as well that these are still pertinent according to evolving geography and priorities of needs, reflecting the fluid nature of conflicts.

The ICRC does its own independent and impartial analysis of all conflict and violence situations and assessment of the humanitarian consequences on the people affected, including in the Health domain. It is able to conduct these because of its proximity to vulnerable communities and its relationship with the various parties to the conflict concerned.
The resulting and proposed objectives and plan of action are based on realities on the ground and reflect the ICRC’s operational capacity. The suggested program is thus the outcome of a careful analysis weighing the ICRC’s understanding of the situation and the needs it has observed; its access to a given population in need; and logistical, human and financial resources requirements.

8.1 Stakeholder Engagement and Information Disclosure

As exposed Error! Reference source not found. under the Social Risk Section, the ICRC integrates the engagement of a variety of stakeholders by embedding the AAP Framework into operational strategies and approaches. This allows it to identify and make use of the most relevant and trusted communication channels so that the population (including marginalized groups) can access timely, useful and actionable information about ICRC services and provide feedback on its programs, and systematically accounting for gender, age, disability and diversity. The readily accessible premises of the ICRC in South Sudan and the diverse daily presence, proximity and accessibility of its staff, whether Health or otherwise, ensures continuous opportunities for stakeholder engagement, in addition to more formal ones with official and traditional authorities.

For Health-related activities specifically, each health facility catchment area has a Community Health Committee, with which ICRC involves in the initial assessments as they represent the population towards the health system. Subsequently, monthly exchanges with the Committees are held to ensure a continuing dialogue and factor in community realities and requests in the program. Where these Committees do not exist, ICRC stimulates and supports their creation and functioning. Whether through verbal exchanges within teams or through more formal processes such as weekly team meetings, ICRC’s approach is made to continually evolve to best fit the fluid and dynamic realities of context and needs in South Sudan, as reflected through the close and frequent interaction of its staff with beneficiaries. Of final note, the MoU (cf. examples attached in Annex) signed with local Community Health Committees detailing ICRC’s support, maintain the final responsibility for the management and running of the supported health facility as being in their hands, to foster greater ownership and sustainability of the efforts engaged.

8.2 Project-Specific Consultations and Community Engagement

Before beginning support to any health facility, a health needs assessment is conducted. Like any of its health activities as per normal modus operandi, in designing the activities proposed above, the ICRC in South Sudan met with relevant authorities and community representatives to discuss and assess needs. Together, they discussed the areas of responsibility of the ICRC and those of the community and health authorities (County Health Department/director).

Where Community Health Committees exist, the ICRC regularly invites their participation in the same meetings. Where CHCs do not exist, the ICRC encourages the communities to form them and elect representatives, encouraging diverse representation. (The ICRC also supports CHCs 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 take place at the health facility itself.

The CHCs are responsible for ensuring that communities are aware of the ICRC’s activities and providing feedback to the ICRC, they also help ensure that the communities make use of the health facilities. The CHCs meet once per month, where they receive updates from the technical team working in the health facility- 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 the health status in their villages.
The ICRC ensures that for all input provided by the ICRC to the community health centers (drugs, materials, and equipment - also any kind of renovation of the health facility), a community representative receives and signs off on the donations.

8.3 Contractual Relationship with Hospitals
ICRC establishes a MoU with the local authorities responsible for the health facilities supported by the ICRC. The MoU stipulates the following rules and responsibilities between the two parties:

- Management responsibilities, transparency and information-sharing;
- Working modalities, including admission criteria and facility rules;
- Scale and scope of operation;
- Management and staffing, including human resource policy;
- Staff Code of Conduct;
- Equipment and supplies;
- Infrastructure reconstruction, renovation, and maintenance;
- Security, including data security and protection and exit strategies;
- Training.

8.4 Staffing and Hiring
The ICRC engages in rigorous hiring practices, which includes mandatory signature of the ICRC’s Code of Conduct.

For mobile health staff, the ICRC selects qualified candidates through a competitive bidding and interview process. It includes notably having to respond to questions to ascertain any criminal background, covering a) whether the candidate has been convicted of a crime or subject to any criminal or administrative penalty by any competent authority; b) whether the candidate has been dismissed or subject to any disciplinary measure or sanction by your employer or had your mission or service ended or curtailed for fraud, harassment, sexual harassment, sexual exploitation or sexual abuse.

If responses are satisfactory, the recruitment then proceeds with language tests (reading comprehension, oral, writing). The candidate must then pass a technical interview, as well as an interview with human resources, which assess the candidate’s motivations and commitment to the ICRC’s humanitarian mission, leadership skills, ability to work in teams, ability to negotiate, ability to learn from mistakes, etc.

ICRC’s human resources department then conducts two reference checks, and reviews the applicant’s certifications – such as diplomas, certificates, letters of recommendation, etc. All health staff have to provide certification of being qualified medical / nursing / technical personal with a license to practice in their home country. They typically have furthermore to showcase several years of working experience, ideally overseas. Average age of ICRC health staff is 41 years.

8.5 Staff Training
ICRC staff training includes internal training courses; staff integration course, team leading course as well as specific curricula related to health including: Health Emergency for Large Populations, Health care assessment, Monitoring and Evaluation, etc.

ICRC staff training focusses on health emergencies. ICRC staff also have access to a variety of external trainings; the below listing of which is a small subset:
8.6 Monitoring and Reporting

ICRC’s robust internal monitoring and reporting mechanisms will provide a basis for environmental and social monitoring and reporting. Additional mechanisms to allow for triangulation of routine programmatic data (results indicators), e.g. georeferenced data on service delivery and delivery of commodities will be adapted from existing in-house technologies and process for the program. The line of thought that has been pursued during preparation has been on how to corroborate data, beyond the classic ICRC-generated monitoring and reporting on the provided indicators, to produce a robust monitoring and reporting platform that tracks results achieved in health facilities supported by the operation. To that end, three processes with regard to results and implementation monitoring will be applied for ICRC-implemented activities. These will include both corroborations of ‘hard’ inputs (i.e. that health care facilities do exist and that medical supplies have been provided for their functioning), and corroborations of ‘soft’ inputs (i.e. that health care facilities have been benefitting from ICRC staff’s expertise and support). These options, to be confirmed during project appraisal, include the following:

(a) Geo-tagged pictures of health care facilities (the acceptability of geo-tagged pictures will need to be cleared with the relevant authorities, whilst photography of individuals is prohibited by ICRC rules for security considerations);

(b) Provision of proof of transfer of medical supplies (i.e. ICRC way-bills and donation certificates signed by the relevant non-ICRC heads of health facilities); potentially additionally triangulated with a geo-tagged proof of (bar-coded) consignments having arrived to the GPS coordinates of the health-care facilities (the acceptability of geo-tagging still needs to be cleared with the relevant authorities); and

(c) Provision of the ICRC GPS data logs of its vehicles having done the journey to the GPS coordinates of the health facilities.

(d) Project implementation will include regular “reverse” implementation support missions to discuss the progress, implementation arrangements, and solution-oriented action plans. These missions will be conducted biannually to: (a) review implementation progress and achievement of the PDO and intermediate indicators; (b) provide support for any implementation issues that may arise; (c) provide technical support related to implementation, achievement of results, and capacity building; (d) discuss relevant risks and mitigation measures; and (e) monitor the health system’s performance through project data and progress narratives. Field visits are not expected to become an option during the lifetime of the project, but if they do they will be added to the options for implementation support missions.

The following is a subset of the Summary Table in Section 6.2, which details the monitoring and reporting roles and indicators for each of the four categories of potential negative environmental and social impacts.
While the ICRC is steadfast in its commitment to following the result-based management approach and the management cycle as rigorously as possible, there are potential barriers to doing so, many of them specific to the volatile situations in South Sudan:

- Assessment capacities may be affected by restrictions on access owing to armed conflicts or other situations of violence; the ICRC’s ability to monitor and review an operation once

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9 All to be reported on a quarterly basis
10 Note that no rehabilitation/renovation works of health-care facilities will be supported by means made available in the frame of this project – resources required will be drawn independently on by the ICRC to this end.
implementation has begun may also become limited, or even no longer useful, owing to a radical change in the situation and security constraints.

Unfavorable weather conditions or damaged infrastructure may also obstruct the management cycle.

Specific circumstances may require urgent action. Where time is of utmost importance, assessments will be kept to a minimum to ensure that the operation can take place and benefit the target population as soon as possible. Similar constraints can also limit monitoring and review processes.

Data collection is frequently hampered by factors such as the non-availability or limited quality of data, the complexity and/or opacity of existing power structures, or internal ICRC constraints.

Though indicators relating to environmental and social safeguards will be built into the Health program monitoring (as detailed in the suggested reporting template), indicators, particularly numerical ones, will need to be interpreted carefully. Some figures might become too sensitive to external variables and can thus only be compared from one region to another or from one year to the next with great difficulty. In other cases, the ICRC works with indicators that are important, but cannot be shared without compromising its mandate as a neutral, impartial and independent humanitarian organization.

Given that result-based management aims to streamline the relevance, efficiency, economy and effectiveness of action for conflict affected people and enable the best use of resources, the ICRC South Sudan health staff will seek to collect the required information through existing systems and data sources (in certain cases with support from other actors) and through pragmatic sampling, rather than by establishing new ones. The ICRC has made it a policy not to set up measurement systems that are not directly required for monitoring the expected results of its action for intended beneficiaries. It strives to avoid an overly bureaucratic system or hard to disaggregate impact studies, preferring to find simpler solutions to identified problems, even if this limits the amount of information that can be gathered and reported. Useful but unwieldy solutions based on the measurement of factors such as knowledge, attitudes, behaviors and practices to evaluate changes are only used exceptionally.

The ICRC is committed to full transparency of its operations, balanced with operational efficiency, environmental and social considerations, as well as meeting the needs of beneficiaries on the ground, including taking into account whether information may infringe upon beneficiaries’ rights to privacy and confidential use of data for their protection, as per frameworks mentioned above. Building on its experience and available methodology, indicators selected from the standard ICRC ones and reflecting ESF considerations will be provided in the quarterly narrative reports done. For this particular project, additionally, triangulation means and methods in addition to standard indicators suitable to report on social and environmental will tried and tested.
9  Annexes

9.1  ICRC Code of Conduct

I. INTRODUCTION
1. The ICRC is an organization with an exclusively humanitarian mission. Its credibility, ability to gain acceptance for its operations and capacity to act are underpinned by observance of the Fundamental Principles of the International Red Cross and Red Crescent Movement (the “Movement”) and the trust vouchsafed it by governments, all parties to armed conflicts and other situations of violence, and the victims in these situations, whom it seeks to protect and assist.

2. This Code of Conduct (the "Code") applies to all ICRC employees. For the purposes of the Code, anyone who works for the ICRC under an employment contract or on another basis (such as a secondment agreement with a National Society or another employer, a consultancy contract or as a volunteer) is considered an employee.

3. The rules set forth in the Code are intended to promote safety, to ensure respect for the people with whom the ICRC comes into contact, to protect employees and to project a positive image of the ICRC so as to guarantee the effectiveness and integrity of its work.

4. More specific rules also apply to employees depending on the context in which they work, their area of activity and their job. Employees are required to comply with the Code and the specific rules insofar as they apply; any violations thereof are likely to entail consequences for the employee(s) concerned. In the event of a conflict between the Code and the specific rules, the latter shall take precedence.

II. RULES OF CONDUCT
A. General rules
1. The conduct of ICRC employees must be consistent with the Fundamental Principles of the Movement.

2. ICRC employees must respect the dignity of the people with whom they come into contact, in particular the beneficiaries of the ICRC’s work, and must carry out their duties for the ICRC ever mindful that each of their actions in this context can have repercussions for the fate of many human beings.

3. ICRC employees' conduct must be characterized by integrity, respect and loyalty to the ICRC's interests and must not in any way harm or compromise the ICRC’s reputation. Supervisory staff and managers have a particular responsibility for ensuring that the Code is observed. Their conduct must set an example for all their colleagues.

4. In operational contexts in particular, employees must, during both working and non-working hours and in their private lives, abstain from any conduct that they know or should know to be or to appear inappropriate, particularly in the specific context they are in.

5. Employees must show due respect, particularly through their conduct, dress and language, for the religious beliefs, usages and customs, rules, practices and habits of the people of the country or context they are in and of their place of work (e.g. a hospital or prison).
6. Employees must obey the law of the countries in which they work, including bilateral agreements between that country’s authorities and the ICRC.

7. Employees must comply with the safety rules to which they are subject. They must at all times demonstrate such self-restraint and discipline as the circumstances require, especially in situations of armed conflict and other situations of violence in which the ICRC operates.

8. Fraud in any form is strictly prohibited. Fraud is defined as any action aimed at obtaining an unauthorized benefit, such as money, goods, services or other personal or commercial advantages, regardless of whether such advantage benefits the employee(s) concerned, the ICRC or a third party.

9. Employees are prohibited from using their position to obtain advantages or favors and from accepting such advantages, favors or gifts in cash or in kind, promises of gifts, and any other advantage other than token presents in keeping with accepted custom, particularly in exchange for the assistance and/or protection provided by the ICRC.

10. Employees may not engage in outside activities, whether paid or unpaid, except where such activities are in no way prejudicial to the work and are not inconsistent with the interests of the ICRC.

B. Specific rules
1. Employees must comply with the rules that govern the use of the Red Cross, Red Crescent and red crystal emblems.

2. Employees must refrain from wearing the official ICRC insignia when not officially on duty.

3. Consuming, purchasing, selling, possessing and distributing narcotic drugs are all strictly prohibited.

4. Employees must refrain from using or carrying about their person or in their luggage any weapon or ammunition.

5. Employees are prohibited from taking photographs, filming or making audio recordings in the course of their duties, irrespective of the medium used, unless their work so requires or they obtain express approval from the ICRC.

6. Any employee who wishes to stand for public office must obtain the ICRC’s prior approval.

III. HARASSMENT, ABUSE OF POWER AND SEXUAL EXPLOITATION
1. Harassment in any form, including sexual harassment, is strictly prohibited. In general, harassment refers to a pattern of hostile language or actions expressed or carried out against an employee over time. Sexual harassment refers to any sexual or gender-related behavior that is not desired by the person who is the victim of it and that violates his or her dignity.

2. The purchase of sexual services and the practice of sexual exploitation are prohibited. Sexual exploitation is understood as abuse of authority, trust or a situation of vulnerability for sexual ends in exchange for money, work, goods or services.

3. Entering into a sexual relationship with a direct beneficiary of the ICRC’s assistance and protection programs or with a member of his or her immediate family, and using one’s position to solicit sexual services in exchange for assistance and/or protection provided by the ICRC, are prohibited.
4. Entering into a sexual relationship with a child (a girl or boy under 18 years of age) or inciting or forcing a child to take part in activities of a sexual nature, whether or not he or she is aware of the act committed and irrespective of consent is prohibited. This prohibition also covers pornographic activities (photos, videos, games, etc.) that do not involve sexual contact with the child, as well as acquiring, storing or circulating documents of a paedophiliac nature, irrespective of the medium used.

5. Abuse, neglect, exploitation and violence against children (boys or girls below 18 years of age) is prohibited. Employees must ensure that children’s safety and well-being is protected at all times, and must prevent and respond to child abuse, neglect, exploitation and violence. In all actions concerning children, the best interests of the child shall be a primary consideration.

IV. DUTY OF DISCRETION

1. Employees must maintain the utmost discretion towards third parties, including other components of the Movement, with regard to information acquired in the course of their work at the ICRC concerning matters that they are dealing with or that come to their attention. They must treat this information confidentially, and in this regard they are bound by an obligation analogous to that of professional secrecy. In particular, unless their work so requires or they obtain express approval from the ICRC, employees are prohibited from commenting on allegations concerning facts or situations that they know or learn of through their work for the ICRC, even if these facts or situations are of a public nature, and from lending them credibility which could harm the ICRC’s work.

2. Unless they have obtained the express prior consent of the ICRC, employees are also prohibited, in the context of legal proceedings, public inquiries, fact-finding proceedings and the like, from giving evidence relating to facts learned in the course of their work at the ICRC and from revealing confidential information that they have gathered in the course of their duties.

3. Employees must refrain from producing or publishing in their private capacity writings, images, photographs, films, sounds or recordings concerning professional aspects of their work or circumstances related thereto, irrespective of the medium (paper, radio or electronic format, including email, blogs, social media and websites). Information and facts that the ICRC explicitly considers not to be covered by the duty of discretion and regarding which it communicates openly are not subject to the prohibition in this paragraph. Employees who plan to produce or publish a work (e.g. an article, book or blog) containing information covered by this paragraph must request prior written authorization from the Director of the Department of Communication and Information Management.

4. Unless their work so requires or they obtain express approval from the ICRC, employees must refrain from taking a public stance on situations or events and from referring to political or military situations in their communications with third parties.

5. Employees must refrain from associating any political positions they may take after leaving the ICRC with their duties while employed by the ICRC.

6. Employees must not permanently store outside the workplace documents and images, including in electronic format that were created in the course of their work for the ICRC, and must return them to the ICRC once they no longer have any use for them and no later than the end of their employment with the ICRC.

7. The rules set forth in this section continue to apply after employment with the ICRC ends.

V. USE OF INFORMATION TECHNOLOGY FACILITIES
1. Employees must use ICRC information technology (IT) facilities for professional purposes. The use of IT facilities for private purposes is permitted as long as such use:
   -- does not affect professional activities or imply any additional cost for the ICRC;
   -- does not involve downloading any software, images, sound or video;
   -- does not involve excessive storage of private data or messages or management of private files on ICRC systems; and
   -- does not violate this Code.

2. Employees must use only those IT tools provided or authorized by the ICRC for all electronic exchange of information that commits the ICRC. It is forbidden to send or store information requiring special handling using IT facilities whose security is not guaranteed by the ICRC.

WHERE TO GO FOR HELP?
The Code of Conduct and details of how employees and people outside the ICRC can report potential misconduct or any other compliance-related matter can be found on the ICRC’s website: https://www.icrc.org/en/document/code-conduct-employees-icrc

Several reporting channels are available:
•• the online form on the confidential reporting platform (https://www.icrc.org/en/document/code-conduct-employees-icrc)
•• letter: Global Compliance Office International Committee of the Red Cross 19 Avenue de la Paix 1202 Geneva Switzerland
•• email: code_of_conduct@icrc.org

ICRC employees can also make a complaint in person, by letter or by phone to one of the people listed below:
•• line manager
•• HR manager or finance & administration manager
•• head of delegation or regional director
•• general counsel
•• any member of the Global Compliance Office based in Geneva.

Please consult the ICRC's intranet page (https://intranet.ext.icrc.org/structure/dirgen/global-compliance-office/dir-gen-globalcompliance-office-reporting-potential-misconduct.html) on reporting potential misconduct for more information. ICRC employees who report potential misconduct or who provide information or otherwise assist in an inquiry or investigation of potential misconduct will be protected against retaliation. The ICRC may take disciplinary measures against employees found to have violated the Code of Conduct, including termination of employment.

Other places for ICRC employees to seek help or advice:
•• Ombuds Office based at headquarters: ombuds@icrc.org
•• worldwide ombuds network.
### 9.2 ICRC Waste Disposal Methods Impacts and Mitigation Measures

<table>
<thead>
<tr>
<th>Waste Disposal Method</th>
<th>Type of Waste</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open air</td>
<td>Not effective for pathological waste. Not good for most pharmaceutical waste.</td>
<td>Disinfects reasonably well, destroying 99% of microorganisms. 80–90% burning efficiency.</td>
<td>Burning may be incomplete and residues still infectious. More hazardous to staff involved. Greater risk of scavenging by waste-pickers or of transfer of pathogens by vectors including insects. Sharps in ashes will still pose physical hazard.</td>
</tr>
<tr>
<td>Drum or brick incinerator</td>
<td>Infectious waste. Sharps waste. Pathological waste.</td>
<td>Disinfects reasonably well, destroying 99% of microorganisms. 80–90% burning efficiency.</td>
<td>Emits black smoke, fly ash, acid gases, and some toxins. May produce odours. Sharps in ashes will still pose physical hazard. Not good for most pharmaceutical or chemical waste.</td>
</tr>
<tr>
<td>Incineration</td>
<td>Infectious waste. Sharps waste. Pathological waste.</td>
<td>Disinfects effectively. Reduces waste volume by 80%; burning efficiency of 90–95%. Low investment and operating costs.</td>
<td>Emits pollutants such as fly ash, acid gases, and some toxins. May produce odours (can be limited by not burning PVC plastics). Sharps in ashes will still pose physical hazard. Not good for most pharmaceutical or chemical waste.</td>
</tr>
</tbody>
</table>

### 9.3 Sample Hospital Medical Waste Area Plan

![Medical waste disposal systems diagram](JMH.pdf)

### 9.4 Sample Montfort Incinerator Design for Hospital

![Montfort Incinerator JMH.pdf](JMH.pdf)
9.5 Geographic scope of the program
ICRC’s NIIHA leads it to target deliver its protection and assistance activities purely on consideration of needs of conflict affected communities. This applies to its South Sudan Health operations where the support provided to health care facilities is arbitrated based on:

- Health needs of significant segments of the population
- Coverage of services by other humanitarian or state actors
- Extent to which the needs are provoked by conflict and/or violence
- Practical considerations linked to ICRC’s field presence in country (pluri-disciplinary approach, security, access, etc.)

9.6 Medical Waste Management Manual Checklists
### Annex 3.1 Example of a form for quantifying waste generation

<table>
<thead>
<tr>
<th>№</th>
<th>Types / Quantities (kg/day)</th>
<th>Operating theatre</th>
<th>Wards</th>
<th>Public areas</th>
<th>Radiology</th>
<th>Admin</th>
<th>Laundry</th>
<th>Kitchen</th>
<th>Total kg/day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Household refuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plant waste, kitchen waste</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Sharps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2a</td>
<td>Wastes entailing risk of contamination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2b</td>
<td>Anatomical waste</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2c</td>
<td>Infectious waste</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3a</td>
<td>Pharmaceutical waste</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3c</td>
<td>Waste containing heavy metals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3d</td>
<td>Chemical waste</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Pressurized containers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total kg/day</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total kg/day/patient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Checklist for describing the current situation

**Date:**

**Filled in by:**

**Post:**

<table>
<thead>
<tr>
<th>1. Description of the hospital</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Name and location of the hospital:</td>
<td></td>
</tr>
<tr>
<td>1.2 Number of patients:</td>
<td></td>
</tr>
<tr>
<td>1.3 Number of out-patients:</td>
<td></td>
</tr>
<tr>
<td>1.4 Total number of beds: Per specialty</td>
<td></td>
</tr>
<tr>
<td>..................................................</td>
<td></td>
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<tr>
<td>..................................................</td>
<td></td>
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<tr>
<td>..................................................</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Sorting, collection, storage and transport</td>
</tr>
<tr>
<td>----</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>2.1</td>
<td>Household refuse</td>
</tr>
<tr>
<td>2.2</td>
<td>Plant waste, kitchen waste</td>
</tr>
<tr>
<td>2.3</td>
<td>Sharps</td>
</tr>
<tr>
<td>2.4</td>
<td>Wastes entailing risk of contamination</td>
</tr>
<tr>
<td>2.5</td>
<td>Anatomical waste</td>
</tr>
<tr>
<td>2.6</td>
<td>Infectious waste</td>
</tr>
<tr>
<td>2.7</td>
<td>Pharmaceutical waste</td>
</tr>
<tr>
<td>2.8</td>
<td>Waste containing heavy metals</td>
</tr>
<tr>
<td>2.9</td>
<td>Chemical waste</td>
</tr>
<tr>
<td>2.10</td>
<td>Pressurized containers</td>
</tr>
</tbody>
</table>
### 3. Staff

<table>
<thead>
<tr>
<th>3.1</th>
<th>Is someone responsible for waste?</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2</td>
<td>Who are the persons involved in handling, collecting, storing and transporting waste?</td>
</tr>
</tbody>
</table>

### 4. Waste policy

<table>
<thead>
<tr>
<th>4.1</th>
<th>Are there any national legislative provisions on waste management? If so, what are they?</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2</td>
<td>Is there any national waste management plan?</td>
</tr>
<tr>
<td>4.3</td>
<td>Is there any waste management plan in the health facility itself?</td>
</tr>
<tr>
<td>4.4</td>
<td>What is the local practice regarding anatomical waste?</td>
</tr>
<tr>
<td>4.5</td>
<td>At what depth is the water table?</td>
</tr>
<tr>
<td>4.6</td>
<td>Is any budget allocated to waste management?</td>
</tr>
<tr>
<td>5. Treatment - disposal</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>5.1 Is the waste treated on-site?</td>
<td>If so, how?</td>
</tr>
<tr>
<td>5.2 Is the waste treated off-site?</td>
<td>If so, by whom and how?</td>
</tr>
<tr>
<td></td>
<td>Is there any waste treatment facility at the regional level?</td>
</tr>
<tr>
<td></td>
<td>Is there a landfill in the vicinity?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Training</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Has any waste management training been set up for the hospital staff?</td>
<td></td>
</tr>
<tr>
<td>6.2 Has any waste management training been set up at the regional or national level?</td>
<td></td>
</tr>
</tbody>
</table>
### Protective measures

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7.1</strong></td>
<td>Do the people who handle waste have PPE at their disposal? If so, what equipment is available to them? Is it appropriate? Is it worn?</td>
</tr>
<tr>
<td><strong>7.2</strong></td>
<td>Are personal hygiene facilities available (wash basins, showers)? Do they work?</td>
</tr>
<tr>
<td><strong>7.3</strong></td>
<td>Have all of the staff been vaccinated against hepatitis A and B and tetanus?</td>
</tr>
<tr>
<td><strong>7.4</strong></td>
<td>Is there a procedure for dealing with AEB or spills?</td>
</tr>
</tbody>
</table>
Example of a waste flow diagram

Domestic waste?
(Kitchen, clean plaster, clean tissues, clean dressings, plastics, papers, etc.)

- No
- Yes

Waste that has been in contact with biological liquids?
Pathological waste?
Sharps?

- Yes
- No

- Yes

Sharps
- Safety boxes
- Incinerator
- Landfill in-site Loping

Non sharps
- Black bags
- Incinerator
- Landfill in-site Loping

- Yes

Expired medicines
- Big amount? (> 1 %)
- Small amount? (< 1 %)

- Yes

- No

- Yes

- No

- Yes

X-ray chemicals
- Treatment in Nairobi
- Recycled - refilled
- Not possible to recycle

- No

- Yes

- No

- Yes

Landfill off-site, Nanam Youth Association
- Landfill in-site Loping

Annex 3.4  **Audit checklist**

**Date:**

**Filled in by:**

**Post:**

- Y = yes
- N = no
- SE = to some extent
- NA = does not apply

<table>
<thead>
<tr>
<th>1.</th>
<th>General issues</th>
<th>Y/N/SE/NA</th>
<th>Comments, measures to be taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Is the working group operational? Are the definitions of the duties of each group member updated?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Is the reporting on waste quantities carried out correctly? Has there been a significant increase in the quantity of waste generated? If so, why?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>Are the resources provided sufficient for implementing the waste management plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4</td>
<td>Is the situation at the national level still the same? Is there a new national or regional waste management plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimization</td>
<td>Y/N/SE/NA</td>
<td>Comments, measures to be taken</td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>2.1</td>
<td>Is care being taken to implement the waste minimization policy - i.e. to reduce the quantity of waste generated at source (less packaging, returning containers to the supplier, reusable equipment)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>Is care being taken to avoid re-using needles and syringes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>Is purchasing policy with a view to minimizing hazardous wastes being applied – i.e. PVC-free and mercury-free supplies, choice of less toxic substances, safe injection equipment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td>Are the following wastes recycled: paper, glass, metals, PET plastic, plant waste, photographic developers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td>Is the purchasing of chemicals and drugs centralized? Is stock management satisfactory (has the quantity of expired or unused drugs been reduced?)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Sorting waste

<table>
<thead>
<tr>
<th></th>
<th>Y/N/SE/NA</th>
<th>Comments, measures to be taken</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1</strong></td>
<td>Is each type of waste clearly identified by a colour code or symbol?</td>
<td></td>
</tr>
<tr>
<td><strong>3.2</strong></td>
<td>Are there containers and bags everywhere where waste is generated?</td>
<td></td>
</tr>
<tr>
<td><strong>3.3</strong></td>
<td>Are there sharps containers everywhere where this type of waste is generated?</td>
<td></td>
</tr>
<tr>
<td><strong>3.4</strong></td>
<td>Does the nursing staff take a sharps container to the patient’s bedside?</td>
<td></td>
</tr>
<tr>
<td><strong>3.5</strong></td>
<td>In the sharps container, are the needles connected to the syringes, without the needle cap?</td>
<td></td>
</tr>
<tr>
<td><strong>3.6</strong></td>
<td>Is sorting carried out effectively throughout the chain (from waste production to storage)?</td>
<td></td>
</tr>
<tr>
<td><strong>3.7</strong></td>
<td>Is household refuse separated from hazardous waste at source?</td>
<td></td>
</tr>
<tr>
<td><strong>3.8</strong></td>
<td>Are all members of staff reminded about sorting waste?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>3.9</td>
<td>Are checks carried out regularly?</td>
<td></td>
</tr>
<tr>
<td>3.10</td>
<td>Is anatomical waste treated in accordance with local customs?</td>
<td></td>
</tr>
<tr>
<td>3.11</td>
<td>Do the bags that have been chosen meet the criteria set out in this manual (PVC-free, strong, appropriate size?)</td>
<td></td>
</tr>
<tr>
<td>3.12</td>
<td>Do the sharps containers meet the criteria listed in data sheet 12?</td>
<td></td>
</tr>
<tr>
<td>3.13</td>
<td>Are there adequate stocks of bags and containers?</td>
<td></td>
</tr>
<tr>
<td>3.14</td>
<td>Are the bags handled correctly (handler wearing gloves, bags closed when 2/3 full and grasped from the top, no piling of bags, no emptying of bags)?</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Collection and storage</td>
<td>Y/N/SE/NA</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>4.1</td>
<td>Is the waste collected regularly?</td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>Are the persons in charge of collecting waste informed that they must take yellow bags and sharps containers only when they have been closed?</td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>Do they wear gloves?</td>
<td></td>
</tr>
<tr>
<td>4.4</td>
<td>Are the bags that have been collected replaced immediately with new bags?</td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td>Is the storage time for category 2 waste limited to 48h?</td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td>Does the storage facility meet the requirements (closed, covered, cleaned regularly, protected from animals, well aired and well lit, etc.)? See Chapter 8.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transport</td>
<td>Y/N/SE/NA</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>5.1</td>
<td>Are there means of conveyance/transport reserved for medical waste? Are separate means used for each type of waste?</td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>Do they meet the requirements (easy to load and unload, no sharp corners, easy to clean)?</td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>Do the off-site transport vehicles meet the requirements (closed, load secured, marked with signs)</td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>Are the means of conveyance/transport cleaned regularly?</td>
<td></td>
</tr>
<tr>
<td>5.5</td>
<td>During on-site transportation, do collection rounds respect clean/sensitive areas?</td>
<td></td>
</tr>
<tr>
<td>5.6</td>
<td>For off-site transport, is the waste correctly packaged and labelled?</td>
<td></td>
</tr>
<tr>
<td>5.7</td>
<td>Is the carrier authorized to transport dangerous substances?</td>
<td></td>
</tr>
<tr>
<td>5.8</td>
<td>Do the consignment notes meet the statutory requirements?</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Treatment and final disposal</td>
<td>Y/N/SE/NA</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>6.1</td>
<td>Is the waste treated off-site in an appropriate infrastructure? If it is, go to Question 6.2. If it is not, go to Question 6.3.</td>
<td></td>
</tr>
<tr>
<td>6.2</td>
<td>Have the treatment methods been assessed in terms of environmental protection and health protection? If they have, go to Question 7.1.</td>
<td></td>
</tr>
<tr>
<td>6.3</td>
<td>Have on-site pre-treatment, treatment and disposal methods been opted for?</td>
<td></td>
</tr>
<tr>
<td>6.4</td>
<td>Has their impact on the environment and on staff health been reduced to a minimum?</td>
<td></td>
</tr>
<tr>
<td>6.5</td>
<td>Have options other than incineration been examined?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Where a small on-site incinerator is used, is care taken to reduce emissions as far as possible (good design, good operating practices, suitable place, regular maintenance, training for operators, emission control)?</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>6.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.7</td>
<td>Is particular attention paid to the treatment of sharps and highly infectious wastes (lab cultures, wastes from care of infectious patients)? Are these wastes rendered harmless and unusable before being transported off-site?</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Staff protection measures</td>
<td>Y/N/SE/NA</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>7.1</td>
<td>Are regular checks carried out to ensure that protective measures are taken?</td>
<td></td>
</tr>
<tr>
<td>7.2</td>
<td>Is the PPE appropriate for the activity concerned, and is it worn correctly?</td>
<td></td>
</tr>
<tr>
<td>7.3</td>
<td>Do employees wear gloves regularly when in contact with waste?</td>
<td></td>
</tr>
<tr>
<td>7.4</td>
<td>Do employees in contact with waste wash their hands properly and regularly?</td>
<td></td>
</tr>
<tr>
<td>7.5</td>
<td>Have all staff members been vaccinated against hepatitis A and B and tetanus?</td>
<td></td>
</tr>
<tr>
<td>7.6</td>
<td>Is there a system for dealing with accidents involving exposure to blood or other body fluids (posters/notices concerning the measures to be taken, post-accident care, registration)?</td>
<td></td>
</tr>
<tr>
<td>7.7</td>
<td>Is every staff member aware of the emergency measures to be taken in the event of an accident, spilling, or splashing/spraying?</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Training</td>
<td>Y/N/SE/NA</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>8.1</td>
<td>Has the ICRC developed any training material, or is external training material available?</td>
<td></td>
</tr>
<tr>
<td>8.2</td>
<td>Have all staff members been trained? Are courses held for new staff members and whenever changes are made in the waste management plan?</td>
<td></td>
</tr>
<tr>
<td>8.3</td>
<td>Is the content of the training adjusted to suit each category of staff?</td>
<td></td>
</tr>
</tbody>
</table>