

# SOUTH SUDAN

## 2020 HUMANITARIAN RESPONSE PLAN

### COVID-19 ADDENDUM

ISSUED JUNE 2020



## Reference map



*The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Final boundary between the Republic of South Sudan and the Republic of Sudan has not yet been determined. Final status of Abyei area is not yet determined.*

This document is produced by OCHA on behalf of the Humanitarian Country Team and partners.

Cover photo caption: Social mobilizers educate people about COVID-19 at a market in Yambio, South Sudan.

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# Foreword by the Humanitarian Coordinator

The global COVID-19 pandemic is affecting countries around the world and is now spreading rapidly in South Sudan. The COVID-19 crisis in South Sudan is more than a national health emergency. It will have a significant negative impact on the humanitarian situation and any socio-economic and political progress the country has made over the past couple years. Responding to the COVID-19 crisis will therefore require a comprehensive approach.

The humanitarian community is working with development actors and donors to support to the national response, putting emphasis on prevention and mitigation; to ensure continuation of delivery of essential services; and to lay the ground for socio-economic recovery.

The Transitional Government of National Unity of South Sudan is responding to the virus through the implementation of the National COVID-19 Response Plan. The United Nations and non-governmental organizations have supported the Government to update this public health response plan, which is included in full in this addendum to the 2020 Humanitarian Response Plan (HRP).

Further to the public health response, the humanitarian community in South Sudan is committed to stay the course and deliver much-needed essential services and assistance for the most vulnerable, including older people, people with disabilities, and women and girls, as well as those who have been newly hit, such as the urban poor. The pre-COVID-19 humanitarian operations must continue while we address new needs created by the virus, to avoid life-threatening consequences for people already facing serious risks including renewed conflict, hunger and other more preventable diseases.

The addendum outlines the humanitarian community's support to the COVID-19 response across all the humanitarian sectors which have seen new vulnerabilities arise in the current context. It also prepares the ground for longer-term efforts to tackle the socio-economic impacts of COVID-19.

Alongside international humanitarian organizations, South Sudanese NGOs and aid workers remain at the heart of the response, and I commend them for their tireless work for their fellow citizens.

**“The humanitarian community in South Sudan is committed to stay the course and deliver much-needed essential services and assistance for the most vulnerable.”**

Our collective response to the COVID-19 crisis in South Sudan will only be effective if we are able to operate in a safe environment. The country is currently experiencing an increasing level of intercommunal violence and continuation of armed conflict in parts of the country. This is killing hundreds, displacing tens of thousands and hampering delivery of assistance. There is therefore an urgent need for political progress to increase stability and security at all levels to protect civilians and humanitarian workers; to ensure predictable access; to enable delivery of humanitarian and health assistance; and to facilitate socio-economic recovery.

Our achievements to date have been possible because of the generous funding provided by the donor community. For the response in 2020, through the HRP and its addendum, we need the continued support of our long-standing donors and the commitment of new partners for timely and flexible funding.

We must come together for a coordinated effort that engages the whole South Sudanese society and international partners, and that prioritizes prevention above all.



**Alain Noudéhou**  
Humanitarian Coordinator in South Sudan





Social distancing at a food distribution in Jonglei State.  
©Catholic Relief Services/James Jok



# Addendum at a glance

REQUIREMENTS IN 2020 HRP C19 ADDENDUM

**\$387M**

OF WHICH NATIONAL C19 RESPONSE PLAN\*

**\$150M**

CANCELLED FROM \$1.55B ORIGINAL 2020 HRP

**\$39M**

NEW TOTAL REQUIREMENTS FOR 2020

**\$1.90B**

\* As of 16 June

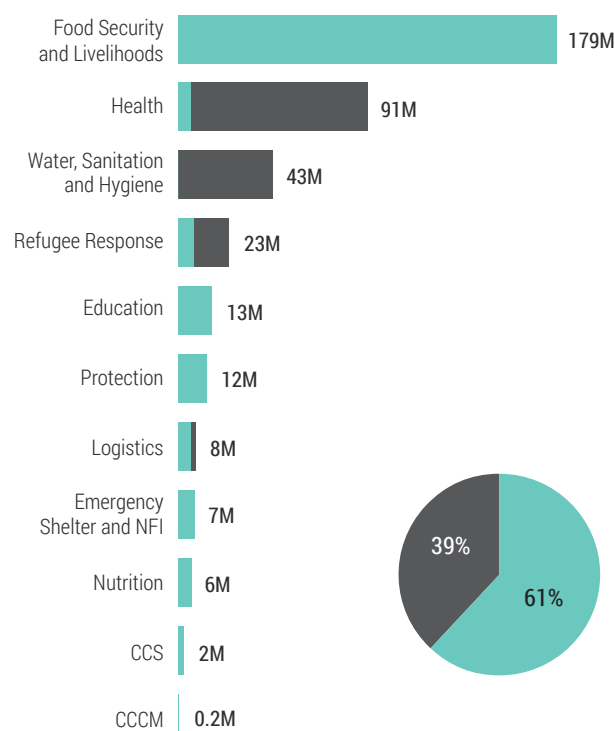
## Introduction

This document summarizes preparedness and response activities to address the coronavirus disease (COVID-19) outbreak in South Sudan through the end of 2020. The addendum includes the activities and financial requirements of the updated National COVID-19 Response Plan. Originally issued in March prior to identification of the first person confirmed with COVID-19 in South Sudan and with a focus on preparedness, the updated plan encompasses a significantly scaled-up national response. Consolidated financial requirements presented in this document are additional to those in the 2020 Humanitarian Response Plan (HRP) for South Sudan. The HRP and associated projects originally seeking \$1.55 billion were finalized in the end of 2019 for non-COVID-19 related needs and largely remain valid, with the exception of projects totalling \$39 million that were cancelled due to operational constraints. Consolidated COVID-19 response activities and requirements in this document hence complement existing HRP programming and are annexed to the HRP.

Financial requirements presented in this document are part of the South Sudan Chapter of the Global HRP for COVID-19 (GHRP), the international community’s primary fundraising vehicle to respond to the humanitarian impacts of the virus in low- and middle-income countries and support their efforts to fight it. Funding for COVID-19 activities summarized in this document is tracked separately from the HRP by the [Financial Tracking Service](#).

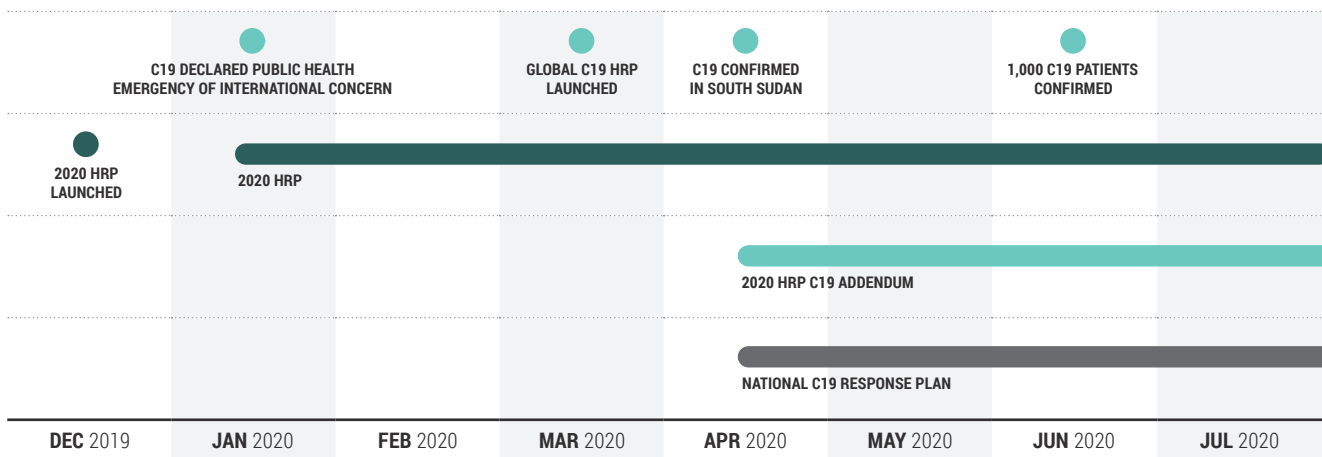
Alongside the HRP addendum prepared by the Humanitarian Country Team, the UN Country Team is finalizing a UN framework to concurrently address the immediate socio-economic effects of COVID-19.

## Addendum requirements by sector (US\$)



complementary humanitarian response national plan

## Response plan timeline



PEOPLE TARGETED  
TOTAL

7.4M

OF WHICH  
TARGETED OUT OF 2020 HNO

5.8M

OF WHICH  
NEWLY VULNERABLE PEOPLE\*\*

1.6M

WOMEN AND  
GIRLS

51%

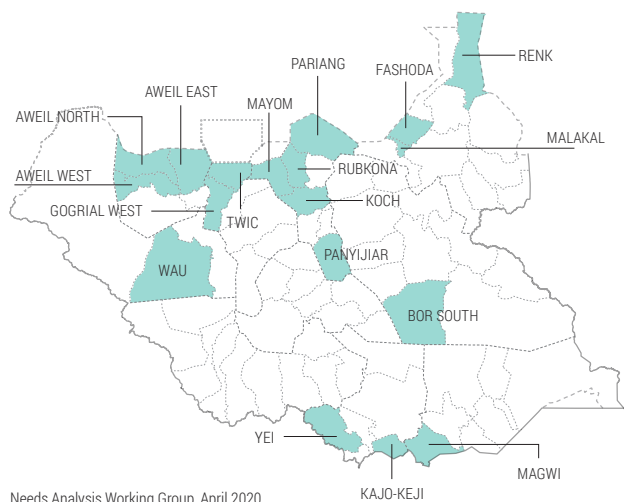
\*\* Food and livelihoods assistance to newly vulnerable people during COVID-19 based on market dependence

### Objectives

**Addendum strategic objective:** Support Government efforts in containing and preventing the spread of COVID-19 while employing a COVID-19 adapted approach to respond to the ongoing emergency, guided by HRP strategic objectives

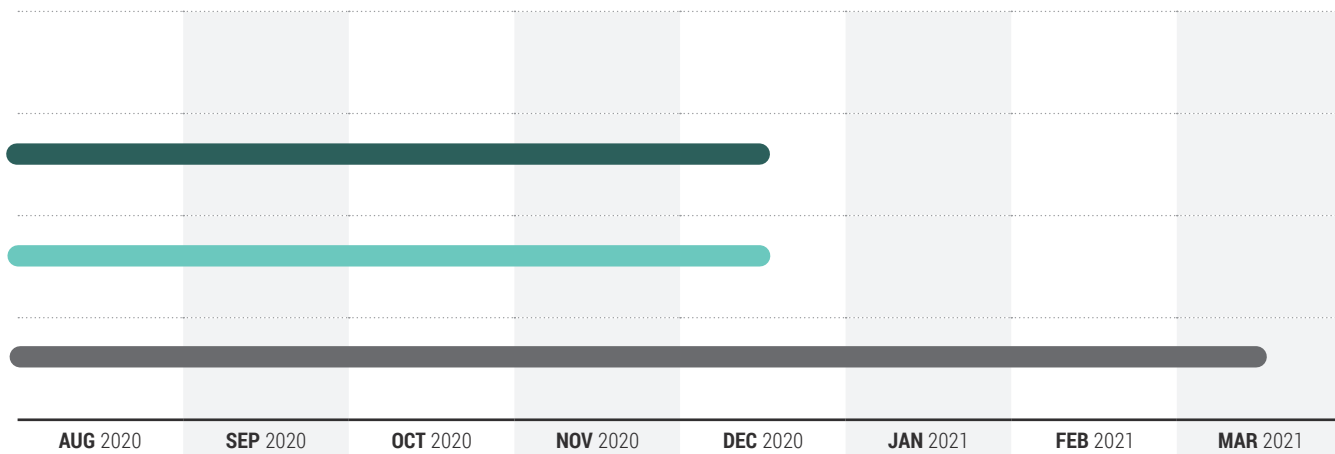
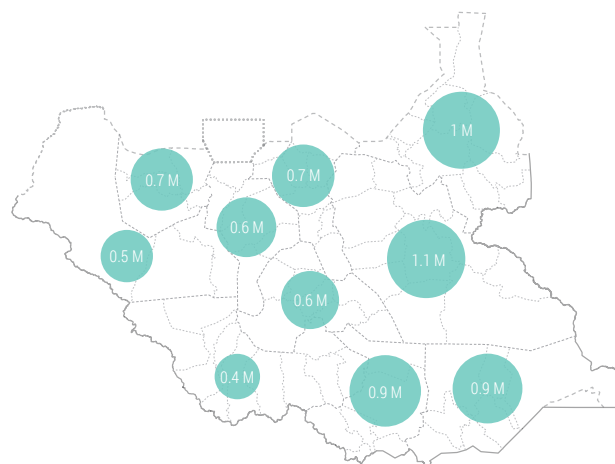
- 1 Reduce morbidity and mortality, as well as suffering from protection threats and incidents, of the most vulnerable populations in areas with severe need
- 2 Facilitate safe, equitable and dignified access to critical cross-sectoral basic services to enable populations to meet their basic needs in areas with severe need
- 3 Enable vulnerable people to recover from crisis, seek solutions to displacement, and build resilience to acute shocks and chronic stresses through targeted programming to support coping capacities and livelihoods in prioritized areas

### Recommended priority counties



Needs Analysis Working Group, April 2020

### People targeted by C19 addendum by state



## PART 1:

# COVID-19 related humanitarian needs and vulnerabilities

### Context of the crisis

The COVID-19 outbreak in South Sudan comes against the backdrop of an already dire humanitarian situation. Some 7.5 million people need humanitarian assistance according to the 2020 Humanitarian Needs Overview (HNO). Close to 1.6 million people are internally displaced. More than half of South Sudan's population are expected to face acute food insecurity at the height of the annual hunger season between May and July, according to projections made before the impacts of COVID-19, the plummeting oil prices and the recent desert locust infestation on food security were anticipated. With COVID-19 and related food price hikes, some 1.6 million people have become newly vulnerable due to their dependence on markets. This includes the urban poor, who were not previously receiving humanitarian assistance, and approximately 10 per cent of the IPC Phase 2 (stressed) rural population who will likely shift to IPC Phase 3 (crisis) or worse later in the ongoing lean season. These needs have not yet been assessed and this new caseload's inclusion in the 2021 HNO and HRP will be evaluated based on forthcoming assessments.

Some 1.7 million women and children are estimated to be acutely malnourished across the country. Intercommunal violence or low-intensity armed conflicts have been witnessed in 2020 in parts of Eastern and Central Equatoria, Jonglei, Upper Nile, Unity, Warrap and Western Bahr el Ghazal. Gender-based violence was rampant in South Sudan already before the pandemic and is expected to only increase with COVID-19.

People's access to basic services was very limited already before the outbreak, and COVID-19 related restrictions on movement and service provision have only made things worse. More than half or 56 per cent of the nearly 12 million population do not have access to primary health care services.<sup>1</sup> Out of approximately 2,300 health facilities, more than 1,300 are non-functional.<sup>2</sup>

While children are less affected by COVID-19 directly, they are **① bearing the brunt** of the effects of the pandemic. About 2 million children were out of school before the global pandemic, and authorities estimate that another 2 million previously enrolled students have now had their learning disrupted due to closure of schools nationwide.

For more information about the humanitarian situation in the first quarter of 2020, before the COVID-19 outbreak in South Sudan, see the **① January-March monitoring report**.

### Impact of COVID-19 on needs and vulnerabilities

In the absence of new needs assessments or clear epidemiological projections made available in the early months of the COVID-19 outbreak in South Sudan, the humanitarian community has adopted several methods to understand the potential impact of the virus and related measures on humanitarian needs and vulnerabilities.

The Inter-Cluster Coordination Group held a scenario-planning exercise in April 2020 to agree on the most likely scenario, based on information available at the time. The full scenario is included in Annex 1 (see page 59).

### Most likely scenario



Number of cases to rise rapidly in May/June



An increase in intercommunal violence



Supply routes under increasing strain



Cost of oil production greater than return



Likely increase in negative coping practices



Regular health services increasingly at risk





### Vulnerability risk framework

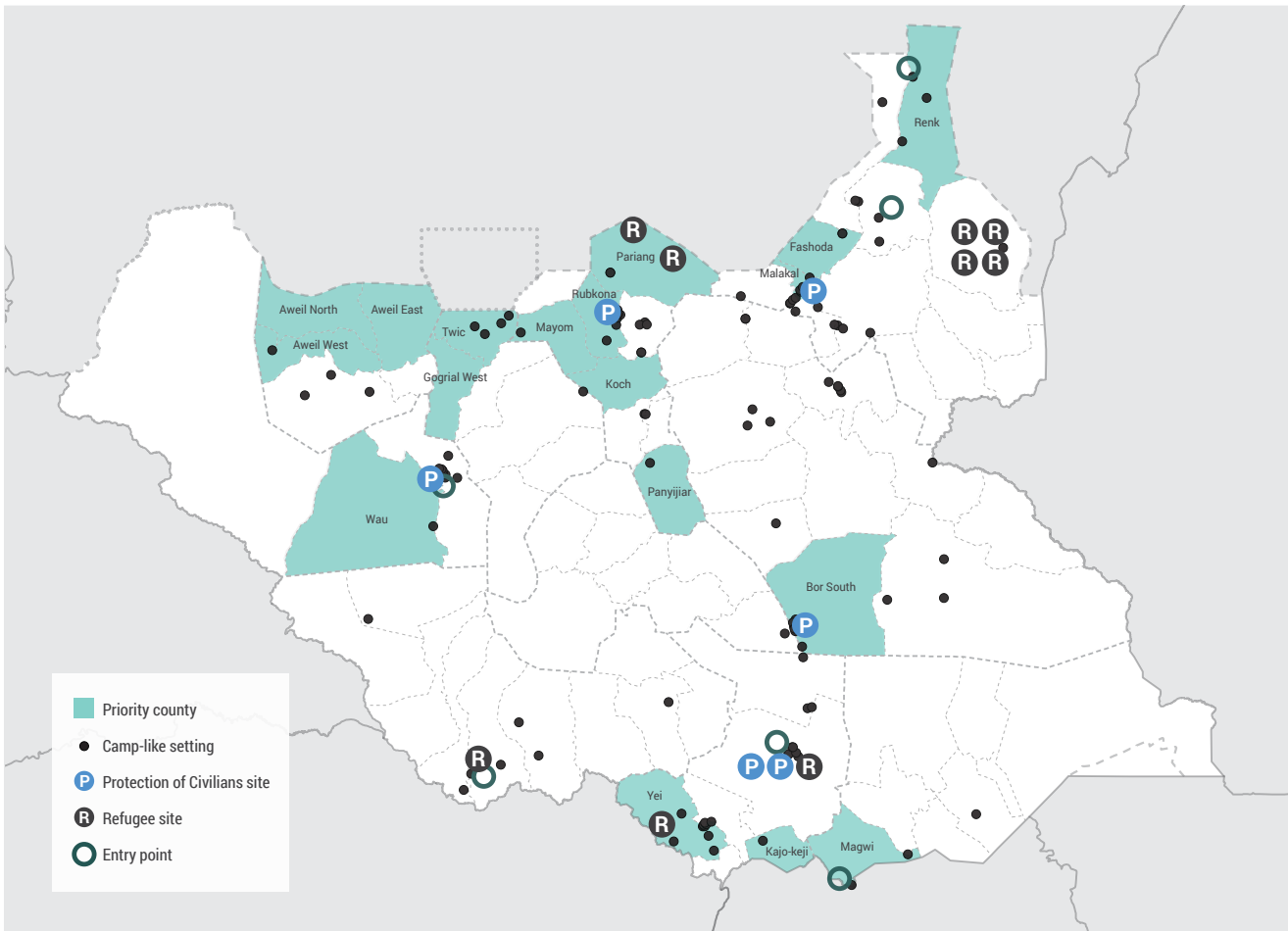
In parallel, the Needs Analysis Working Group, co-chaired by OCHA and REACH, developed a risk framework to prioritize vulnerable areas across South Sudan where COVID-19 would first enter the country, and which areas have populations at greater risk of severe COVID-19 outcomes. The framework aims to support inter-sectoral prioritization of the COVID-19 and broader humanitarian response.

Factors such as cross-border population movements, population density, urban centres, food insecurity, acute malnutrition, access to basic water, sanitation and hygiene (WASH) services, co-morbidities and demographics were considered in assessing population vulnerability to the pandemic. The framework was endorsed in May 2020.

The endorsed framework, including its analytical notes and list of indicators, is presented in Annex 2 (see page 60). It is currently being revised to include additional considerations, such as internal displacement and COVID-19 caseloads, and will be updated regularly.

| COUNTY NAME  | RISK OF ENTRY AND SPREAD 0-12 | INTERSECTORAL VULNERABILITY 0-25 |
|--------------|-------------------------------|----------------------------------|
| RUBKONA      | 10                            | 13                               |
| YEI          | 10                            | 13                               |
| JUBA         | 9.75                          | 12.75                            |
| PARIANG      | 8.5                           | 14.5                             |
| MAGWI        | 8.5                           | 7.5                              |
| WAU          | 8.5                           | 9.5                              |
| MALAKAL      | 8                             | 12.5                             |
| AWEIL WEST   | 7.5                           | 9.5                              |
| KOCH         | 7.25                          | 11.25                            |
| KAJO-KEJI    | 6.5                           | 12                               |
| PANYJIAR     | 6.5                           | 11.5                             |
| RENK         | 6.5                           | 14                               |
| AWEIL NORTH  | 6.25                          | 11.25                            |
| BOR SOUTH    | 6.25                          | 11.75                            |
| GOGRIAL WEST | 6.25                          | 11.75                            |
| TWIC         | 6.25                          | 11.75                            |
| AWEIL EAST   | 6                             | 12.5                             |
| MAYOM        | 6                             | 11.5                             |
| FASHODA      | 5.5                           | 15                               |

### Highest risk counties recommended for prioritization based on the entry, spread and intersectoral vulnerabilities to COVID-19



## COVID-19 outbreak model projections

In addition to the vulnerability framework developed by humanitarian partners in South Sudan, several risk modelling initiatives have been developed internationally in the wake of the pandemic. While modelling is critical to the COVID-19 response, it is not possible to predict with any certainty the exact number of cases for any given country or the precise mortality and disease burden that will result.

The Africa Center for Strategic Studies mapped various [① risk factors for the spread of COVID-19 on the continent](#). South Sudan topped the list of African countries at highest risk for the next phase of the outbreak, informed by the following factors: public health system, density of and total population in urban areas, population age, government transparency, press freedom, conflict magnitude and forced displacement.

The London School of Hygiene and Tropical Medicine prepared simulation-based estimates for COVID-19 epidemic scenarios in South Sudan, based on COVID-19 spread in Europe. In an unmitigated epidemic—meaning no interventions such as physical distancing or shielding—the study anticipates that one year after the initial introduction of the virus in South Sudan, the total number of symptomatic cases will have been between 2.8 million and 3.4 million (using a population of 11 million). The projection of total deaths is estimated at between 23,000 and 31,000. The model also provides estimates in the presence of different potential interventions.

The World Health Organization (WHO) also developed a [① predictive model](#) to estimate the potential effects of widespread community transmission of COVID-19 in Africa. The model uses country-specific probabilities and assigns a risk of exposure and vulnerability index for countries based on currently available country information. With this model, it is estimated that South Sudan will have a total of 725,250 infections and 462 deaths for an estimated population of 11 million, over a period of one year of community transmission. The distinctive feature of this model is that it integrates country-specific socio-ecological factors which may play a role in the early pattern of COVID-19 transmission in many African countries, with slower transmission, fewer cases, less severe infections and fewer deaths than in other parts of the world.

OCHA's [① Centre for Humanitarian Data](#) in partnership with Johns Hopkins University has developed a model to understand the impact of COVID-19 on humanitarian operations in various contexts, and is at the time of publishing the COVID-19 addendum finalizing the model for South Sudan. The COVID-19 model projections are related to the scale of the crisis (i.e. the number of cases and deaths); the duration of the crisis in subnational locations; and how different response interventions can be expected to impact the epidemic curve. The envisioned outcome is to provide decision makers and responders with an outbreak model that can be adjusted by location, informing the best strategies for humanitarian response ahead of and during the expected

COVID-19 epidemic peak in South Sudan. Parameters include the average number of people infected from one infected person, case fatality rate, and estimated probabilities that an individual person may contract COVID-19. The model then simulates an outbreak and provides estimates for cases, hospitalizations and deaths. The model will include vulnerability indicators such as age, gender, food insecurity and disease prevalence that can inform the model results at a subnational level. In a country like South Sudan, where more than half of the population is in crisis levels of food insecurity or worse (IPC Phase 3 or above), and where more than 95 per cent of the population relies on polluting fuels for cooking, these aggravating factors are expected to have a significant impact.

Given the evolving nature of the pandemic and the modelled scenarios, the impact on the South Sudanese population is expected to be more severe than elsewhere in the region due to the protracted humanitarian crisis, displaced populations, weak public health capacities, and longstanding vulnerabilities related to the same.

## Next steps

As new information and modelling becomes available, the Humanitarian Country Team and its working groups will continue to develop interventions that reduce the population's risk to contracting the virus, be that communication and social mobilization, the delivery of testing kits and medical supplies, the installation of handwashing stations or the provision of food assistance.

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A woman participates in a livelihood skills training at the Women and Girls Friendly Space in the Bentiu PoC site.

©UNFPA South Sudan



# Spotlight on women and girls

Pre-existing gender inequalities, discriminatory social norms, armed conflict, intercommunal violence and cattle raiding, and poverty, described in detail in the 2020 HNO, are likely to be exacerbated by the COVID-19 pandemic and further limit women and girls' access to health and other essential services.

South Sudanese women and girls already face extreme levels of gender-based violence (GBV), much of which goes under-reported. Frequently reported incidents included physical assault, rape including conflict-related sexual violence, sexual assault, emotional abuse, denial of resources and forced marriage. A total of 1,730 GBV incidents were reported in the first three months of 2020—before COVID-19 was confirmed in the country—an 8 per cent increase compared to the reports received over the same period of 2019.

Despite the pervasive nature of GBV, there is limited availability and access to GBV service delivery points. Clinical management of rape survivors' service is available in 34 per cent of the assessed 253 health facilities.<sup>3</sup> Similarly, in nine hotspot counties for conflict-related sexual violence in Central Equatoria, Unity and Western Equatoria, on average, only one health facility per 10,000 persons and an estimated 72 per cent of the population in these areas live more than 5 kilometres away from their nearest functional public health facility. Many of these health facilities are not capable of providing specialized care to treat survivors of

sexual violence.<sup>4</sup> Regarding the availability of service delivery points for psychosocial support, Women and Girls Friendly Spaces are available in 54 per cent of all the 78 counties in the country.<sup>5</sup> Disruption to livelihoods, public services, food insecurity and the lack of freedom of movement can also exacerbate the risks of sexual exploitation and abuse. As more strict measures are adopted to curb the spread of COVID-19 coupled with the loss of means of livelihoods for most women, there is growing alarm that it might inadvertently trigger a rise in GBV. Intimate partners most often perpetrate this violence at home. According to 2019 GBV Information Management System data on the alleged perpetrator survivor relationship, 54 per cent of the reported incidents were perpetrated by intimate partners. Intimate partner violence is anticipated to increase with stay-at-home and other disease containment measures. Various models of GBV case management would be considered in accordance with the changing measures.

Due to power dynamics in the society, women and girls have poor access to information, which is vital to ensure that they can receive details on how they can prevent contraction and spread of the disease. Literacy rates are remarkably lower for girls, 40 per cent compared to 60 per cent for boys in 2018.<sup>6</sup>

The closure of schools further exacerbates the burden of unpaid care work on women and girls, who absorb the additional unpaid work of caring for children and the sick. Of particular concern are girls who are living in fear due to shrinking household incomes, who are afraid that their families out of desperation can force them into early marriage to source funds from the wedding ceremonial or bridal price. In the South Sudan context where the healthcare system is weak, care responsibilities for COVID-19 cases are also anticipated to fall onto women and girls, who usually care for ill family members and the elderly. Their roles in caring for others, thus differentially exposing them to transmission, higher risk of physical and mental stress.

Gender mainstreaming remains a shared responsibility among different stakeholders and will ensure the protection of women, girls, men and boys, addressing the differential needs, and ensuring that GBV services remain available to and accessible by women and girls, in a complementary way within the ongoing efforts to respond to COVID-19. Protection from sexual exploitation and abuse must be integrated into the response to COVID-19 to protect and assist people receiving humanitarian assistance.

As with all humanitarian assistance, COVID-19 related needs must not be responded to at the expense of regular service provisions. For example, in the health sector, COVID-19 response should not mean discontinuing sexual and reproductive health, maternal health and hygiene services. A Rapid Gender Analysis for COVID-19 carried out in May 2020 in Juba noted that there is a need to ensure essential services are functional including prioritizing prevention, preparedness and response to violence against women and girls through police and justice systems, health and social services. A Protection Reference Group under the leadership of the Ministry of Gender, Child and Social Welfare and the Protection Cluster was created to ensure that protection and human rights issues remain central to the COVID-19 response and that vulnerable populations are not left behind.



# COVID-19 related population movements

## General context of population movements in South Sudan

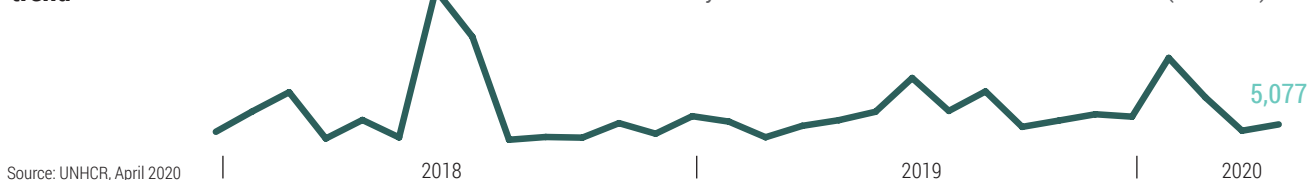
South Sudanese people are highly mobile due to forced displacement, spontaneous returns, and seasonal and cultural population movements. COVID-19 may now create new patterns in people's mobility or lead to the virus spreading to new areas. The upcoming planting season is expected to trigger livelihood movements from urban settlements including Juba to rural areas, particularly in the Equatorias. While many of these movements are internal, some South Sudanese refugee household members temporarily return from refugee camps in one of the six neighbouring countries or other situations abroad to assist with planting. The period just prior to the May-September rainy season usually registers brief spikes of people moving internally and across borders. Population movements tend to decrease as roads become impassable.

## Impact of COVID-19 on internal and cross-border flows

In early April, anecdotal field information indicated a slight increase of inter-state movement prior to the implementation of COVID-19 related movement restrictions, as people anticipated lockdown enforcement and return to homesteads for cultivation, cattle-grazing and other livelihood activities. There were also reported internal population movements prompted by fears of rapid spread of COVID-19 in Juba as well as school closures. However, field reports indicated that internal movements of people depended on local conditions, including Government imposed movement restrictions, perceptions of safety and security, and comparative perceptions of risk and availability of basic services in return locations, including habitual residence and other intended areas of return.

Following confirmation of COVID-19 in South Sudan, there are rising concerns that if the COVID-19 pandemic continues to spread in its current trajectory, particularly in the Protection of Civilians (PoC) and collective sites, and sites where internally displaced persons (IDPs) are taking shelter, thousands could voluntarily return to insecure places, locations without basic services or areas with humanitarian access constraints as a mitigation measure to avoid infection. According to recent focus group discussions held in Akobo, Aweil, Bentiu, Bor PoC site, Juba, Maridi, Mingkaman, Nyal, Pariang, Renk, Wau

## Spontaneous refugee return trend



and Yambio, participants reported that, if COVID-19 came to their area, some people would move to or remain close to functional health facilities, and particularly any facilities approved for treatment of COVID-19 cases, while others would move to rural areas perceived as safe from disease spread.

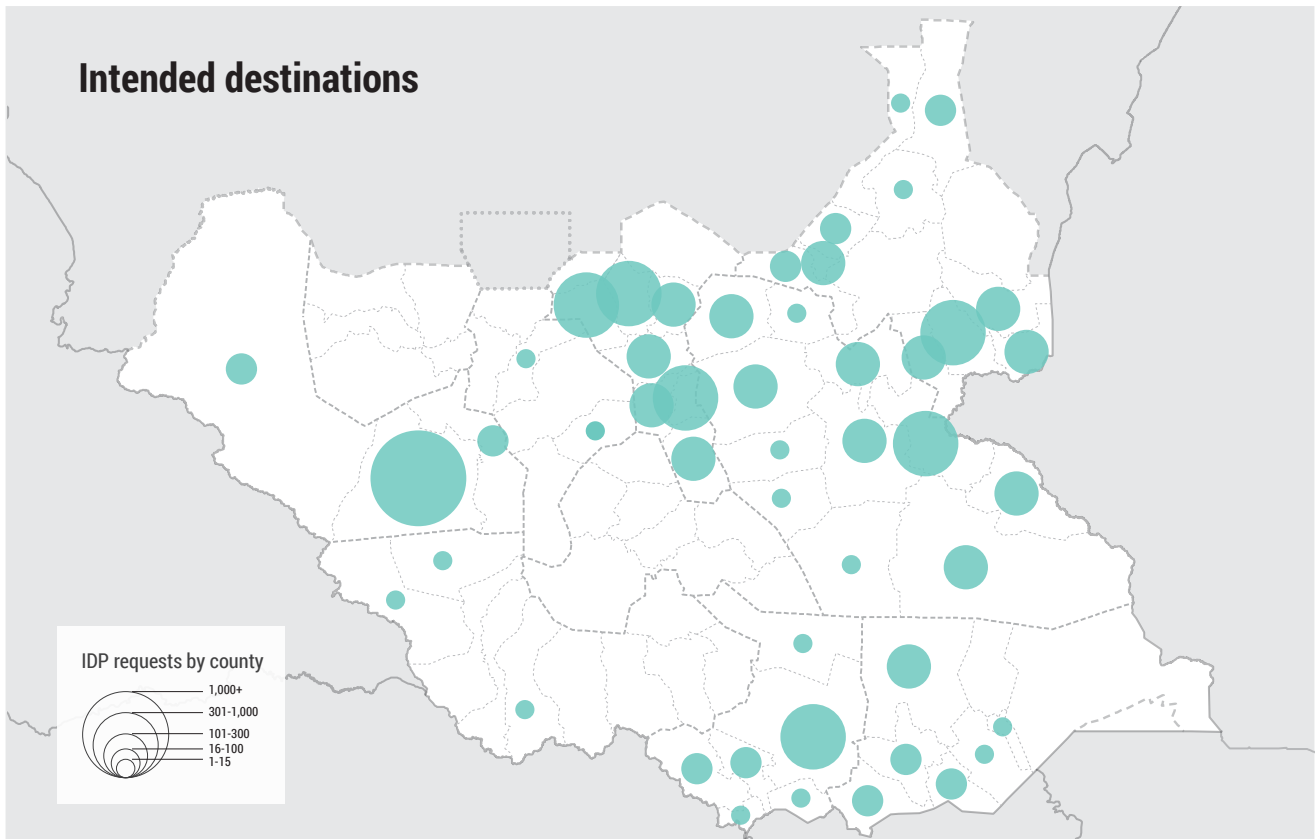
Anecdotal field updates and ports and road monitoring indicate that COVID-19 motivated returns from abroad have not been large-scale, although some population mobility driven by fear of COVID-19 appears to be taking place. According to [data on COVID-19 inflows](#) from neighbouring countries, in March, combined by IOM, REACH, UNHCR and UNICEF, cross-border movements were either localized around border areas or led to entry into urban centres and the PoC sites<sup>7</sup>, especially in Bentiu, Unity. While the number of reported refugee returns have decreased, more cross-border movements are happening through unofficial border crossing points in order to avoid authorities. A government directive in March closed all international air, land and water routes, with only a few official border crossing points where COVID-19 screening measures are present. This directive was lifted in May and people continue to move across official border points, including those without COVID-19 screening measures. The government's Relief and Rehabilitation Commission and UNHCR reported that 5,077 South Sudanese refugee returnees were verified across various return locations in April, mainly from Ethiopia and Sudan. The returnees indicated that the main reasons for their return were family reunification; fear of a COVID-19 outbreak in their refugee site; crowded locations in Khartoum, Sudan, and the relatively low number of confirmed cases in South Sudan.

## COVID-19 related population movement out of PoC sites and other internal displacement sites

Since confirmation of the COVID-19 outbreak in South Sudan, fear of infection and spread of the virus have increasingly reshaped the pattern and scale of population movements out of internal displacement sites. A church in Wau, Western Bahr el Ghazal, gave an eviction notice to the 5,500 IDPs being hosted on their grounds over COVID-19 fears. The majority of IDPs left voluntarily before the given deadline. Others relocated to another IDP site after the closure of the grounds. UNHCR supported 42 vulnerable persons to be placed under family care. At the same time, the Wau Protection of Civilians Area Adjacent site witnessed [a relative spike in departure](#), following information campaigns by the United Nations Mission in South Sudan (UNMISS) on



## IDP requests for humanitarian support to return or relocate to intended areas of return within South Sudan



① UNHCR: Overview of IDP requests for humanitarian support to return or relocate within South Sudan

as of April 2020

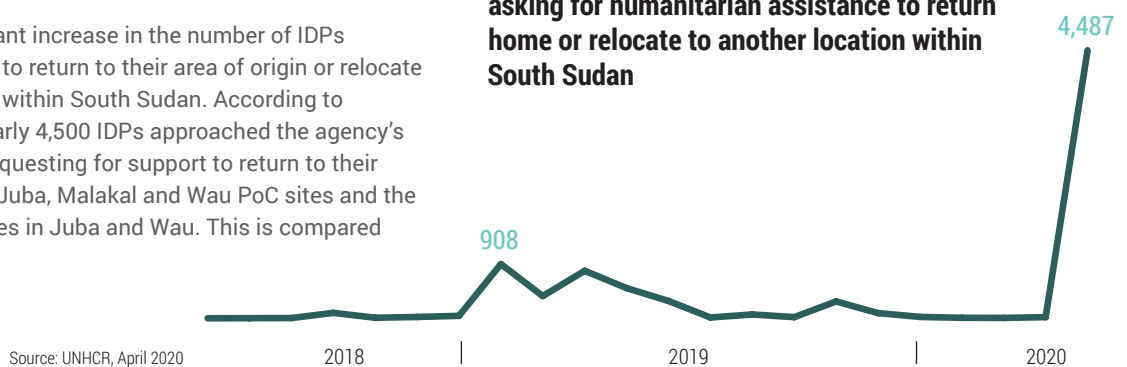
the risk of COVID-19 transmission in the site, though most of the IDP population remained on site. Recent IOM-DTM displacement site flow monitoring suggests that two thirds of all recorded individuals permanently leaving the displacement sites in Wau in April left for their former homes. Sixty per cent of permanently exiting individuals were female. In May, continued intercommunal violence caused new internal displacement of civilians in Jur River and Wau counties, but local community leaders dismantled many of the temporary IDP shelters in the area to discourage them settling there due to the fear of COVID-19.

### IDPs in PoC and urban sites requesting humanitarian support to return home or relocate to another location within South Sudan

April saw a significant increase in the number of IDPs requesting support to return to their area of origin or relocate to another location within South Sudan. According to UNHCR, in April nearly 4,500 IDPs approached the agency's protection desks requesting for support to return to their area of origin from Juba, Malakal and Wau PoC sites and the urban collective sites in Juba and Wau. This is compared

to only 20 requests in March, as seen in the graph below. The map above shows the IDPs' intended destinations. The sharp increase was attributed to perceptions of safety from COVID-19 in their area of origin, relative reduction of tensions and insecurity in areas of return following formation of the revitalized Transitional Government of National Unity. However, requests to support voluntary returns are not necessarily linked to the actual returns. According to the same UNHCR report, there were about 1,700 supported returns in April, almost a third of the overall requests of about 4,500. In a UNHCR survey, conducted before COVID-19 was confirmed in South Sudan, 48 per cent of IDPs in the PoC and collective sites said they were likely to leave the sites only when their areas of return were safe and secure.

### Registrations of IDPs in PoC and urban sites asking for humanitarian assistance to return home or relocate to another location within South Sudan



Source: UNHCR, April 2020

## PART 2:

# Humanitarian response

### Response strategy and objectives

The strategic objective of the addendum is to support Government efforts in containing and preventing the spread of COVID-19 while employing a COVID-19 adapted approach to respond to the ongoing emergency. This will be guided by the below three HRP strategic objectives:

- 1 Reduce morbidity and mortality, as well as suffering from protection threats and incidents, of the most vulnerable populations in areas with severe need
- 2 Facilitate safe, equitable and dignified access to critical cross-sectoral basic services to enable populations to meet their basic needs in areas with severe need
- 3 Enable vulnerable people to recover from crisis, seek solutions to displacement, and build resilience to acute shocks and chronic stresses through targeted programming to support coping capacities and livelihoods in prioritized areas



Sudanese refugees observe physical distancing while listening to health and sanitation messages over a speaker system at Ajuong Thok camp in South Sudan. ©UNHCR/Elizabeth Stuart

The three Strategic Objectives for the 2020 HRP remain valid and will guide the response through the COVID-19 addendum. In addition, the strategy for the national response plan will inform the response to those cluster partners contributing to the government and WHO-led health response. Cluster-specific response strategies, in line with the overall strategy and objectives, are presented in Part 4 of the addendum. The clusters have also reviewed their priorities stated in the 2020 HRP, based on funding availability (24, 50, 75 or 100 per cent funded cluster appeal), and the ① *revised prioritization table*.

The priority activities related to the addendum strategic objective include:

- Preventing transmission through awareness creating, contributing to positive behaviour change
- Containing and preventing outbreaks in displacement and refugee sites, and ensuring that correct response measures related to case management are in place to limit the spread of the virus
- Maintaining routine health facility and community-based health care services while focusing on the COVID-19 response
- Scaling-up WASH response through increased handwashing stations and targeting public places like markets and schools (in preparation for reopening) to prevent the spread of the virus
- Providing emergency food assistance complemented by livelihood and livestock support to COVID-19 affected people
- Ensuring quality learning for out-of-school children as a result of school closures due to implementation of COVID-19 risk mitigation measures
- Providing logistical capacity to enhance access to people by transporting humanitarian personnel in compliance with national regulations on internal movements
- Addressing protection issues particularly for vulnerable women and girls that are anticipated to multiply, exposing them to GBV and other grave rights violations beyond COVID-19
- Ensuring access of the persons with specific needs to the services and targeted assistance

The Inter-Cluster Coordination Group will review the response priorities regularly based on information and analysis available through assessments, the Needs Analysis Working Group, and risk modelling described in Part 1.



## Key COVID-19 response achievements by UN and NGOs as of May 2020



### 4,000,000

people reached with risk communications materials and messages



### 300,000

IDPs reached with COVID-19 preventive messaging in PoC sites and camp-like settings



### 3,200,000

people reached with advanced food rations ahead of the lockdown and travel restrictions



### 2

national helplines established to provide remote support and facilitate referrals for GBV survivors during COVID-19



### 5,100

tests conducted by the National Laboratory



### 133,000

travellers screened for COVID-19 at points of entry



### 8

weekly radio shows held on COVID-19 related protection and human rights issues



### 190,000

people benefitted from functional handwashing stations in Juba



### 265

health facilities supported with infection prevention and control supplies



### 132

beds made available for admission of severe and critical COVID-19 patients



### 211

samples transported by air as part of logistical support to humanitarian partners involved in COVID-19 sample transfers



### 350,000

refugees and host community members have received soap on a monthly basis



### 1,740m<sup>2</sup>

of storage space availed for COVID-19 supplies in Juba



### 100

children released from detention as part of the ongoing decongestion efforts

# Humanitarian access and other operational constraints

COVID-19 and related measures to curb the spread of the virus have exacerbated pre-existing access concerns and created new challenges to delivering assistance to people in need. Prior to the confirmation of COVID-19 in South Sudan, the High-Level Task Force (HLTF) implemented a series of policies to prevent the importation of COVID-19 into the country. With effect from 25 March to 12 May, restrictions on movement were put in place that led to the closure of the Juba International Airport to inbound passengers, severely limiting the movement of key staff in and out of the country and staff who might be recruited specifically to tackle the virus. Cargo, humanitarian flights, fuel and food shipment, however, remained operational.

COVID-19 has magnified pre-existing access constraints and aggravated their impact on humanitarian operations, including the COVID-19 response. Some of these constraints include bureaucratic impediments, violence against humanitarian personnel, restriction on movement, and insecurity as a result of intercommunal violence and roadside ambushes.

## Violence and threat of violence against humanitarian personnel

The first four confirmed patients of COVID-19 in South Sudan were United Nations staff members. This triggered social media outrage, and anti-UN and anti-foreigner sentiments online. The hate speech was followed by threats and verbal abuse against foreigners as well as national staff working for the UN. National staff reported stigmatization in their communities, as they were regarded as COVID-19 carriers. Reports of verbal abuse against humanitarian staff and volunteers conducting COVID-19 related awareness activities persist at the time of issuing this document.

## Restriction of movement of humanitarian personnel

After the announcement of the first person with COVID-19 in April 2020, South Sudanese security forces blocked staff movement in and out of UN bases in various locations across the country, including Juba in Central Equatoria and Malakal in Upper Nile. Some of the UN bases host UN Protection of Civilians sites, which are home to IDPs who have been sheltering there since 2013. These restrictions affected service delivery to IDPs in several protected sites.

The HLTF further extended restrictions on movement, restricting some internal passenger flights, thus affecting United Nations Humanitarian Air Service (UNHAS) and other humanitarian flights and movement. It became a requirement that every passenger should secure a COVID-19 free certificate before flying from Juba to the states or a requirement for humanitarian workers to quarantine for 14 days before travelling to the field. At the time of issuing the addendum, lack of clarity about these requirements continues to impact the speed at which aid workers are able to respond to needs across the country, conduct assessments and rotate staff in and out of Juba.

The restrictions on movement, both at a national and state levels, have a significant impact on the ability of humanitarians to reach people in need. Border closures, international flight suspensions, quarantine policies and visa restrictions around the world put a halt to or significantly hindered the movements of humanitarian actors. Some critical staff are still stranded outside of their duty stations, and staff are unable to rotate. The surge-response capacity by humanitarian actors is particularly challenged by these measures, with a few actors having been able to send staff before the suspension of international flights and border closure. The rapidly evolving situation and the pace at which new measures or policies to curb the spread of the virus are being put in place continues to delay implementation of humanitarian activities.

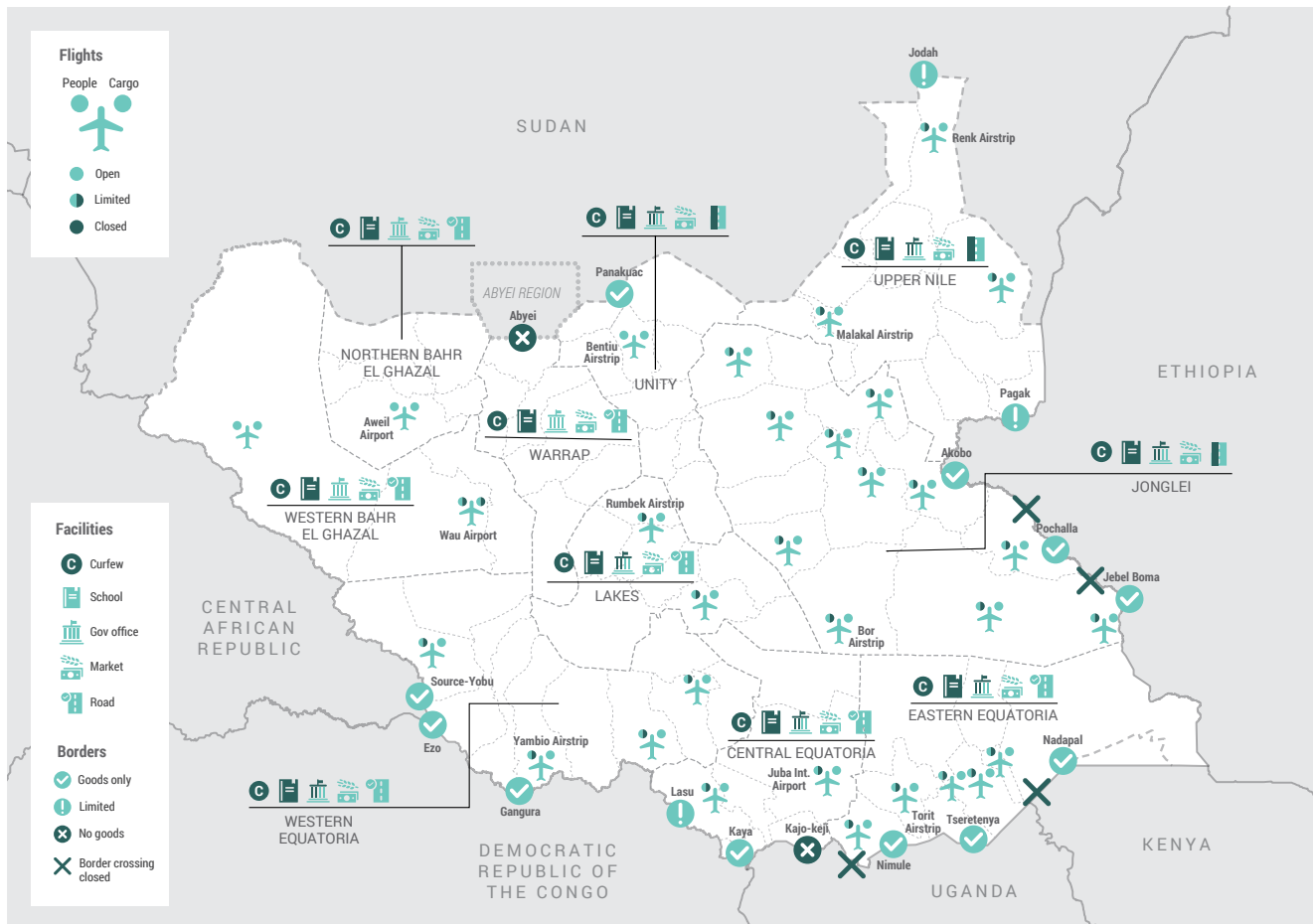
Recurring intercommunal violence and the resurgence of military clashes involving the National Salvation Front, South Sudan People's Defense Forces and Sudan People's Liberation Army-in-Opposition in parts of Central Equatoria since the end of April have created new humanitarian needs, and in addition to insecurity, COVID-19 related movement restrictions are making it difficult for humanitarian organizations to respond.

## Movement of humanitarian supplies

Relief, food and cargo flights are excluded from the government-issued travel restrictions. However, food airdrops were affected due to the administrative processes required prior to flying and the delays in dispatching of Drop Zone Coordinators to airdrop sites.

The movement of cargo has also been temporarily affected. For example, several UN agencies' trucks were held at the Sudan border as the drivers did not have COVID-19 free certificates to enter South Sudan. The delivery of agricultural seeds and tools to communities in preparation for planting and locust monitoring activities in affected areas has been put on hold due to the restrictions.

## COVID-19 restriction measures



Internal flights are limited out of Juba to the states, pending the passenger's COVID-19 free certificate or a 14-day quarantine prior to movement. The limited movement across some borders is due to the requirement of the COVID-19 free certificate. The map will be updated on a regular basis as the dynamic situation evolves and restrictions are eased. as of 2 June 2020

## Other constraints

South Sudan is dependent on medical supplies imported from outside the country in order to facilitate routine care. Given that the public health emergency response is already constrained, capacity for emergency response is extremely limited. South Sudan is also highly dependent on imported food commodities.

The capacity of humanitarian partners to import emergency life-saving relief items is contingent to availability of funding. Prior to the COVID-19 outbreak, an alert was raised on funding core pipelines that would likely dry up by May 2020 in the absence of timely funding. Food assistance, nutrition treatment supplements, reproductive health kits, education supplies, dignity kits and WASH supplies were all at risk of imminent pipeline breaks. Some of the WASH supplies are those related to handwashing and crucial to COVID-19 response.

Limited availability of critical medicines and hospital supplies, Personal Protective Equipment (PPE), masks and other consumables constrain response. PPE procurement is ongoing but the very limited stock of PPEs in country is severely hampering the response. Furthermore, efforts by the humanitarian partners to distribute COVID-19 household kits targeting hard-to-reach areas, has been hampered by lack of funding and timely sourcing of supplies.



# COVID-19 response modalities

## Adjustments to aid distribution modalities

Humanitarian organizations have been adjusting their response modalities since the risk of COVID-19 first became evident, even before the first people with COVID-19 were confirmed. Two to three months' combined food, and cash and voucher assistance were distributed with all the precautions in order to avoid large and frequent gatherings, especially in already high risk areas such as IDP sites and refugee camps. When aid distributions do take place, social distancing and hygiene practices have been put in place to reduce the risk of transmission. Assistance that was previously done in groups, such as psychosocial support, is now done individually.

Given the already stretched health capacity, partners developed a household kit aimed at reducing the burden of common diseases such as malaria and acute watery diarrhoea on health facilities. The kit includes mosquito nets, soap and items for home water treatments. It also supports good hygiene practices, one of the key strategies for COVID-19 prevention.

Essential drugs and medical supplies were pre-positioned early to high-risk locations when movement was still possible. Health professionals have been deployed in one-stop crisis centres in the hospitals, health centres and safe houses to prevent the transmission of COVID-19 while handling GBV survivors. When possible, psychosocial support is provided remotely. Hotlines and airtime have been provided in all GBV service coordination sites to facilitate referrals for intimate partner violence and other forms of GBV services.

Since COVID-19 was confirmed, international humanitarian organizations have accelerated their ongoing capacity strengthening with South Sudanese NGOs, while trying to limit the transfer of risks. At the same time, with the constraints on movement into and out of the country, it is recognized that the response will depend more than ever on national staff on the frontline, not only of national NGOs but as the majority of staff of the UN and international NGOs. Local aid workers have been supported remotely from the capital. In displacement sites, community representatives have been trained to take on additional responsibilities in camp management.

Assessments have also changed in nature. Organizations are using their networks of key informants to interview them remotely about evolving needs and response gaps. Satellite imagery is employed to provide information otherwise gathered during in-person assessments, about issues such as population density.

## Area-based response and rapid response

Efforts to scale up support towards existing capacities for area-based response, particularly in remote locations in South Sudan, are important in the face of challenges posed by unprecedented heavy rains. The rainy season causes

floods and makes road networks impassable, cutting off humanitarian assistance and aid workers to hard-to-reach areas. Travel restrictions from Juba to the states, including interstate travel put in place by the government to prevent the spread of COVID-19 amplify the need to pre-position crucial humanitarian relief items in locations across the country. The travel restrictions and the mandatory 14-day quarantine requirement also indicate that humanitarian partners will have limited opportunities to rotate mobile response teams frequently, thus a need to establish safe, secure, reliable facilities to allow teams to deploy for longer periods to implement COVID-19 preparedness and response activities and other relief efforts. This is also an opportunity to further support localization of humanitarian response.

In parallel with efforts to establish work and residential facilities at three strategic locations (Leer, Kajo Keji, and Raja) to enable organizations to deploy teams for longer term, humanitarian organizations will explore increasing the collective rapid response capacity in areas of highest need. Organizations will look into alternative options of consolidating and deploying other rapid response partners with WFP's Rapid Response Teams to ensure a multi-cluster response outside Juba. In addition, humanitarians will continue ongoing efforts to train and strengthen the capacity of static partners in high risk areas as first responders, on case-by-case basis.

## Community engagement

The need to take into account local knowledge and expertise is crucial in the prevention and containment of the spread of COVID-19 in the country. The [Rift Valley Institute](#) has identified a raft of key issues on public messaging and how understanding of the local context, perceptions and influencers such as chiefs is the best way to build trust and confidence in the messaging among the community.

As humanitarian partners respond to COVID-19 needs, an understanding of community perceptions of the assistance given is key for strengthening response programming based on direct community perspectives and perceptions. A recent [research report by REACH Initiatives](#) captures the perceptions including levels of community awareness and relevance of humanitarian service delivery. The information serves as a benchmark so that implementers of humanitarian assistance can draw from the findings to strengthen programming. Community engagement and risk communication efforts have been mobilized jointly to address these requirements for adapting the response.

## Conflict-sensitivity

Integrating conflict sensitivity in the design of COVID-19 related programming is critical to ensure interventions do not exacerbate existing tensions or trigger new ones among communities. Humanitarian organizations should regularly assess how COVID-19 and the humanitarian response are

impacting South Sudan's social, economic and political relationships at the national, state and local levels. Factors that should be considered include elite capture of state resources, particularly as these resources become scarcer and more contested; conflict between citizens and the state apparatus, particularly around lockdowns, curfews or the closure of 'non-essential' businesses; and conflicts within or between communities over access to key and scarce resources or perceived unequal treatment. In engaging with affected communities, humanitarian organizations should ensure that COVID-19 related messages are culturally and conflict sensitive, and that key influencers in the community are tapped to spread messages. Organizations will uphold the humanitarian principles throughout the programming and operational planning.

## Disability mainstreaming

Persons with disabilities and chronic illnesses, and elderly, face higher risk of violence, greater inequalities during the pandemic due to inaccessible information and environments, as well as stigma and misperception that may magnify the discrimination they experience. Mainstreaming of disability in all COVID-19 planning, response and recovery is important to ensure systematic inclusion of these groups and to prevent exacerbating pre-existing barriers and inequalities. To this end, humanitarian organizations in South Sudan are taking steps to identify the heightened risks and specific needs of these groups to respond accordingly. A **① rapid needs assessment** was conducted in May in Central Equatoria. Some of the **① gains made** in disability mainstreaming to date include risk communication materials and community engagement in diverse formats, adapted to specific needs of persons with different types of disabilities; mapping of services available; and awareness raising of COVID-19 frontline responders on stigma and non-discrimination, and the need for planning for continuation of care when primary caregivers are quarantined.

To enable adaptation of services to meet needs of persons with disabilities and elderly, humanitarian partners need to enhance data collection on inclusive service provision and disaggregate programme data by disability in addition to gender, age and other relevant criteria to monitor and address the gaps in response towards specific groups. There is also a need to include organizations of persons with disabilities in planning and decision making about the humanitarian programme cycle.

## Cash and voucher assistance and social protection

Cash and voucher assistance (CVA), especially multipurpose CVA, is a rapid, efficient and flexible tool to respond to the diverse needs for vulnerable people, including displaced and returning people, during the COVID-19 related health and economic crisis, while supporting local markets. CVA can protect vulnerable women and girls from GBV, including sexual exploitation and abuse, and survivors of GBV to escape abusive partners and reduce costs related to medical care or psychosocial support such as transportation. CVA

would also assist women and girls in stocking up menstrual hygiene management products such as sanitary pad if they will go into quarantine/physical distancing/restricted movement. Clusters should continue to coordinate closely with the inter-agency Cash Working Group to ensure common approaches and principles.

Market assessments show that food prices have increased in the wake of COVID-19, due to a combination of stockpiling, supply shock and increased cost of transport in Juba. Only shops dealing in food items were able to operate following government-imposed measures to prevent the spread of the virus, while street vendors were prevented from working. Should the restrictive measures continue this is likely to translate into an early onset of the hunger season for market-reliant populations.

Humanitarian organizations in South Sudan are making efforts to adapt their CVA to the current COVID-19 situation. These mainly include:

1. Shifting from in-person to remote registration, assessment, and prioritization processes, wherever feasible
2. Monitoring the continuous risks associated with the different modalities of assistance under COVID19 situation, and remote monitoring where feasible
3. Investing in collaborative efforts to assess and monitor the level of access and functionality of markets of key essential items, due to the disruption in supply chains and mobility restrictions; and the capacity from Financial Service Providers to respond at scale, with quality, and reaching marginalized communities, such as elderly and people with disabilities
4. Minimizing the use of digital fingerprints or signatures
5. Adjusting targeting mechanisms and processes, to include emerging vulnerabilities, given the impact of the pandemic and to reduce the risk of contagion, for example, remote targeting or targeting through local authorities or CBOs
6. Communicating, listening, and receiving feedback from CVA recipients by phone, for instance, and contributing to delivering COVID-19 prevention key messages

In South Sudan where the national social protection system is weak or cannot yet be used, CVA are being implemented through parallel systems by humanitarian and development partners. The inter-agency Cash Working Group, co-led by WFP and IOM and the National Social Protection Working Group chaired by the Ministry of Gender, Child and Social Welfare, and supported by UNICEF and World Bank is working with global social protection actors to map out the linkages in social protection and humanitarian activities. In the first phase, the World Bank's South Sudan Social and Safety Net Programme will scale up direct income support in Juba from July-August to provide rapid CVA to address emerging vulnerabilities amidst the COVID-19 outbreak. As the COVID-19 situation subsides, CVA will be expanded in all the other project locations across the country. At the same time, World Food Programme has continued its CVA, and added urban recipients to its programme.

## PART 3:

# Funding requirements

### Aligning clusters and national response pillars

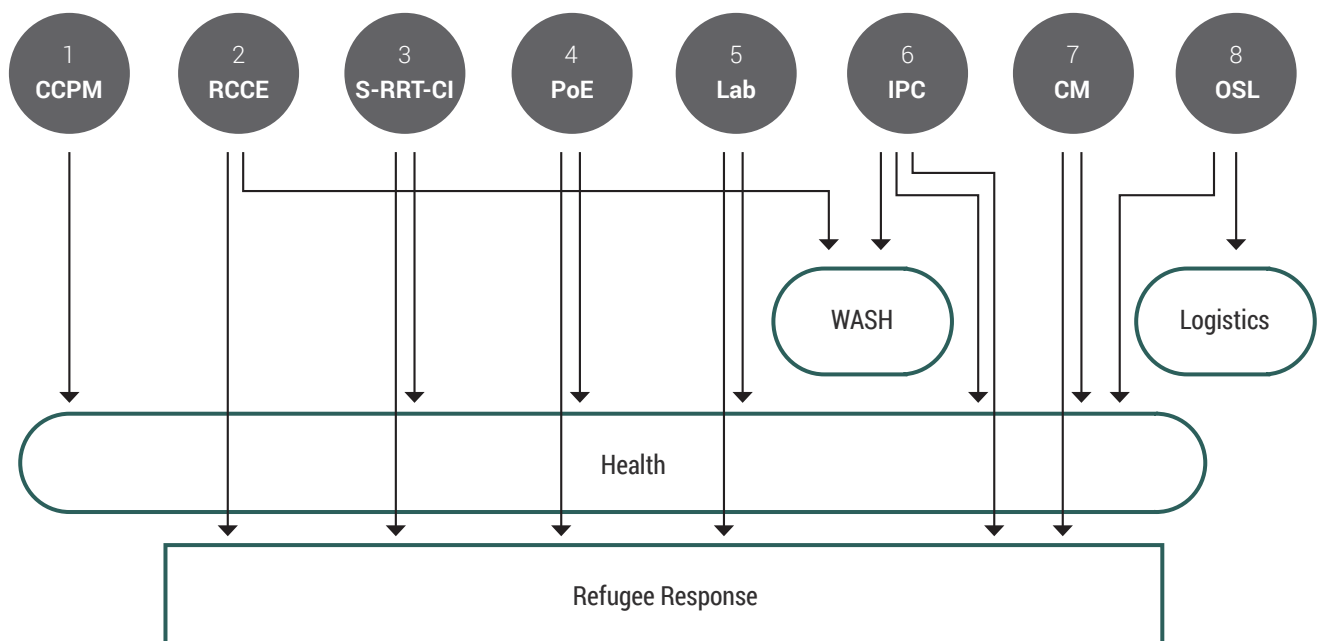
For the purposes of presenting coherent sectoral response plans in the addendum in line with the Inter-Agency Standing Committee cluster system, the eight pillars of the government-led, health-focused COVID-19 preparedness and response plan have been harmonized with the existing clusters in South Sudan. The diagram below aims to provide a factual graphical representation about how the requirements of the national plan map onto the clusters in the HRP addendum. All eight pillars are included either in full or in part in the Health Cluster. Some pillars are also reflected in WASH and Logistics clusters, and refugee response budgets.

The second graphic on the next page illustrates the overall funding requirements for the humanitarian response in South Sudan in 2020. In light of COVID-19 and its impacts on

operations, some \$39 million worth of projects were cancelled from the original 2020 HRP. The COVID-19 emergency and associated risk mitigation measures put in place to stop the spread of the virus have resulted in either the halting of a number of ongoing humanitarian activities or re-purposing others to focus on the COVID-19 response. Closure of schools has meant a scale-down of school feeding programmes in learning centres and cancellation of distribution of education supplies and training sessions. Longer-term WASH activities have been replaced with quick impact activities integrated with broader protection-centered emergency response, such as restoring access to safe water. Public messaging on hygiene have been nuanced to address COVID-19 preventative measures.

Funding for COVID-19 activities summarized in this document is tracked separately from the HRP by the [Financial Tracking Service](#).

### Mapping of financial requirements: Linking National COVID-19 Response Plan pillars to the clusters and the refugee response in the COVID-19 HRP Addendum



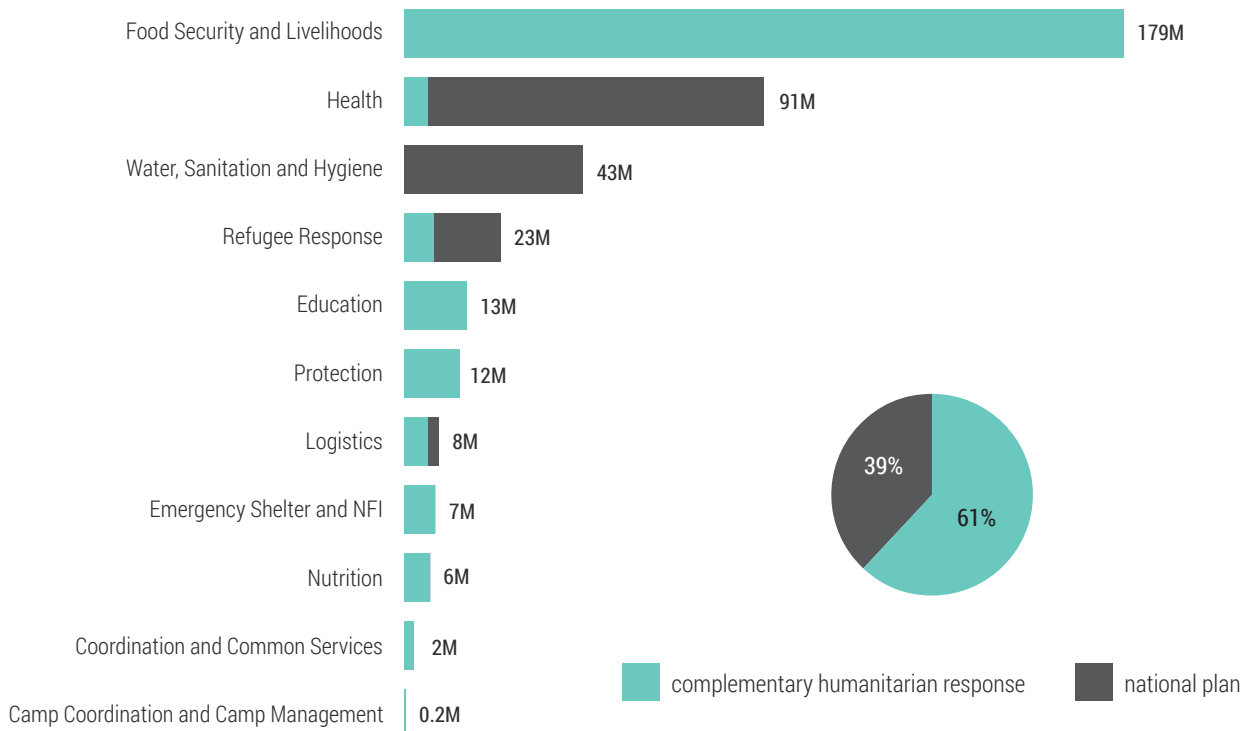
**CCPM:** Country-level Coordination, Planning and Monitoring  
**RCCE:** Risk Communication and Community Engagement  
**S-RRT-CI:** Surveillance, Rapid Response Teams, and Case Investigation  
**PoE:** Points of Entry

**Lab:** National Laboratories  
**IPC:** Infection Prevention and Control  
**CM:** Case Management  
**OSL:** Operational Support and Logistics

● Pillars  
 ○ Clusters  
 □ Refugee response



### Addendum requirements by sector (US\$)

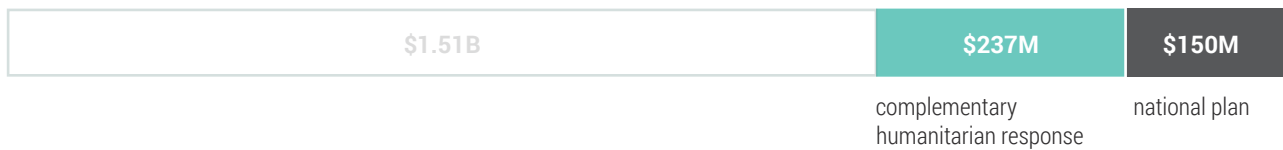


### Breakdown of funding requirements for humanitarian response 2020 (HRP and its addendum)

HRP decreased from \$1.55B to \$1.51B due to operational feasibility



New C19 requirements are \$387M including national plan



Total requirement for South Sudan 2020 is \$1.90B



Net increase in requirements from original HRP is \$348M



# Part 4: Response by sector



24



26



28



30



32



36



40



42



44



52



56

## Sectoral response, targeting and monitoring

The following chapter presents sectoral plans for the COVID-19 response. Each sector page includes a number of key figures, an explanation of the new vulnerabilities created by COVID-19, the response strategy, operational capacity, the cost of response and monitoring indicators. As the overall response strategy for 2020 continues to be guided by the strategic objectives and cluster strategies presented in the 2020 HRP, the following pages and the strategies presented therein focus on additional activities responded through the addendum.

In the absence of COVID-specific assessments, the number of people targeted for the addendum were estimates based on HNO/HRP sex and age disaggregated. People targeted data was collected by OCHA from all sectors, including refugee response but excluding the Logistics Cluster, at the county level. To avoid inter-sectoral double-counting, people targeted for each county was derived as a maximum value of people targeted across the sectors then adding the number of refugees targeted. The people targeted by the overall response was calculated by summing up people targeted for each county. Finally, sex and age proportions (%) from the 2019 country-wide Food Security and Nutrition Monitoring System (FSNMS) survey data was used to calculate county-level sex and age disaggregated people targeted. The overall people targeted for each demographic was derived by summing people targeted by demographic for each county.

Although data on persons with disabilities in South Sudan is scarce, WHO estimates 15 per cent of every population to be persons with disabilities with a higher prevalence rate expected in humanitarian crisis settings. Recent FSNMS data suggests 13 per cent of assessed South Sudanese live with physical disabilities. UNFPA estimates that about 3 per cent of the South Sudanese population is above 65 years of age and therefore at particular risk.

Each sector page concludes with new monitoring indicators related to the COVID-19 response. In line with global guidance, the inclusion of sectoral indicators against the Global Humanitarian Response Plan for COVID-19 has been prioritized in the development of new indicators. The HRP addendum monitoring framework presented on the following pages has been aligned against the structure of the pre-existing HRP monitoring framework contained in the [2020 HRP](#), maintaining the three overarching strategic objectives of the plan. The combination of the original and new indicators here forth becomes the monitoring framework for humanitarian action in South Sudan through 2020.

The Inter-Cluster Coordination Group and the Information Management Working Group will monitor the response achievements on a quarterly basis to balance informing operational adjustments with allowing sufficient information management resources for the upcoming 2021 HNO and HRP. The globally agreed monitoring indicators informing the Global Humanitarian Response Plan for COVID-19 will be channelled to headquarters at regular intervals.

| SECTOR                              | PEOPLE IN NEED (HNO) | PEOPLE TARGETED (ADDENDUM) | ADDENDUM REQUIREMENTS (US\$) | OF WHICH NATIONAL PLAN REQUIREMENTS | C19 PARTNERS |
|-------------------------------------|----------------------|----------------------------|------------------------------|-------------------------------------|--------------|
| Camp Coordination & Camp Management | 1.6 M                | 800 K                      | 230 K                        | -                                   | 9            |
| Coordination & Common Services      | -                    | -                          | 2.4 M                        | -                                   | 2            |
| Education                           | 3.1 M                | 800 K                      | 13.4 M                       | -                                   | 20           |
| Emergency Shelter & NFI             | 2.3 M                | 200 K                      | 7.5 M                        | -                                   | 17           |
| Food Security & Livelihoods         | 6.7 M                | 6.9 M*                     | 179 M                        | -                                   | 35           |
| Health                              | 3.6 M                | 2.2 M                      | 91.4 M                       | 87.7 M                              | 23           |
| Logistics                           | -                    | -                          | 8.4 M                        | 2.7 M                               | 1            |
| Nutrition                           | 2.1 M                | 1.3 M                      | 6.2 M                        | -                                   | 26           |
| Protection                          | 4.8 M                | 388 K                      | 11.6 M                       | -                                   | 56           |
| Water, Sanitation & Hygiene         | 5.5 M                | 2.8 M                      | 43.5 M                       | 43.5 M                              | 47           |
| Refugee Response                    | 300 K                | 410 K                      | 23.3 M                       | 16.1 M                              | 1            |

\* Food and livelihoods assistance to newly vulnerable people during COVID-19 based on market dependence





# Camp Coordination and Camp Management

HNO PEOPLE IN NEED

1.6M

PEOPLE TARGETED BY C19 ADDENDUM

800K

ADDENDUM REQUIREMENTS (US\$)

\$230K

NUMBER OF C19 PARTNERS

9

## New vulnerabilities

COVID-19 presents an exceptional concern for some 1.3 million IDPs who need Camp Management and Camp Coordination (CCCM) services in South Sudan. The Protection of Civilians sites, collective sites and other camp-like settings have very limited living space per person. Forcibly displaced populations residing in camps or camp-like settings may be particularly vulnerable to the virus due to overcrowding, poor access to safe water and sanitation, and limited access to health care and water and sanitation services. People living in these settings are highly vulnerable to a potential COVID-19 outbreak, which could result in a high number of cases and fatalities. Further, IDPs can become increasingly vulnerable if humanitarian assistance, and any livelihood and income activities, are curtailed by the pandemic.

## Sectoral strategy

In response to COVID-19, the CCCM Cluster is preparing for potential outbreaks in displacement sites and ensuring that correct response measures are in place to limit the spread of the virus and isolate those infected. The cluster will continue to ensure that IDPs have access to Camp Management (CM) services in sites during the outbreak and will strengthen displaced communities' and camp management teams' capacity to respond effectively to COVID-19. CM partners will strengthen community engagement with women, elders and persons with disabilities. Communicating effectively with communities is vital in providing accurate messaging to IDPs, especially vulnerable groups, to help them to safely and effectively prepare for COVID-19.

Through messaging and rumour tracking, the CCCM Cluster will feed into the Risk Communication and Community Engagement Pillar of the COVID-19 National Response Plan. Similarly, the cluster presents operational guidance to camp management to adjust their programme to maintain community engagement with a focus on behavioural change communications and promoting communal sanitation practices.

## Cluster capacity and response modalities

As the operating environment changes, the CCCM Cluster has developed a Camp Management Operational Guidance to support the camp management agencies in camps and camp-like settings on COVID-19 preparedness and response. Based on different site scenarios, the CCCM Cluster is supporting partners in sites to develop contingency plans in which remote management when needed will be adopted. The

impact of limited movement is reflected in the contingency plans developed by camp management agencies and service providers in PoC sites and camp-like settings. Additionally, in coordination with Point of Entry (POE) Pillar Working Group, the CCCM Cluster contributed to the development of POE Standard Operating Procedures (SOP) for population of humanitarian concern in camps and camp-like setting.

There is a special focus on capacity building of community workers and community governance structures who will be able to interact directly with the IDP communities and humanitarians. Through these new delivery modalities that focus on remote management and a community-based response, the cluster will ensure the continuation of communication and engagement with affected communities and coordinate the delivery of critical services in the sites. To ensure continuation of activities and accountability to affected population, CCCM cluster and partners will continue to identify, train and mobilize different IDP groups, including women, youth and persons with disabilities, to enhance their active representation and participation in the information and engagement of the community to the COVID-19 response, aiming to maintain two-way communication systems and continue the management of the sites through remote management. However, some tasks cannot be done remotely or by IDPs or community structures, such as operating heavy machineries for site maintenance/improvement in preparation for rainy season, provision of technical training to key community members and outreach workers, and support to community-led initiatives aimed at reducing local transmission of COVID-19.

The CCCM Cluster will maintain the static response in PoC sites and in specific camp-like settings during the COVID-19 response. Where possible the mobile response modality will be used for camp-like settings that have no static camp management presence taking note that it will be challenging to reach displaced people in hard-to-reach areas through a mobile approach in the current context of restrictions. Therefore, the cluster will focus on supporting displaced people that can be reached effectively through its static response and will strive to enhance its response in other areas highlighted in the 2020 HRP once the security environment improves. For those at increased risk of intimate partner violence or domestic violence, CCCM would work in closely with GBV actors to identify alternative shelter options, wherever possible.

## Cost of response

CCCM activities focusing on establishing coordination mechanisms and community engagement in response to COVID-19 will require additional operating funds for human resources and logistics including activities that require additional measures related to prevention and mitigation of COVID-19. Additional funding will be required to increase the capacity of the cluster's partners to address the outstanding and anticipated COVID-19 related needs of vulnerable people in displacement.

Increasing the cluster envelop by \$230,000 will enable the cluster to absorb additional measures that needs to be put in place for prevention and mitigation of COVID-19. The cluster partners shall also be able to hire additional staff and utilize them to improve humanitarian access and coordination during a movement restriction and or lockdown scenario. This will improve the quality of COVID-19 planning and response to relevant community engagement activities for the affected population. Furthermore, the cluster will be able to increase access to COVID-19 related information in the target communities and enable community members to make choices that contribute to developing a more secure environment.

## Additional COVID-19 monitoring

| OBJECTIVE  | INDICATOR   | IN NEED | TARGETED |
|--|---|---------|----------|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>                                   |   |         |          |
| SO 1.3: Reduce excess morbidity and mortality rates from epidemic-prone diseases (malaria, diarrhoea, acute respiratory infection and measles) in priority areas                   |   |         |          |
| Enhance outreach response for COVID-19 to displaced population in PoC sites and camp-like settings   | % of sites reporting information sharing with partners through the coordination forums  | 100 %   | 80 %     |
|  | # of sites reporting use of clear dead body management guidelines, plan for dead body handling, procurement of body bags completed                        | 12      | 12       |
|  | % of sites with clear guidelines of reporting of access issues for key humanitarian partners and suppliers/contractors for essential services established | 100 %   | 100 %    |
|  | # of sites with clear entry screening procedures developed  | 12      | 12       |
| SO 1.4: Reduce vulnerability of 640,000 people at risk of mortality and morbidity (psychosocial and mental health needs) as well as protection incidents/threats in priority areas |   |         |          |
| Improve engagement with vulnerable population with priority on addressing COVID related gaps and building resilience   | % of rumours tracked per site with debunking mechanisms established   | 100 %   | 80 %     |
|  | # of trainings on COVID-19 and key messages to community governance structures conducted  | 120     | 120      |
| <b>Strategic Objective 2: Ensure safe, equitable and dignified access to critical cross-sectoral basic services to enable populations meet their basic needs</b>                   |   |         |          |
| SO 2.1: Provide equitable access to cross-sectoral basic services to 3 million people (including women, children, the elderly and persons with disabilities) in priority areas     |   |         |          |
| Ensure equal access and needs based assistance to improve the quality of integrated services for populations affected by displacement  | # of sites reporting community engagement in COVID-19 preventive messaging  | 40      | 40       |
|  | # of sites with clear referral pathways developed and communicated to all relevant actors   | 40      | 12       |
|  | # of sites with contingency plans developed with participation of all service providers   | 40      | 12       |
|  | # of people reached with adequate information on COVID-19 by Communication with Communities team  | 800 K   | 800 K    |
|  | # of sites with contingency spaces for expansion of services such as isolation and quarantine areas, health facilities and burial sites                   | 40      | 12       |



# Coordination and Common Services

ORGANIZATIONS TARGETED BY COVID-19 ADDENDUM

**305**

ADDENDUM REQUIREMENTS (US\$)

**\$2.4M**

NUMBER OF C19 PARTNERS

**2**

## Needs

The demand for Coordination and Common Services (CCS) has increased with the COVID-19 outbreak in South Sudan. Information about humanitarian needs, vulnerabilities, response gaps and priorities is limited and requires CCS expertise to best support coordinated humanitarian action. Risk communication and community engagement must be prioritized for community understanding and uptake of essential public health measures to prevent and control the spread of the disease.

## Sectoral strategy

In the absence of clear epidemiological trends or projections in the country to determine vulnerability, REACH and OCHA have worked with all clusters through the Needs Analysis Working Group to develop a vulnerability framework to support inter-sectoral prioritization, while undertaking an analysis of population movement and household-level surveys to inform the COVID-19 and broader humanitarian response. The vulnerability mapping will feed into strategic coordination forums such as the Inter-Cluster Coordination Group for decision-making on needs and response prioritization, as well as the COVID-19 Operations Working Group and National Steering Committee.

IOM's Displacement Tracking Matrix (DTM), in collaboration with partners, tailored data collection and analysis focusing on population mobility and COVID-19 vulnerability, informing the COVID-19 country-wide response. The existing countrywide data collection activities were continued with adjusted methodology and field modalities in response to COVID-19 information needs and gaps. In response to mobility restrictions, combining flow monitoring data and remote key informant interviews at priority locations were adopted. Enumeration areas in major urban centres, using satellite imagery and high-resolution building footprints, were developed to support efforts for multi-sectoral epidemiological and vulnerability studies in urban areas. To support IDPs who voluntarily decide to return home to mitigate risks of COVID-19, biometric registration and service provision will be considered.

CCS partners will work with relevant stakeholders to map health facilities throughout the country, identify which healthcare facilities may be overwhelmed and the routes that affected populations may take in an attempt to access medical care.

The Communication and Community Engagement (CCE) Working Group supports the National Risk Communication and Community Engagement Pillar for COVID-19, including through facilitating Rumor Tracking Management and analysis in and around PoC sites, and in hard-to-reach locations. In terms of accountability to affected population, two-way communication with communities will be established using language and modalities preferred by the affected people, in disseminating COVID-19 messaging. Recognizing that the PoC sites are high-risk area due to the high-population density, living conditions and the vulnerability of the population, the CCE Working Group will expand its platform to support intensive risk communication and awareness raising to enable the population to make informed choices. This includes providing feedback on cultural sensitivity of messaging and offering contextual tailoring of messages.

As COVID-19 will affect operation modalities for the foreseeable future, IOM will continue its project presented in the original 2020 HRP to establish safe, secure, reliable work and residential facilities. In the COVID-19 environment, three strategic locations (Leer, Kajo Keji, and Raja) are prioritized to enable organizations to deploy teams for longer term. The current COVID-19 related travel restrictions and the mandatory 14-day quarantine requirement also indicate that humanitarian partners will have limited opportunities to rotate mobile response teams frequently thus establishment of safe, secure, reliable work and residential facilities is critical to ensure humanitarian actor will be able to maintain presence in prioritized areas to implement COVID-19 preparedness and response activities and other relief efforts. This is also an opportunity to further support localization of humanitarian response.

## Cluster capacity and response modalities

A limited humanitarian footprint across the country due to movement restrictions will be mitigated by implementing alternative models of data collection and analysis, to produce valuable insights for the response, while minimizing human contact. Travel restrictions put in place to contain the spread of the virus have impacted the effective delivery of humanitarian assistance.

Given that 80 per cent of health services in South Sudan are provided by NGOs, the cluster and partners are supporting high level advocacy efforts to facilitate a continuation of humanitarian assistance. A standard operating procedure outlining data collection and biometric registration

activities in-line with new COVID-19 contingency protocols was developed. New modalities such as remote data collection through phone calls and secondary data analysis will be adopted. Frontline staff are trained to ensure COVID-19 measures are mainstreamed and respected in all preparedness and response activities. The cluster and partners are also working with respective clusters to set up hygiene and sanitation facilities in data collection sites, camps and camp-like settings. Field operations are maintained at a scale that does not compromise adherence to COVID-19 restrictions and measures.

## Cost of response

A total of \$2.4 million will be required for the COVID-19 response, adapting new modalities and ensuring the existing programmes are aligned with the COVID-19 measures. This includes \$700,000 which is needed for IOM's area-based response. Facilitating and maintaining COVID-19 direct data collection will require extra resources, with building a COVID-19 information management system within the

existing programming seen as one of the main cost drivers. This will ensure the continuity of provision of data and information on humanitarian needs across sectors.

REACH is planning to use its existing 15 field bases and country-wide network of enumerators and key informants to support an intersectoral evidence based response to COVID-19 throughout the country and complimented by primary and secondary analysis support. DTM will build COVID-19 information management systems within the existing programming to ensure cost-efficiency of its operations and sustainability of the overall programme. IOM will maintain a dedicated position in coordination of the CCE Working Group with technical support from Internews and CCCM Cluster, and support the overall risk communication in the country, offering analytical coverage on rumor tracking in all states through its membership network.

In support of an area-based approach, IOM is establishing three work and residential facilities to ensure that humanitarian partners are able to reach field locations from outside of Juba.

## Additional COVID-19 monitoring

| OBJECTIVE   | INDICATOR  | IN NEED | TARGETED |
|---|--|---------|----------|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>  |  |         |          |
| SO 1.5: Population groups targeted to receive assistance feel consulted and informed throughout the entire programme cycle  |  |         |          |
| Enhance programme quality through strengthened Accountability to Affected People (APP)  | Percentage of humanitarian service providers [by cluster] who disseminate information about complaint mechanisms and COVID-19 to the population targeted for assistance  |         | 100 %    |
| <b>Strategic Objective 2: Ensure safe, equitable and dignified access to critical cross-sectoral basic services to enable populations meet their basic needs</b>  |  |         |          |
| SO 2.4: Increase in the use of strategic humanitarian hubs or operational centres for provision of safe access, security and humanitarian space; as well as provision of flexible, timely and expanded multi-sectoral response to women, men, boys and girls affected by protracted displacement and for return populations, non-displaced and host communities in areas of highest severity need |  |         |          |
| Enable operations through provision of safe access, security and humanitarian space   | Percentage reduction in the number of access impediments   |         | 30 %     |
| <b>Strategic Objective 3: Enable vulnerable people to recover from crisis, seek solutions to displacement, and build resilience to acute shocks and chronic stresses through targeted programming to support coping capacities and livelihoods in prioritized areas</b>   |  |         |          |
| SO 3.1: Restore self-sufficiency of returnee populations through capacity strengthening of community-based mechanisms, access to cross-sectoral basic services and predictable access to livelihoods including recovery of livestock and small holder agriculture in geographical locations   |  |         |          |
| Strengthen joint needs analysis and strategic response planning for effective and well-coordinated humanitarian action  | Number of multi-sectoral assessments, collaborative data analysis/exercises, intention and perception surveys, household level COVID-19 related surveys, flow monitoring reports to inform prioritization of humanitarian response |         | 78       |
|   | Number of DTM reports addressing COVID-19 risk and vulnerability   |         | 35       |





# Education

HNO PEOPLE  
IN NEED

3.1M

PEOPLE TARGETED BY  
C19 ADDENDUM

800K

ADDENDUM  
REQUIREMENTS (US\$)

\$13.4M

NUMBER OF C19  
PARTNERS

20

## New vulnerabilities

The Government of South Sudan announced on 21 March 2020 the closure of all educational institutions for a period of one month—the school closure was later extended for an unspecified period. The closures were a precautionary measure, to mitigate the risk of human to human transmission of the COVID-19, to protect children from being affected and to minimize the further spread of the virus in the community. Over 2 million school-aged children currently enrolled in formal and non-formal schools will not be able to attend regular schooling. This is in addition to approximately 2.4 million children estimated to be out of school in 2020.<sup>8</sup> Left without access to the protective environment at schools, the risk of children being neglected, abused or exploited increases significantly. The COVID-19 pandemic is an unexpected setback to the already fragile education system.

As well as interrupting educational progress, the school closures also limit access to essential services such as school feeding and health and nutrition programmes; information on disease prevention; and access to clean water and sanitation services. The provision of psychosocial support is an essential component for children, teachers and school community during the time of crisis. The school closures disrupt children's routine and social support and may also not allow children to learn and take part in recreational sports and game activities and further limit the chance of social interaction. Girls are among the most vulnerable group. The combination of being out of school and the loss of family livelihoods caused by COVID-19 can leave girls especially vulnerable to different forms of GBV including sexual violence, unwanted pregnancy and early marriages.

## Sectoral strategy

To support Government's efforts to contain the disease and prevent further spread, the Education Cluster and partners developed the COVID-19 preparedness and response strategy that outlines the joint strategic response approach to the outbreak during school closure and beyond. The strategy is intended to complement wider plans developed by the Ministry of General Education and Instruction (MoGEI), UN agencies, Inter-Cluster forums and development partners to ensure all elements are harmonized and aligned. The primary focus of the response is to prevent the spread of the disease, restore access to safe learning opportunities including psychosocial support, WASH services in schools and other lifesaving and protection interventions. The strategy includes three objectives corresponding to two response phases: school closure (Objective 1 and 2) and school reopening (Objective 3). Objective 1 aims to: prevent

the spread and transmission of COVID-19 among teachers, learners and school communities. Objective 2 focuses on mitigation/minimizing the negative impact of the COVID-19 crisis on learning and well-being of teachers, learners and school communities through alternative learning and support mechanisms. The purpose of objective 3 is to: ensure safe return to quality learning for teachers, learners and school communities.

Following the school closures, the Education Cluster has re-prioritized interventions to facilitate distance learning through radio teaching and other alternative programme until schools reopen. At the same time, education partners de-prioritized activities from existing HRP projects which include massive construction and rehabilitation of Temporary Learning Spaces (TLS), provision of school supplies, school WASH services, and training of teachers and community members. The education partners will also support activities related to risk mitigation and protection of school children from the impact of COVID-19 through developing messaging and awareness-raising campaigns.

The Education Cluster identified an estimated 3.1 million school-aged children in need of education response in 2020. Of the 3.1 million, the cluster is targeting 0.8 million children for 2020 based on existing capacity of partners, their outreach and funding estimates from previous years. Among the children in need, IDPs, returnees from within South Sudan, refugees and South Sudanese refugee returnees are identified as the most vulnerable groups. The planned activities will target teachers and learners through radio instruction programmes in high risk areas and beyond. Not all children will have access to the digital platforms, therefore alternatives will be developed to make education available for hard to reach children and vulnerable children and youth. Partners will be able to develop and adapt other materials for remote learning and radio instruction programmes.

Education actors will ensure a safe return to quality learning for learners, teachers and the community through preparedness activities such as a back to school campaign, school kit distributions and WASH services in school. Some protection and psychosocial support activities will also be organized to ensure the safety and protection of children in and around schools. The education cluster would consider messaging and information on sexual and reproductive health, menstrual hygiene management, gender and GBV risks when new materials are being developed in as part of response to COVID19—for both boys and girls, as appropriate.

While this plan is primarily focused on emergency humanitarian efforts, there are humanitarian-development nexus activities to build the country's resilience and

strengthen education response systems. The line ministry adapted the Education Cluster COVID-19 Preparedness and Response strategy into the national response plan to bring humanitarian and development partners under one coordination network. This will allow partners to complement resources in a more effective and strategic manner. The COVID-19 response activities are temporary and ad-hoc to prevent the spread of the disease, minimize academic loss and bring children back to learning. The Education Cluster and partners will eventually transit back to the activities included in the 2020 HRP once schools reopen.

## Cluster capacity and response modalities

UN agencies and NGOs are physically present across the country delivering education services outlined in the 2020 HRP and the implementation of the cluster plan will be carried out in support of MoGEI efforts, and in coordination with partners, inter-cluster forums and donors.

Education Cluster partners are already implementing activities aimed at preventing the spread and transmission of COVID-19 in communities through teachers and school committees. Given additional funding, Education Cluster partners will be able to rapidly establish or scale up COVID-19 related education activities as a result of having a long-established presence and programming in schools and communities throughout the country.

The Education Cluster is functional in ten states to ensure effective coordination among partners, support service delivery and fast-track education response in prioritized locations. The State MoGEI chairs the meetings and provides regular guidance, assisting partners in addressing access barriers including timely approval of programme

implementation. Coordination of education response through the cluster is crucial to ensure the most efficient use of resources, integration of services and reduce the risk of duplication and overlap.

The movement restrictions in place to prevent the virus from spreading may disrupt the education organizations' ability to deploy experts into hotspot areas to scale up activities. However, the restrictions will not affect key interventions such as radio instruction programmes, distance learning and prevention activities.

## Cost of response

The costing and budget for the Education Cluster COVID-19 response were developed in consultation with the Strategic Advisory Group and key education stakeholders. The costing aims to harmonize the costing for different activities and provide an overview of the resources required for the education sector to adequately respond to the needs resulting from the COVID-19 crisis. As schools will remain closed for an indefinite period, activities and resources are re-programmed to cover alternative learning options through radio instruction programmes, distance learning and home-based lessons, where appropriate. Other key areas that require resources include prevention activities such as teachers supporting risk communication activities, sensitization of communities, parents and children around COVID-19 activities. The WASH in school particularly handwashing facilities, provision of hygiene material and disinfecting schools to prepare school to reopen were prioritized with allocated resources. Psychosocial support programming, protection referrals and essential recreational supplies were budgeted. Additional costs include assessments, monitoring and evaluations at sector level.

## Additional COVID-19 monitoring

| OBJECTIVE   | SECTORAL RESPONSE APPROACH   | INDICATOR  | IN NEED | TARGETED |
|---|--|--|---------|----------|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>                                    |  |  |         |          |
| SO 1.3: Reduce excess morbidity and mortality rates from epidemic-prone diseases (malaria, diarrhoea, acute respiratory infection and measles) in priority areas                    |  |  |         |          |
| Prevent spread and transmission of C19 among teachers, learners and school communities  | Sensitize learners, teachers and school management committees (SMC) regarding C19, its mode of transmission, signs of infection and mitigation/referral measures               | # of teachers and children reached with C19 prevention messaging         | 3.1 M   | 800 K    |
| <b>Strategic Objective 2: Ensure safe, equitable and dignified access to critical cross-sectoral basic services to enable populations meet their basic needs</b>                    |  |  |         |          |
| SO 2.1: Provide equitable access to cross-sectoral basic services to 3 million people (including women, children, the elderly and persons with disabilities) in priority areas      |  |  |         |          |
| Mitigate/Minimize the negative impact of the C19 crisis on learning and well-being of teachers, learners and school communities through alternative learning and support mechanisms | Children have the opportunity to continue to access quality education services through learning at home/distance or radio education programming in the case of school closures | Number of children regularly attending alternative learning              | 3.1 M   | 800 K    |
|   | Teachers and students will continue accessing education, psychosocial support and other lifesaving services in a safe environment  | Number of children benefitting of returning to safe and quality learning | 3.1 M   | 800 K    |



# Emergency Shelter and Non-Food Items

| HNO PEOPLE IN NEED | PEOPLE TARGETED BY C19 ADDENDUM | ADDENDUM REQUIREMENTS (US\$) | NUMBER OF C19 PARTNERS |
|--------------------|---------------------------------|------------------------------|------------------------|
| 2.3M               | 200K                            | \$7.5M                       | 17                     |

## New vulnerabilities

People who live in highly populated areas such as urban centres, PoC sites, collective sites and informal settlements are more at risk to the spread of COVID-19. Emergency shelter and non-food item (ES/NFI) related needs were already high due to new displacements and returns from the neighbouring countries prior to the virus threat. PoC and collective sites, informal settlements and host communities continue to receive newly displaced and returning people who are in need of emergency shelter and NFIs. Shelter requirements are also high to support primary health care centres, particularly in PoC sites.

Physical distancing and isolation are difficult to achieve in crowded PoC sites, collective centres and informal settlements where land is limited. Decongestion of sites is essential to lower overcrowding in living spaces and will also allow humanitarians to provide NFIs such as household items, mosquito nets, blankets and plastic sheets to people as safely as possible. Partitions are needed in communal shelters and more WASH NFIs are required to improve hygiene and sanitation practices in the sites. Having access to clean water and sanitizing agents are necessary to stop widespread transmission of the virus.

## Sectoral strategy

To ensure effective response, the ES/NFI Cluster will pre-position shelter and NFIs in hubs close to hotspot counties identified by the Needs Analysis Working Group. Working closely with Health and WASH partners, the cluster will target the most vulnerable newly displaced populations and returnees in PoC sites and a limited percentage of host communities with underlying conditions in 19 counties. To increase case management capacity in PoC sites, informal settlements and collective sites, the ES/NFI Cluster will support health partners in the construction of case management centres, upon request. These requests will be coordinated with camp management agencies and the Health Cluster partners.

To improve NFI distributions, the cluster and partners will work with WASH partners to ensure that handwashing and sanitation facilities are available at all distribution sites. The cluster will also work with camp management to map empty shelters in PoC sites, collective centres and informal settlements left behind by returning IDPs. These shelters could be used to decongest overcrowded sites. Furthermore, to enhance social distancing, living spaces especially in informal settlements and collective sites will be improved by

partitioning communal living spaces. IDPs identified as being the most at risk of contracting COVID-19 will receive extra plastic sheeting, blankets and mosquito nets. Critical shelter care and maintenance and upgrades will help to mitigate the spread of the virus by improving living conditions and create a safer environment in the sites.

The cluster intends to target close to 200,000 people including more than 91,000 of the most vulnerable and newly displaced people, returnees and host communities in 19 hot spot counties: Rubkona, Yei, Juba, Pariang, Malakal, Koch, Renk, Kajo-Keji, Panyijiar, Bor South, Gogrial West, Twic, Aweil North, Aweil East, Mayom, Wau, Magwi, Aweil West, and Fashoda. The elderly in and outside PoC sites and vulnerable people with pre-existing conditions will be assisted with shelter and NFI assistance. The cluster will also target people in and outside of PoC sites who suffer from acute malnutrition and acute health conditions with shelter and NFI support to provide protection from the elements and mitigate adverse impact on pre-existing conditions.

The cluster has reprioritized the planned activities under the 2020 HRP in support to the COVID-19 response. Activities such as training and workshops previously planned by the cluster's partners are deprioritized to decrease the risk of exposure to COVID-19. Some unfunded projects in the 2020 HRP have been modified to include hotspot counties. The cluster will conduct market assessments to determine feasibility of CVA where applicable especially in urban settings which are not severely affected by logistical constraints.

The cluster will expand on approaches to improve resilience and contribute to long-term activities such as supporting and reinforcing case management capacity in IDP settlements, and engaging in housing, land and property issues. The ES/NFI Cluster will continue to do more shelter settlement programming to build upon the multi-sectoral approach and increased CVA in areas of return where markets are functional to enhance resilience building and coping mechanisms.

## Cluster capacity and response modalities

The ES/NFI Cluster will use both static and mobile outreach methodologies. The cluster has 22 state and site focal points across the country, living and working within the affected communities. The cluster's partners will use in-kind and CVA modalities to fill existing gaps. Community-appropriate solutions will increase resilience while building coping mechanisms such as self-supported solutions for shelter reconstruction, multi-sectoral settlement-based solutions

and committees supporting their communities in the long-term. Given the current situation on travel restrictions and requirement to reduce footprints in rural areas, state and site focal points will be the major drivers of the response supported by the national coordination team.

The ES/NFI Cluster will work with pipeline manager with support from the Logistics Cluster to pre-position shelter and NFIs in different warehouses and hubs close to the 19 hotspot counties. In urban areas where markets are functional, CVA will be encouraged.

### Cost of response

The cluster requires a total of \$7.5 million, of which \$3.9 million which are re-prioritized HRP activities and \$3.6 million which are the additional requirements. The cluster anticipates \$35 per person for in-kind support, including supplies and logistics. The cluster employs cost efficient

measures, primarily through its core pipeline, about 36 per cent of funding, and a coordination mechanism through state and site focal points who coordinate timely and appropriate response, deploying both static and mobile partners. The cluster has reduced unnecessary and unused distributed in-kind items through improved targeting, increasing biometric registration and coping mechanisms. Cost for the care, maintenance and shelter upgrades of empty shelters in PoC sites, informal settlements and collective centres is estimated at \$72 per shelter while partitioning communal shelter in targeted locations will cost \$31 per communal shelter. Shelter to increase case management capacity will cost approximately \$2,700 per facility. Each facility has a bed capacity of 50. On average, \$25 per head will be needed to provide CVA, 19 per cent of programming as functioning markets proliferate.

### Additional COVID-19 monitoring

| OBJECTIVE  | INDICATOR   | IN NEED | TARGETED  |
|--|---|---------|---|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>                               |   |         |   |
| SO 1.3: Reduce excess morbidity and mortality rates from epidemic-prone diseases (malaria, diarrhoea, acute respiratory infection and measles) in priority areas               |   |         |   |
| Improve access to shelter by decongesting crowded shelters through, shelter upgrades, partitioning for communal shelters to reduce transmission and exposure                   | Number of people with access to shelter and NFIs  |         | 46 K  |
| Support health partners with shelters for case management  | Number of case management facilities constructed by SNFI cluster  |         | 30 case management facilities 50 beds each and other facilities including changing room, wash room, disinfecting room, etc. |
| <b>Strategic Objective 2: Ensure safe, equitable and dignified access to critical cross-sectoral basic services to enable populations meet their basic needs</b>               |   |         |   |
| SO 2.1: Provide equitable access to cross-sectoral basic services to 3 million people (including women, children, the elderly and persons with disabilities) in priority areas |   |         |   |
| Support care and maintenance activities for shelters in and/or outside the PoC sites to increase social distancing and reduce vulnerabilities                                  | Number of people with upgraded shelters   |         | 46 K  |
| Improve the distribution process during provision of life saving emergency shelter and non-food items working with WASH partners   | % of distribution conforming to WFP distribution SoPs at distribution sites and coordinated with WASH and Health partners |         | 100 %   |





# Food Security and Livelihoods

| HNO PEOPLE IN NEED | PEOPLE TARGETED BY C19 ADDENDUM | OF WHICH 2020 HNO PEOPLE IN NEED | OF WHICH NEWLY VULNERABLE PEOPLE | ADDENDUM REQUIREMENTS | NUMBER OF C19 PARTNERS |
|--------------------|---------------------------------|----------------------------------|----------------------------------|-----------------------|------------------------|
| 6.7M               | 6.9M                            | 5.3M                             | 1.6M                             | \$179M                | 35                     |

## New vulnerabilities

Prior to the emergence of the COVID-19 threat, more than half of South Sudan's population, 6.5 million people out of nearly 12 million, were expected to face severe food insecurity (IPC Phase 3 and above) at the height of the annual hunger season (May-July 2020). Indirect impacts of COVID-19 are adversely affecting market dependent households at a critical time of the year (entering the lean season) when market prices are already 'normally' high. The growing and significant number of urban poor, not already supported by humanitarian assistance, were identified through a World Bank study and actors operating on the ground, as a vulnerable population who live day to day from casual labour and petty trade in order to survive. The newly emerging vulnerabilities due to plummeting oil prices, rising food prices, loss of employment and livelihoods make it difficult for this new caseload to meet their daily subsistence needs.

The rural poor are also likely to become more vulnerable and food insecure due to the disruption in trade flows exacerbated by COVID-19. Agriculture and livelihood activities were severely affected by unprecedented flooding in 2019, and people living in the hardest-hit flood areas were already struggling to rebuild their lives and livelihoods prior to the arrival of a global pandemic. With data from the Food Security and Nutrition Monitoring System (FSNMS) highly market dependent rural poor, not already supported, were identified from approximately 10 per cent of people initially projected, at the January IPC analysis, to be in Phase 2 (Stressed), but are now likely to shift into IPC Phase 3 or above. This population is also strongly dependent on food markets and derives most of their income from livelihood sources that are expected to be affected by COVID-19 and measures enforced to prevent the spread of the virus.<sup>9</sup>

The arrival of the desert locusts in several counties in the country since February is yet another shock with potential to generate additional vulnerabilities resulting from crop and pasture damage to farming and pastoral households. This is projected to be most severe in locations which are already facing severe food insecurity and disrupted livelihoods. The desert locusts invasion, ravaging neighbouring Ethiopia, Kenya and Uganda during the first quarter, further threatened food security in South Sudan in April and May with a second wave of desert locusts estimated to be twenty times larger than the first wave. FAO estimated in May that 2.76 million

people are under threat from the expanding swarms. The actual numbers requiring livelihood support will not be known until the completion of the crop and pasture damage assessments that are taking place and that will continue over the next few months.

## Sectoral strategy

The cluster's strategy is to save lives by providing emergency food assistance (cluster objective 1) which is complemented by livelihood and livestock support (cluster objective 2) that is designed to contribute directly towards the first strategic objective of the 2020 HRP. The implementation of the existing HRP target of 5.3 million, excluding refugees, remains a top priority given the existing high levels of food insecurity. The COVID-19 addendum Food Security and Livelihood (FSL) strategy will remain very similar, focusing on the main two cluster objectives whilst ensuring that all in kind, cash transfer and livelihood and livestock support measures are introduced in a way that they reduce the spread and transmission of COVID-19 when delivered to both the existing caseload and the new caseload. All activities will adhere to the new standard operating procedures and guidelines that keep staff and beneficiaries safe by providing key messages for understanding COVID-19, ensure social distancing, correct use of protective equipment and have handwashing facilities available for use. Additionally, WFP will provide food to designated isolation and quarantine centers whilst FAO will support community messaging and the disinfection of community infrastructure such as market facilities.

Much of the training and capacity building (cluster objective 3) of beneficiaries in large numbers has been reprioritized and based on the learning from the Ebola crisis in West Africa, partners are encouraged to build on their existing linkages at community level to build trust and understanding, working with key influencers within the community to provide all the necessary essential COVID-19 information, education and communication materials, and messaging. Protection mainstreaming will prioritize people with special needs, particularly the elderly, chronic sick and those with underlying health issues, who may need to have assistance delivered directly to their homes. Targeting will be based on community-based vulnerability targeting, and working especially with Health, Nutrition and WASH clusters to deliver multisectoral services to vulnerable households and individuals.

## Assistance to newly vulnerable people

Exceptionally, the FSL Cluster will target an additional caseload outside the people in need identified through the IPC analysis and the 2020 Humanitarian Needs Overview. The new urban caseload includes 1.13 million vulnerable households across 19 urban centres identified by the Needs Analysis Working Group as having the highest degree of vulnerability, and based on existing intersectoral vulnerabilities and the risk of spread and transmission of the virus. Highest ranked locations of Juba, Nimule and Yei will have the greatest allocation of planned support subject to the monitoring of the effects of the virus over time. The urban poor already enrolled in existing humanitarian assistance programmes will not be included. The new rural caseload (450,000) is in addition to the original 2020 HRP caseload, and is spread across 57 counties that include people from IPC Phase 2 market-dependent households, expected to shift into IPC Phase 3 or worse due to the indirect impacts of COVID-19.

## Cluster capacity and response modalities

The biggest challenge for the FSL Cluster and partners is to ensure that commercial and humanitarian supply routes remain open given the high and precarious dependency that South Sudan has on both commercial and humanitarian food imports and which will further increase over the next three to six months until after the harvest period. Travel restrictions alongside the curtailment of face to face interactions is currently limiting assessments of perennial crisis events triggered especially by intercommunal violence, desert locusts and renewed flooding hindering the ability of actors to determine needs and respond in a timely manner.

Most cluster partners are national and have not reduced their presence or staffing levels significantly in their field operations. All of the 91 2020 HRP partners remain and continue to implement the existing HRP. Of those HRP partners, a further 22 will be implementing specific new safety net projects targeting the new COVID-19 caseloads. International partners have relocated some staff out of the country and in many cases remaining within the region. The COVID-19 induced travel and movement restrictions and need for greater social distancing has created a general slowing down of operations and increase in operational costs related to transport, fuel and commodities.

The COVID-19 addendum new safety net caseload alongside the existing HRP caseload will be supported by WFP with more than 80 partners and FAO with over 60 partners extending to new locations and new COVID-19 safety net and desert locust caseloads. Of the existing HRP partners, 23 have made enlargements to their existing HRP projects and 22 have designed new projects and are delivering, as WFP and FAO, also with their own implementing partner, to the new COVID-19 caseload. Finally, 32 FSL Cluster partners have re-prioritized and/or designed new projects.

## Cost of response

A further \$179 million will be required to provide food assistance (\$125 million), livelihood support (\$49.7 million) and respond to the desert locusts invasion (\$4.3 million). Two funding streams with separate caseloads have then been identified: \$55.4 million (WFP \$45 million; FAO \$4.3 million and NGOs \$6.1 million) will be used to target the existing HRP caseload and the desert locust response with additional costs incurred for transport, increased operational costs and to ensure that interventions are COVID-19 compliant; and \$123.6 million (WFP \$80 million; FAO \$39.4 million; and NGOs \$4.2 million) will be used to target the new COVID-19 caseload.

Partners are experiencing delays and significant price rises in transport and operational costs related to items such as buckets, soap and PPEs that had not previously been budgeted for. The cost and time spent in organizing and implementing distributions in a COVID-19 compliant manner are seen as major challenges.

## Additional COVID-19 monitoring

| OBJECTIVE  | INDICATOR   | IN NEED  | TARGETED   |
|--|---|--|--|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>   |   |  |  |
| <b>SO 1.3: Reduce excess morbidity and mortality rates from epidemic-prone diseases (malaria, diarrhoea, acute respiratory infection and measles) in priority areas</b>  |   |  |  |
| Provide food assistance to a new C19 and desert locust impacted population in a way that prevents the spread and transmission of C19 (compulsory use of new SOP & guidelines); to the new urban (1.125 million) and new rural case load (450,000)            | Number and % of people most vulnerable from C19 who have received food assistance and/or livelihood support e.g. cash transfer, in-kind food, livelihood kits etc.                          | 6.3 M+ new emerging needs                                | 6.9 M  |
|  | Number and % of people most vulnerable from C19 who have benefited from an increased or expanded social safety net scheme   | 6.3 M+ new emerging needs                                | 6.9 M  |
| Provide complementary livelihood support to a new C19 and desert locust impacted population in a way that prevents the spread and transmission of C19 (compulsory use of new SOP & guidelines); to the new urban (960,000) and new rural case load (450,000) | Number and % of people most vulnerable from C19 who have received food assistance and/or livelihood support e.g. cash transfer, in-kind food, livelihood kits etc.                          | 6.3 M+ new emerging needs                                | 6.7 M  |
|  | Number and % of people most vulnerable from C19 who have benefited from an increased or expanded social safety net scheme   | 6.3 M+ new emerging needs                                | 6.7 M  |
| Reduce dependency on food and agricultural inputs to support and strengthen households' ability to absorb shocks specifically in mitigating the affects of desert locusts  | Number and % of people most vulnerable from the impact of desert locusts who have received food assistance and/or livelihood support e.g. cash transfer, in-kind food, livelihood kits etc. | Population affected by desert locusts is still not known | Population to be targeted desert locust response is also still not known |









# Health

| HNO PEOPLE IN NEED | PEOPLE TARGETED BY C19 ADDENDUM | ADDENDUM REQUIREMENTS (US\$) | OF WHICH, NATIONAL PLAN REQUIREMENTS | NUMBER OF C19 PARTNERS |
|--------------------|---------------------------------|------------------------------|--------------------------------------|------------------------|
| 3.6M               | 2.2M                            | \$91.4M                      | \$87.7M                              | 23                     |

## New vulnerabilities

South Sudan is highly vulnerable to COVID-19, and an outbreak would severely impact the people of South Sudan and quickly overwhelm the health care system. The country would see an increase in mortality rates, as existing HRP programmes and resources struggle with increased needs and caseloads. The outbreak could also shift attention away from routine health facility and community-based health care services and focus on a COVID-19 response. Estimated 10 per cent of the Health Cluster's HRP target is the new vulnerability created by the COVID-19 pandemic.

The restrictions on movement related to COVID-19 have limited the transportation of personnel and essential drugs and medical supplies. This directly affects the ability of the health system to respond to an outbreak and other health needs while indirectly affecting people's health. People's vulnerability to epidemic diseases, an already weak health system and the poor hygiene and sanitation practices among communities exacerbate the needs, and increase the risk of an outbreak. To address additional needs and gaps, the health system has to scale up both existing and new interventions at health facilities at the community-level. Interventions include better surveillance, risk reduction and community engagement, Infection Prevention and Control (IPC), hygiene best practices in health facilities, case management, home-based care, community isolation and hospital care for cases.

## Sectoral strategy and contribution to national plan

The strategic objective of the Health Cluster is to contain the spread of the COVID-19 outbreak and avoid excess morbidity and mortality. The cluster and partners aim to mitigate the impact on the health system due to the outbreak with particular focus on the most vulnerable.

The cluster's first specific objective is to reduce people's risk by scaling up risk communication and community engagement (RCCE) activities to ensure safe practices in the community. The second objective focuses on early detection and referral of suspected cases by strengthening community-based surveillance, screening, alert reporting, case investigation, and contact tracing. The cluster will also work towards reducing community transmission through establishment of community isolation facilities under its third specific objective. Aligning with the fourth specific

objective, the cluster and partners will provide personal protective equipment (PPE) and IPC supplies to improve IPC-WASH practices in the health facilities. Under the fifth specific objective, the cluster and partners will provide safe and effective diagnosis, treatment and care by building the capacity of health workers and health facilities. This will be done through the establishment of triages and isolation units, capacity building of staff, increasing lab capacity and the provision of supplies and consumables. The sixth specific objective focuses on supporting the continuation of existing community- and facility-based services through pre-positioning essential drugs and supplies, and improving the monitoring and evaluation of activities. Activities under the seventh objective aim to provide safe and dignified access for reproductive health, GBV and mental health to women at risk in COVID-19 sensitive locations. The last specific objective is to strengthen sectorial and decentralized coordination at COVID-19 sensitive locations.

The Health Cluster and partners will engage and collaborate with relevant clusters including WASH, Nutrition, Food Security and Livelihoods, and other stakeholders at national and subnational levels. This will ensure that the health interventions are linked to other relevant sector interventions and complement each other and avoiding duplication. The Health Clusters is targeting more than 8 million people with new activities planned in addition to the 2020 HRP projects. Priority will be given to the most vulnerable and high risk as identified by the multi-sector need analysis and will include people in PoC sites, IDPs, women and children, older people and those with underlying health conditions. The Health Cluster priority intervention locations will be aligned with the national identified high transmission risk areas and leveraging for vulnerable locations such as IDP and PoC sites, that will be prioritized by the Humanitarian Country Team.

The Health Cluster's responses are aligned with and complement the national plan on response pillars and advocacy for the same. Cluster triaging of development and emergency contributions to the COVID-19 response continue to highlight critical gaps to bring stakeholders together on supporting the national plan. Coordination capacity will be decentralized to maximize information sharing to optimize participation and accountability including tracking of response efforts.

As the cluster lead agency, WHO has also established a centralized supply chains system to facilitate a consolidated requisition, procurement and distribution of COVID-19 commodities including PPE, diagnostic and treatment supplies for all partners responding to COVID-19 in the country to support the national efforts and address the pressing global shortage in these supplies.

### Cluster capacity and response modalities

The movement restriction related to COVID-19 will directly affect the health systems ability to respond to an outbreak and other health needs. There are now limits on the transportation of personnel and essential drugs and medical supplies, indirectly affecting people's health. These limitations will also impact the health sector's ability to respond to the seasonal outbreaks of malaria, diarrhoea, acute respiratory infection, and other vaccine preventable communicable diseases.

The restrictions will impact the health system's ability to deploy rapid response teams to the field to respond to alerts as well as the capacity to conduct community-based health promotion and disease prevention activities. The impact of intercommunal violence has already led to staff evacuations from certain provinces limiting the scale and quality of healthcare services. To prepare for a possible rise in caseloads at health facilities, there is a need now to pre-position essential drugs and medical supplies and strengthen remote support and our capacity to scale up mobile clinics to alleviate the extra caseloads.

The Health Cluster using the humanitarian-development nexus will lead the mapping and leveraging of resources to support the COVID-19 response. A focused platform will be dedicated to the COVID-19 discourse for emergency responders to play a central role in supporting relevant gaps in case management, surveillance, infection prevention and control, and water and sanitation services. Technical capacity in the form of harnessing partnerships to provide guidance and written standard operating procedures for clinical and community responses will be provided including the supply chain which is core to the pandemic activities.

### Cost of response

Overall, the estimated COVID-19 health costs are \$91.4 million, of which \$87.7 million are from the national response plan. This is to cover emergency responders' needs for the COVID-19 response.

The major drivers of the cost are establishing and managing isolation/quarantine facilities; improving infection prevention and control, and water and sanitation practices in the health facilities; building capacity to provide safe and effective diagnosis; and treatment and care. The treatment and care will include increasing human resources capacity, adding additional units and structures to existing health facilities, increasing lab capacity, and gap fill on supplies and consumables. The new vulnerabilities will require even stronger prevention interventions given the already weak health system and poor access to hygiene and sanitation facilities in the context.

## Additional COVID-19 monitoring

| OBJECTIVE  | SECTORAL RESPONSE APPROACH  | INDICATOR   | TARGETED                      |
|--|---|---|-------------------------------|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>   |   |   |                               |
| SO 1.3: Reduce excess morbidity and mortality rates from epidemic-prone diseases (malaria, diarrhoea, acute respiratory infection and measles) in priority areas   |   |   |                               |
| To contain the spread of the C19 outbreak and avoid excess morbidity and mortality as well as the impact on the health system due to the outbreak with particular focus to the vulnerable population groups in the country |   | Case fatality rate;<br>Crude mortality rate;<br>Under five mortality rate;  | <3%<br><1/10,000<br><2/10,000 |
|  | Reduce population risk by scaling up risk communication and community engagement (RCCE) activities to ensure safe practices in the community  | Number of community members reached with key messages on C19 transmission and prevention methods                    | 1.98 M                        |
|  |   | Proportion of community members who have knowledge about C19 transmission and prevention methods                    | 90 %                          |
|  | Early detection and referral of suspected cases by strengthening community-based surveillance, screening, alert reporting, case investigation, contact tracing and follow ups   | Proportion of C19 alerts investigated within 72 hours   | 100 %                         |
|  |   | Proportion of contacts of positive cases followed up or traced  | 100 %                         |
|  |   | Number of people screened for C19   | 589 K                         |
|  | Reduce community transmission through establishment of community isolation facilities   | Number of isolation facilities established  | All hotspots                  |
|  | Improve IPC-WASH practices in the health facilities by providing PPEs and IPC supplies  | Number of facilities provided with IPC-WASH supplies  | All hotspots                  |
|  |   | Number of health workers provided with PPEs   | All frontline health workers  |
|  | Provide safe and effective diagnosis, treatment and care by building the capacity of health workers and health facilities through establishment of triages and isolation units, capacity building of staff, building the lab capacity and provision of supplies and consumables | Number of health facilities supported to provide C19 diagnosis, and case management services                        | 50                            |
|  |   | Number of health staff trained (diagnosis, case management & lab services)  | 15 K                          |
|  |   | Number of health facilities provided with essentials drugs and C19 supplies   | All hotspots                  |
|  | Support continuation of existing community and facility based services through timely prepositioning of essential drugs and supplies and improving monitoring and evaluations of activities   | Proportion of health facilities with zero stock-outs of essential drugs and medical supplies for routine activities | 0                             |
|  |   | Number of consultation per clinical officer per day   | 50                            |
|  | Provide safe and dignified access for reproductive health/GBV/mental health to women at risk in C19 sensitive locations   | Proportion of C19 positive people receiving mental health and psychosocial services                                 | 100 %                         |
| Proportion of C19 positive SGBV survivors receiving clinical management of rape services   |   | 100 %   |                               |
| Strengthen sectorial and decentralized coordination at C19 sensitive locations   | Number of counties with functional coordination mechanism established (technical working groups, task forces, etc.)   | 100 %   |                               |
|  | Proportion of counties with lead agency identified and in place for C19 response  | 100 %   |                               |

Passengers screened for their temperature at Juba International Airport in Juba, South Sudan on January 31, 2020.  
©Alex McBride/AFP via Getty Images









# Logistics

ORGANIZATIONS TARGETED BY C19 ADDENDUM

305

ADDENDUM REQUIREMENTS (US\$)

\$8.4M

OF WHICH, NATIONAL PLAN REQUIREMENTS

\$2.7M

NUMBER OF C19 PARTNERS

1

## New vulnerabilities

The impact of COVID-19 on logistics operations in South Sudan is expected to be severe and affect both passenger and cargo movement across the country. According to the most likely scenario, increased numbers of COVID-19 cases will coincide with the start of the rainy season in South Sudan, which typically lasts from May through November. Coupled with the short 2019-2020 dry season and a scale-down of humanitarian operations across the country due to the COVID-19 outbreak in South Sudan at the end of dry season, the humanitarian community's ability to pre-position cargo during dry season was reduced. This will put a further significant strain on the logistics operation, making the humanitarian community reliant on costly air transport to reach vulnerable populations during the rainy season in addition to the potentially massive COVID-19 response. The use of air assets will also be crucial to ensure a timely response to the COVID-19 outbreak in South Sudan.

Overall, the outbreak of COVID-19 in South Sudan has reduced the capacity of the United Nations Humanitarian Air Service's (UNHAS) performance in serving humanitarian workers and their light cargo with safe, effective, and efficient air service. UNHAS's transportation of passenger has also been highly impacted as a consequence of mitigation measures put in place to prevent the spread of COVID-19. Indeed, since the outbreak of COVID-19 in South Sudan, the monthly UNHAS passenger figure has already decreased by 94 per cent, from 6286 passengers transported in March to only 369 in May 2020. Reduced movements of humanitarian passengers might affect organizations' ability to deploy rapid response teams, which ultimately will affect the Logistics Cluster's ability to deliver cargo if there are no teams in deep field locations to receive humanitarian cargo.

## Sectoral strategy and contribution to national plan

The Logistic Cluster lead agency is a member of the South Sudan National COVID-19 Steering Committee (previously called National Task Force on COVID-19), co-leading the Operations Support and Logistics pillar through the Logistics Cluster, in support of the National Response Plan. Building on measures and procedures put in place for Ebola virus disease preparedness, the Logistics Cluster expanded warehouse space available to partners in Juba for storage of COVID-19 cargo by acquiring an additional 1,740 cubic metres of warehouse space, including temperature-controlled storage. The storage needs will be continuously evaluated,

and additional space secured, if necessary. COVID-19-related supplies will be transported by the Logistics Cluster where needs have been identified using the common services portfolio, including IOM-managed Common Transport Service, and will be treated as priority cargo. The Logistics Cluster is also supporting coordination of the in-country logistics, which is part of the National Plan for COVID-19 response, anticipating increased volumes in supply chains, including higher demand for distribution and warehousing.

With COVID-19 cases confirmed in South Sudan, the COVID-19 National Steering Committee and UNHAS partners identified the need for a special air transport system in the COVID-19 context. In relation to the second cluster objective of enhancing access to people and project implementation sites, UNHAS will continue to support operating organizations by transporting humanitarian passengers in compliance with national regulations on interstate movements, ultimately enabling national plan implementation.

The Logistics Cluster will continue supporting the humanitarian community in South Sudan with coordination, information management, and common services, including the IOM Common Transport Services project. In addition to its continued support to ongoing responses across the country, under the first cluster objective of providing logistics coordination, support and technical advisory services to the humanitarian community, the cluster will support humanitarian organizations in South Sudan with air transport and storage of COVID-19 related cargo. Common storage space for COVID-19 related supplies, including temperature-controlled storage, will be available to ensure immediate deployment and distributions.

## Cluster capacity and response modalities

The Logistics Cluster is continuing to provide free-to-user storage and air, road, and river transport of humanitarian cargo, with an emphasis on items for COVID-19 preparation and response. The cluster has augmented its storage capacity by adding additional temperature-controlled warehouses in Juba for storing COVID-19 prep and response materials. Due to the nature of the response, the cluster will utilize its air assets to transport COVID-19 cargo quickly rather than rely on more efficient modes of transport.

In order to respond to the identified need to provide special air transport system in COVID-19 context, UNHAS already deployed an additional and dedicated aircraft for COVID-19 Suspected Sample Transfer, COVID-19 medical evacuation (if applicable) and COVID-19 supplies transportation (light

cargo). UNHAS will also ensure that sample collection and COVID-19 supplies delivery are being prioritized. To comply with national regulations including social distancing measures, UNHAS has already reduced by half the transport capacity of each aircraft and will also continue re-adjusting flight schedules as needed.

## Cost of response

Overall, the estimated additional COVID-19 logistics budget is \$8.4 million—\$1,500,000 for the Logistics Cluster project and \$ 6,869,269 for the UNHAS project. The Logistics Cluster is adding additional warehouse space in Juba for storage of COVID-19 cargo and anticipates needing to transport COVID-19 prep and response cargo by air rather than more efficient transport modalities.

For 2020, the UNHAS initial annual target was to transport 78,000 humanitarian workers and 1,200 metric tons of light cargo, however these values had to be revised downwards due to the expected drastic decrease in passenger numbers caused by COVID-19. UNHAS was expected to cover 50 per cent of the budget through its cost recovery system, however, the COVID-19 threat to South Sudan will not allow UNHAS to cover this amount as projected. Consequently, UNHAS will experience a shortfall on its annual budget and will thus require an additional budget of \$5,681,227 to ensure the continuity of its operations to continue transporting humanitarian workers across South Sudan. Additionally, to respond to the increasing number of COVID-19 suspected samples collection requests and COVID-19 supplies transport, UNHAS will need additional funds of \$1,179,042 for a dedicated aircraft.

## Additional COVID-19 monitoring

| OBJECTIVE  | INDICATOR   | TARGETED            |
|--|---|---------------------|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>   |   |                     |
| <b>Strategic Objective 2: Ensure safe, equitable and dignified access to critical cross-sectoral basic services to enable populations meet their basic needs</b>   |   |                     |
| <b>Strategic Objective 3: Enable vulnerable people to recover from crisis, seek solutions to displacement, and build resilience to acute shocks and chronic stresses through targeted programming to support coping capacities and livelihoods in prioritized areas</b>                  |   |                     |
| Specific Objective: Through the facilitation of access to logistics services for the entire humanitarian community, the Logistics objectives are linked to all the Inter-Sectoral Specific Objectives as it supports humanitarian actors to meet their corresponding specific objectives |   |                     |
| Strengthen joint needs analysis and strategic response planning for effective and well-coordinated humanitarian action   | Number of organizations utilizing logistics and coordination services   | 100                 |
|  | Number of information products shared with partners   | 180                 |
|  | Annual performance survey for Logistics Cluster and UNHAS by National and International users                 | 80                  |
|  | Square metre of common storage space availed for C19 related supplies;  | 13 K m <sup>2</sup> |
|  | Number of mobile storage units in stock available for immediate deployment for storage and medical facilities | 5                   |
| Enhanced access to beneficiaries and project implementation sites through safe, effective, and efficient passenger air service. Support humanitarian workers with a dedicated aircraft for C19 response  | Number of passengers transported per month  | 5 K                 |
|  | Amount of light humanitarian cargo transported by UNHAS per month   | 60                  |
|  | Number of evacuations (medical and security) performed  | 100                 |
|  | Percentage of C19 suspected samples collected against request   | 100 %               |
|  | Amount C19 related light cargo transported by UNHAS per month   | 5                   |
| Maximize logistics and cost efficiencies through the expansion of road and river transport modalities and a decreased reliance on air operations, considering the C19 context  | Percentage of humanitarian relief cargo moved by river and road versus by air                                 | 25                  |
|  | Amount of cargo moved with IOM Common Transport Services truck in support of air, river and beyond responses  | 18 K MT             |
|  | Number of destinations reached that were previously unreachable by road and river                             | 25                  |



# Nutrition

| HNO PEOPLE IN NEED | PEOPLE TARGETED BY C19 ADDENDUM | ADDENDUM REQUIREMENTS (US\$) | NUMBER OF C19 PARTNERS |
|--------------------|---------------------------------|------------------------------|------------------------|
| 2.1M               | 1.3M                            | \$6.2M                       | 26                     |

## New vulnerabilities

In South Sudan, the prevalence of global acute malnutrition stands at 16.2 per cent among under-five children, above the WHO emergency threshold.<sup>10</sup> This translates into an expected 1,770,861 people in need of treatment for acute malnutrition in 2020; more than 292,000 children suffering from severe acute malnutrition; over 1 million children suffering from moderate acute malnutrition and about 470,000 pregnant and lactating women suffering from acute malnutrition.

The COVID-19 pandemic presents an unprecedented challenge with deep social and economic consequences, including compromising food security and nutrition.<sup>11</sup> As a result of the COVID-19 related morbidity, movement restrictions, social distancing rules, labour shortages are likely to impact producers, processors, traders and trucking/logistics companies in food supply chains. At the same time, loss of income and jobs have impacted people's ability to buy food and compensate farmers for their production. While food access is likely to be affected especially for the most vulnerable who rely on daily incomes and wages, there is no sufficient evidence to determine the extent to which this will affect the levels of acute malnutrition in South Sudan. Besides, the direct effect of the COVID-19 infection on nutritional status, and therefore on the incidence of malnutrition in communities is unknown. However, it is expected that the people in need estimated for the 2020 HRP was inclusive enough to accommodate the COVID-19 related changes in community's nutrition situation.

While available evidence on COVID-19 infections indicates that children generally present milder symptoms than older groups, it is unknown how the pandemic will affect wasted children. It is reasonable to assume that such children are at higher risk of COVID-19 related complications, and therefore to have of malnutrition and COVID-19 co-morbidity in affected people.

## Sectoral strategy

The 2020 HRP prioritized the treatment and prevention of acute malnutrition, as well as integration with other sectors as key focus areas. The Nutrition Cluster will continue to pursue the four sectoral objectives set in the 2020 HRP that contribute to decreasing suffering, morbidity and mortality related to malnutrition among vulnerable people in South Sudan. In addition to these four objectives, against the backdrop of COVID-19, the Nutrition Cluster will ensure continuity of critical services that address nutrition-related life-threatening conditions among the most vulnerable

populations while protecting beneficiaries and service providers from contracting COVID-19. This will help to tailor to the additional requirements created by the COVID-19 and provide additional essential actions and measures in place.

Nutrition services are provided by more than 40 partners, both national and international, in more than a thousand static nutrition sites throughout the country. Two-thirds of nutrition sites are within a health facility setting and the remainings are stand-alone nutrition sites. Hard-to-reach areas are covered through outreach services and integrated rapid response mechanisms, emergency response team and multi-sector emergency team.

With two-thirds of the nutrition sites operating in a health facility-setting, building synergies with health partners were prioritized. Furthermore, specific activities are planned such as triage set up at health and nutrition service delivery points, integrating of nutrition module in case management training for health care workers and screening of children under five, pregnant and lactating women for provision of nutrition treatment according to the national guidelines.

## Cluster capacity and response modalities

The Nutrition Cluster has developed and disseminated guidelines to assist implementing partners in integrating COVID-19 preparedness and response into the ongoing humanitarian nutrition response. This includes reprioritizing and adapting of the nutrition services; equipping the nutrition sites and service providers with skills; providing necessary equipment and materials; and capacity building to ensure uninterrupted delivery of preventative and life-saving nutrition services. The cluster will also take measures to ensure people in need and the service providers are protected from the risk of infection. The cluster's partners have reviewed their 2020 HRP plans and identified activities that cannot be implemented in the context of COVID-19 and replaced them with COVID-19 related activities.

All implementing partners have so far continued to provide nutrition response services, albeit with some challenges relating to movement restrictions put in place to contain the spread of the virus. This is likely to have an effect on the quality and monitoring of the ongoing nutrition response. To mitigate this, the Nutrition Cluster continues to have regular calls with the cluster's partners and the sub-national cluster to identify issues in a timely manner. A two-way communication mechanism where partners are supported with COVID-19 related updates was established, and the platform also provides partners with an opportunity to share experiences and good practices.

Border and in-country restrictions resulting from the pandemic presents potential challenges with prepositioning and delivery of nutrition specific commodities to the service delivery sites particularly those required for treatment of acute malnutrition. In addition, the scale down of community related nutrition and health services is likely to affect the prevention of acute malnutrition and sustain the emergency levels of acute malnutrition.

To protect users and service providers from contracting COVID-19, the Nutrition Cluster has identified additional measures and essential actions that need to be put in place at nutrition sites at the community level. This will ensure uninterrupted provision of services for nutrition-related life-threatening conditions, such as management of acute malnutrition for children, pregnant and lactating women, elderly, people living with HIV or TB, and infant and young child feeding practices in emergencies.

## Cost of response

The Nutrition Cluster applies an activity-based costing approach to estimate the overall resources needed for the nutrition activities included in the 2020 HRP. The 2020 HRP budget remains at \$223 million.

The cost of COVID-19 related activities that support continued nutrition response is estimated at \$6.2 million. The estimated cost is mainly for orientation of nutrition partners and workers on COVID-19 related risks and mitigation measures at site and community levels, which will amount to \$876,800. Supporting risk communication to increase awareness on COVID-19 for nutrition workers and communities and protecting users and service providers from contracting COVID-19 will cost \$3.7 million.

## Additional COVID-19 monitoring

| OBJECTIVE  | SECTORAL RESPONSE APPROACH   | INDICATOR   | IN NEED | TARGETED  |
|--|--|---|---------|-----------|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>   |  |   |         |           |
| SO 1.3: Reduce excess morbidity and mortality rates from epidemic-prone diseases (malaria, diarrhoea, acute respiratory infection and measles) in priority areas   |  |   |         |           |
| To ensure continuity of critical services that address nutrition-related life-threatening conditions among the most vulnerable populations while protecting beneficiaries and service providers from contracting C19 | Development and dissemination of guidelines for nutrition service delivery in a C19 context, in line with national response strategies and plans               | A guideline document for nutrition service delivery in a C19 context is available                           | 0       | 1         |
|  | Conducting cascade orientation sessions for nutrition service providers on C19 related messaging and use of tools in liaison with the RCCE response mechanisms | Number (%) of nutrition sites with at least one staff trained on C19 related risks and mitigations measures | 1.1 K   | 1 K (95%) |
|  | Integration of risk communication for increased awareness on C19 with nutrition services   | Number (%) of nutrition sites equipped with risk communication posters                                      | 1.1 K   | 1 K (95%) |
|  | Protection of nutrition service users and service providers in the nutrition sites from contracting C19  | Number (%) of nutrition sites with staff provided with Personal Protective Equipment                        | 1.1 K   | 1 K (95%) |





# Protection

HNO PEOPLE IN NEED

**4.8M**

PEOPLE TARGETED BY C19 ADDENDUM

**388K**

ADDENDUM REQUIREMENTS (US\$)

**\$11.6M**

NUMBER OF C19 PARTNERS

**56**

## New vulnerabilities

With the arrival of COVID-19, the humanitarian context and needs in South Sudan have changed significantly, increasing protection and human rights concerns. The COVID-19 outbreak is a public health emergency, and along with South Sudan's lack of any viable national social safety net, poses multiple protection challenges and threats to human rights. As a result of years of armed conflict, public health services are not able to provide adequate prevention, treatment and control of epidemic, endemic, occupational and other diseases to the people of South Sudan. Therefore, a prevention and response to COVID-19 cannot be only medical, but must also address human rights and protection challenges, whether they arise from the health crisis itself or measures to contain it. While recognizing the right to place proportionate restrictions to preserve public health, the absence of due process of law in South Sudan may affect fundamental rights to freedom of movement, the right to leave and return to the country, including through the arbitrary closure of borders, as well as a variety of other human rights and protection considerations.

From the standpoint of protection, those who are considered vulnerable and at high risk from COVID-19 will be similar to those with specific vulnerabilities for protection purposes. Older persons, persons with disabilities, those with chronic illness, persons suffering from mental health issues and IDPs face specific challenges related to safety and assistance in the event of restrictions on movement. Attention must also be paid to detainees who are potentially at higher risk of infection. In general, there are human rights implications to restrictions on movement and basic principles would need to be observed, and many sub-groups already affected by ongoing intercommunal violence and cattle raids, armed conflict, displacement and natural disaster could be affected by these restrictions. Border areas with appropriate quarantine facilities will also be critical from a protection and human rights standpoint.

Collective sites, IDP settlements and other densely populated areas with people in humanitarian need will have a potentially increased risk of forced eviction with the stated basis being decongestion, or COVID-19 transmission prevention. An increase in incidents of actual or attempted evictions has already been noted by the Protection Cluster and partners.

Hotspot areas are identified as areas of high return/displacement/population movements; high density-population locations; areas affected by armed violence;

cantonment/training site areas; areas affected by high levels of food insecurity; and areas with high numbers/incidence of traditional protection concerns.

The potential also exists for hate speech and xenophobia against specific groups who could be associated in misguided rhetoric with COVID-19 transmission, with other specific groups potentially facing protection risks on this basis. Persons affected by COVID-19 are also at risk of possible stigmatization.

Psychosocial distress is likely to increase based on loss of livelihoods, restrictions on movement, loss of family members and other loved ones to COVID-19, and concern surrounding the numerous uncertainties brought by the pandemic. This then has the potential to lead to negative coping strategies along with loss of livelihoods and other concerns, with a further breakdown in the social fabric and lack of protection for those with specific needs such as older persons, persons with disabilities and those suffering from chronic illness and those with mental health needs.

## Child protection

The current COVID-19 crisis poses enormous risks to children, families and communities including mental health and psychosocial distress, family separations, violence against children, physical and emotional maltreatment, and risk of exploitation including child labour among others. While children seem to be less vulnerable to the physical impacts of the virus, the socioeconomic impacts on children and their families of COVID-19 and the measures being adopted to prevent its spread, are already devastating. Constant fear, worry, stigma, discrimination and acute stress experienced by children, families and communities, loss of livelihood and access to basic services such as education and routine health services are some of the immediate impacts of the COVID-19, which are likely to increase risk of abuse, neglect, exploitation and violence. Currently the Ministry of Education estimates that over 2.2 million previously enrolled in formal and non-formal schools have seen their education disrupted due to closure of schools nationwide to prevent transmission of the disease. Such measures used to prevent and control the spread of COVID-19 including school closures can negatively impact children and their families, disrupting children's routine and social support systems. Left without access to the protective environment at schools, the risk of children being neglected, abused or exploited increases significantly.

Particular attention will be paid to children with specific needs including unaccompanied and separated children, children with disabilities, children in detention or care centers, children associated with armed forces and groups. Currently over 100 children have been released from detention as part of the on-going effort by the government of South Sudan to decongest detention facilities. These children and many more to be released are in urgent need of sustained case management support including family tracing and reunification. Furthermore, displaced children and their families, spontaneous refugee returnees, IDP returnees, IDPs living in congested sites, including the PoC sites, and refugees in camps with limited access to social services are particularly at greater risks due to lack access to basic handwashing facilities and living conditions in which social distancing is almost impossible.

## Gender-based violence

As more strict measures are adopted to curb the spread of COVID-19, there is a growing alarm that self-isolation and social distancing might inadvertently trigger a rise in gender-based violence (GBV). In South Sudan, according to the 2019 GBV Information Management System data analysis, 54 per cent of the reported incidents were perpetrated by intimate partners. Compared to the reports for the first quarter of 2019, there is an eight per cent increase in reported GBV incidents in the same period of 2020. Similarly, the reported incidents of physical assault have been increasing in the first three months of 2020. In such context, where intimate partner violence is pervasive even before COVID-19, there is an anticipated increase in the general trend of intimate partner violence with self-isolation, social distancing, and other stay-at-home measures in place.

In addition, the existing vulnerabilities of women and girls are anticipated to further multiply and pre-dispose them for serious implications that go beyond COVID-19 time. Besides, most women lose their means of livelihood, especially those engaged in the informal economic sector, such as the small businesses that are closed. It would lead to conflict at homes, resulting in intimate partner violence. Women in abusive relationships will be further exposed to violence as they spend more time in close contact with the abuser. Women would also have less contact with family and friends who may provide support and protection from violence.

Sexual exploitation and abuse, especially among girls forced to be out of school due to COVID-19, is also anticipated to increase. Similarly, when schools are closed and resources are limited, forced marriages would increase in anticipation of the dowry.

In the same context, at times of the economic hardship, basic hygiene and menstruation items are unlikely to be prioritized. Thus, the women and girls need assistance through the provision of dignity kits. Women and girls are also at heightened vulnerability to COVID-19 transmission because of their primary care giver's role to children, the elderly, and

the ill. While the COVID-19 has resulted in an increased vulnerability and need that requires additional resources, the ongoing GBV case management and support for the caseload of GBV survivors.

## Mine action

Amid the COVID-19 crisis, the risk of explosive hazards remains, threatening the physical safety of the civilian population and humanitarian workers. Population movement prompted by the COVID-19 related drivers may particularly remain as risk factors to the interaction with the hazards. For instance, the COVID-19 restrictions in the neighbouring countries may prompt movement of refugee returnees. Similarly, fear of being infected by COVID-19 may prompt movement of IDP returnees from sites or camp-like setting or of people from urban areas to less populated areas. Currently, the highest level of explosive contamination is concentrated in the Equatorias—Juba, Lainya, Magwi, Morobo, Terekeka, Torit, and Yei—straddling the main routes and areas for returnees from neighboring countries. Some counties in Jonglei and Upper Nile which are also known to be highly contaminated by explosive hazards are arrival points or primary access routes for IDP and refugee returnees.

Ensuring the safety of the routes and areas through survey, removal, and/or disposal of explosive ordnance is critical to protect civilians and facilitate humanitarian assistance. Delivering explosive risk awareness messaging through explosive ordnance risk education (EORE), in a form complying with health protocols and national-led efforts to prevent the spread of the virus, is also critical to mitigate the risk of people being killed or injured by explosive ordnance.

## Sectoral strategy

The Protection Cluster and partners will mainstream protection in the COVID-19 National Response Plan. The Protection Cluster and partners re-prioritized the response activities, targeting new beneficiaries to ensure coverage of new protection needs and human rights concerns arising from COVID-19. Simultaneously, the cluster and partners will maintain as much as possible the planned response for the 2020 HRP notwithstanding the restrictions imposed by COVID-19. In particular, mobile and static protection monitoring; psychosocial support; case management and support to persons with specific needs including individual protection assistance; protection messaging and awareness-raising; human rights monitoring, and legal support to those facing potential eviction will be strengthened.

Given the significant negative impact of COVID-19 on the psychosocial well-being of communities including children, increased intervention of psychosocial support will be vital to promote resilience and reducing the potential for negative coping strategies.

In terms of new interventions, there will be a need for additional human rights monitoring with a wide footprint throughout the country. This will provide strengthened data on the human rights consequences and human rights concerns arising as the result of COVID-19 and the response to it, to further inform advocacy at multiple levels and increase protection and rights for those affected.

Legal support for persons, in particular displaced persons and those located in collective sites and informal settlements, will also need to be significantly strengthened given an increased risk of forced evictions on the basis of COVID-19. COVID-19 and the need for physical distancing are becoming a pretext for decongestion of sites and eviction of displaced people. This needs to be done in accordance with law and legal assistance along with other housing, land and property interventions where relevant will be critical in this period.

The remaining protection activities within the 2020 HRP will continue with some reductions to allow for more COVID-19 focus, and in some cases unchanged. This will overall support protection in response to ongoing non-COVID-19 concerns such as intercommunal violence and cattle raiding, as well as support the protective environment which will also have an impact on COVID-19 affected individuals.

Various forms of social safety net interventions will require engagement with development actors. CVA will continue to be a modality which is used in line with a thorough risk analysis for protection purposes. This would mainly become relevant for individual protection assistance .

To prevent the spread of COVID-19 and mitigate the negative impact of the crisis on children and their families, critical child protection services will be continued, adapting flexible alternative modalities for the delivery of the prioritized services. This includes case management support for existing caseload and new child protection cases including children released from detention; delivery of CVA to identified vulnerable households as part of case management; provision of alternative care arrangement for children who are separated from their parents or other primary care givers due to hospitalization, quarantined or death; provision of age-sensitive individual- and family-based mental health and psychosocial support, and caregivers support to help families cope with the impact of the disease; COVID-19 awareness raising on facts around COVID-19; child protection-related risks and available child protection services; establishing child help hotlines and child protection desk to support remote case management and follow up; and provision of personal protective equipment for child protection frontline worker.

The Child Protection Sub-Cluster will also continue to work closely with other sectors including Education, Health and WASH actors integrate child protection interventions such as mental health and psychosocial support into relevant response activities as well as to enhance follow up and access to child protection services.

The GBV Sub-Cluster will maximize protection to counter GBV related incidents and gaps in service provision resulted from the COVID-19. In addition to the hotspot counties identified for COVID-19 transmission by the National Task Force and the Needs Analysis Working Group, fourteen counties—Aweil East, Aweil North, Ayod, Balliet, Bor South, Cueibet, Gogrial East, Ibba, Longochuk, Maridi, Tonj East, Tonj North, Twic and Wulu—will continue as priority locations for GBV. Risk mitigation measures will be mainstreamed across sectors in their respective COVID-19 response plans. CVA will be promoted to ensure that women are considered as target beneficiaries in this time of economic hardship, and steps would be taken to identify, monitor, and mitigate associated risks to GBV.

GBV interventions, as part of COVID-19 response, are implemented in compliance with the minimum GBV program standards and prioritized to fit the COVID-19 context. Among the interventions, some of them include provision of psychosocial support and GBV case management transitioning to remote service provision modality; provision of services in Women and Girls Friendly Spaces aligning with the COVID-19 measures; justice and legal aid; dignity kit distribution; and safety and risk mitigation. GBV caseworkers will be deployed in health facilities with appropriate infection prevention and control measures to support GBV survivors. Strengthening the referral mechanisms, procurement of personal protective equipment for frontline staff and establishment and operationalization of GBV helplines will be carried out.

The delivery of risk awareness messaging on landmines and explosive remnants of war (ERW) in the form of door-to-door activities or through mass media could be integrated in protection awareness raising activities, incorporating it with COVID-19 preventive messages. The targeted population will be returnees, IDPs and members of host communities.

## Cluster capacity and response modalities

Budgetary and programmatic changes have been necessitated for many protection interventions due to the restrictions posed by COVID-19. Adjustments to modalities for General Protection partners have included changing from a group to an individual modality; changing from in-person to remote; and where remote intervention is not possible, increase in hygiene measures to ensure the safety of the implementing partners and beneficiaries. Awareness-raising messaging conducted on mass media will also need to be revisited to incorporate the updated information relevant to COVID-19.

As a result, alternative modalities will need to be considered. Group psychosocial support needs to be adapted to individual and potentially using a remote modality. Having said that, given travel restrictions presently in effect throughout South Sudan, remote modalities will need to be considered. Protection and human rights monitoring would need to be adapted with alternative modalities and the

potential for a remote modality, for the same reason. Case management and referrals, along with individual protection assistance, for persons with specific needs, potentially need to adapt to a remote modality even for existing cases and new cases arising from the COVID-19 response. Awareness raising activities need to adapt COVID-19 related measures including shifting from group session to one-on-one, incorporating COVID-19 messages to the existing awareness-raising materials or developing new ones and supplementing the existing protection and human rights messaging. In some instances where individual interventions or small group interventions cannot be avoided, the procurement of personal protective equipment and other hygiene-related equipment will be needed to ensure the safety of both frontline workers and beneficiaries.

The Child Protection Sub-Cluster and partners will adapt and temporarily switching to remote and alternative modalities to ensure continuity in the provision of priority child protection services in times of limited access or movement, while avoid mass gatherings. Critical child protection services will continue to be implemented through the alternative modalities such as hotlines, CVA, radio programmes, and remote mental health and psychosocial support. Through close collaboration with Education, Health and WASH clusters, and the Risk Communication Task force, child protection interventions will be mainstreamed.

The service delivery of GBV interventions would include both static and mobile response depending on location and access. The sub-cluster has adopted modalities of GBV response especially in relation to psychosocial activities and case management at Women and Girls Friendly Spaces. Case workers offer individual counselling instead of group counselling and where possible remote counselling have been provided. Water and sanitation facilities and equipment are installed in the centres and clinics. Working with the Cash Working Group, the GBV Sub-Cluster will integrate CVA in the response.

The Mine Action Sub-Cluster maintains critical activities including responding to emergency calls for explosive ordnance disposal. EORE through public gathering and direct group sessions has been suspended, however, emergency EORE activities through alternative measures, such as media campaigns and/or door-to-door services, to support the voluntary return, relocation and resettlement of the population will be adopted, if and as required.

## Cost of response

The predominant cost anticipates the additional budget required for modifications and/or expansions of existing activities to take into account individuals previously not included in the proposed 2020 HRP activities. In addition, inclusion of human rights monitoring taking place countrywide is a cost driver given the need to ensure systematic and consistent monitoring countrywide and collection and analysis of data, with the overall view toward informing advocacy and response to the most accurate extent possible. A total of \$4.6 million will be required for General Protection activities in respond to the COVID-19.

The Child Protection Sub-Cluster estimates that an additional \$4 million will be needed to adapt new remote and alternative modalities to ensure continuity in the provision of priority child protection services in times of limited access, while avoid mass gatherings. The main cost drivers are provision of alternative care, setting up remote case management including hotlines (\$1.95 million) and psychosocial support (\$1 million) interventions, CVA, awareness raising and information dissemination and procurement of personal protective equipment for frontline workers (\$1 million).

For the COVID-19 response, the GBV Sub-Cluster will require \$6.2 million to procure critical GBV supplies such as dignity kits and personal protective equipment and to set up hotlines for remote access of GBV survivors. Change in modalities of psychosocial support and case management at the Women and Girls Friendly Spaces may require additional supplies with social distancing. There may also be a need to have more caseworkers on board as psychosocial services will be changed to an individual instead of group sessions. Similarly, the transitioning from static to mobile court service provision also drives additional cost. The limited access to transportation because of movement restriction is also another critical factor that increases the cost of response.

The Mine Action Sub-Cluster will require an additional \$520,000. The main drive for cost is a shift in the form of EORE activities to adjust to the COVID-19 operational environment, including the procurement of COVID-19 preventative items for the frontline workers.



## Additional COVID-19 monitoring

| OBJECTIVE   | INDICATOR  | IN NEED | TARGETED |
|---|--|---------|----------|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>  |  |         |          |
| Specific Objective 1.4: Reduce vulnerability of 640,000 people at risk of mortality and morbidity (psychosocial and mental health needs) as well as protection incidents/threats in priority areas  |  |         |          |
| Enhance protection assessment and protection and human rights monitoring to inform protection and overall humanitarian response   | Number of women, men, girls and boys reached with protection concerns identified during static or mobile protection monitoring and assisted in compliance with prevention and mitigation measures put in place for C19   |         | 7 K      |
| <b>Strategic Objective 2: Ensure safe, equitable and dignified access to critical cross-sectoral basic services to enable populations meet their basic needs</b>  |  |         |          |
| Specific Objective 2.1: Provide equitable access to cross-sectoral basic services to 3 million people (including women, children, the elderly and persons with disabilities) in priority areas  |  |         |          |
| Ensure the provision of critical protection related assistance and specialized services through an integrated approach to address the priority needs of targeted people among vulnerable women, men, girls and boys in hard-to-reach and priority geographical areas  | Number of women, men, girls and boys provided with individual, group, specialized psychosocial support and other related services (e.g. recreational activities, livelihood services) in compliance with prevention and mitigation measures put in place for C19 |         | 600      |
|   | Number of staff and beneficiaries provided with protective equipment and/or supplies related to protection from C19 transmission   |         | 200      |
|   | Number of people benefitting from individual protection assistance in compliance with prevention and mitigation measures put in place for C19  |         | 3.5 K    |
| Specific Objective 2.2: Provide quality, timely and inclusive protection services (including medical care, legal support, safety and mental health and psychosocial services) to 1.1 million children, women at risk and GBV survivors.   |  |         |          |
| Prevent and mitigate protection risks through enhanced preparedness and resilience  | Number of women, men, girls and boys reached through awareness raising activities including radio messaging on protection/human rights/C19   |         | 42 K     |
| <b>Strategic Objective 3: Enable vulnerable people to recover from crisis, seek solutions to displacement, and build resilience to acute shocks and chronic stresses through targeted programming to support coping capacities and livelihoods in prioritized areas</b>                                     |  |         |          |
| Specific Objective 3.1: Restore self-sufficiency of returnee populations through capacity strengthening of community-based mechanisms, access to cross-sectoral basic services and predictable access to livelihoods including recovery of livestock and small holder agriculture in geographical locations |  |         |          |
| Enable durable solutions for IDPs and other population  | Number of women, men, girls and boys supported with housing, land and property legal counselling and aid in compliance with prevention and mitigation measures put in place for C19  |         | 600      |

## Child Protection

| OBJECTIVE  | INDICATOR   | IN NEED | TARGETED |
|--|---|---------|----------|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>   |   |         |          |
| Specific Objective 1.4: Reduce vulnerability of 640,000 people at risk of mortality and morbidity (psychosocial and mental health needs) as well as protection incidents/threats in priority areas   |   |         |          |
| Ensure the provision of critical child protection services through provision of case management and integrated approach to address the priority needs of vulnerable women, men, girls and boys priority geographical area  | Number of boys and girls with protection concerns supported through case management including alternative care, child detention, CVA as part of case management |         | 6.5 K    |
| <b>Strategic Objective 2: Ensure safe, equitable and dignified access to critical cross-sectoral basic services to enable populations meet their basic needs</b>   |   |         |          |
| Specific Objective 2.2: Provide quality, timely and inclusive protection services (including medical care, legal support, safety and mental health and psychosocial services) to 1.1 million children, women at risk and GBV survivors                               |   |         |          |
| Ensure the provision of critical protection related assistance and specialized services through an integrated approach to address the priority needs of targeted people among vulnerable women, men, girls and boys in hard-to-reach and priority geographical areas | Number of boys and girls, men and women provided with remote mental health and psychosocial support   |         | 100 K    |
|  | Number of boys and girls, men and women reached with messages on C19 and related child protection risk  |         | 103 K    |
|  | Cluster coordination, capacity building, remote supportive supervision and procurement of PPE for child protection frontline workers                            |         | lump sum |

## Mine Action

| OBJECTIVE  | INDICATOR  | IN NEED | TARGETED |
|--|--|---------|----------|
| <b>Strategic Objective 2: Ensure safe, equitable and dignified access to critical cross-sectoral basic services to enable populations meet their basic needs</b>   |  |         |          |
| Specific Objective 2.2: Provide quality, timely and inclusive protection services (including medical care, legal support, safety and mental health and psychosocial services) to 1.1 million children, women at risk and GBV survivors |  |         |          |
| Prevent and mitigate protection risks through enhanced preparedness and resilience   | Number of women, men, boys and girls trained on explosive ordnance risk education (disaggregated by age and sex) |         | 25 K     |
|  | % of Explosive Ordnance Disposal spot tasks responded to requests from humanitarian entities or communities      |         | 100 %    |

## Gender-based violence

| OBJECTIVE  | INDICATOR   | IN NEED | TARGETED |
|--|---|---------|----------|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>   |   |         |          |
| Specific Objective 1.4: Reduce vulnerability of 640,000 people at risk of mortality and morbidity (psychosocial and mental health needs) as well as protection incidents/threats in priority areas   |   |         |          |
| Reduce the suffering of women, men, girls, and boys who have experienced various forms of GBV in times of C19, with particular emphasis to women and girls who suffer intimate partner violence and other forms of GBV   | Number of women, men, girls and boys provided with GBV case management services   |         | 1.5 K    |
| <b>Strategic Objective 2: Ensure safe, equitable and dignified access to critical cross-sectoral basic services to enable populations meet their basic needs</b>   |   |         |          |
| Specific Objective 2.2: Provide quality, timely and inclusive protection services (including medical care, legal support, safety and mental health and psychosocial services) to 1.1 million children, women at risk and GBV survivors                                       |   |         |          |
| Reduce the suffering of women, men, girls, and boys who have experienced various forms of GBV in times of C19, with particular emphasis to women and girls who suffer intimate partner violence and other forms of GBV   | Number of women, men, girls and boys reached through awareness raising activities on GBV prevention and available response services   |         | 300 K    |
|  | Number of women, men, girls and boys provided with psychosocial support in compliance with prevention and mitigation measures put in place for C19                                  |         | 110 K    |
|  | Number of women and girls accessing quality services, information and activities that promote healing, well-being and empowerment   |         | 54 K     |
|  | Number of GBV cases receiving legal aid services  |         | 500      |
| Ensure the provision of GBV prevention and risk mitigation measures in times of C19 to address the priority needs of people among vulnerable women, men, girls, and boys   | Number of women and girls receiving dignity-kits (if possible by including face masks, sanitizer, tissue paper, linformation, education and communication materials on GBV and C19) |         | 12 K     |
| Ensure access of vulnerable women, men, girls, and boys to livelihood support and economic resources to counter the effect of C19 impact as a result strict movement restrictions to enhance resilience, reduce vulnerability and mitigate the risk to gender-based violence | Number of women and girls provided with livelihood support schemes including production of soap and locally made hand washing appliances  |         | 500      |

Wilma is a tailor, a single mother and supports her nine children with the income she receives from Women Advancement Organization.  
©WFP/Saddal Diab







# Water, Sanitation and Hygiene

| HNO PEOPLE IN NEED | PEOPLE TARGETED BY C19 ADDENDUM | ADDENDUM REQUIREMENTS (US\$) | OF WHICH, NATIONAL PLAN REQUIREMENTS | NUMBER OF C19 PARTNERS |
|--------------------|---------------------------------|------------------------------|--------------------------------------|------------------------|
| 5.5M               | 2.8M                            | \$43.5M                      | \$43.5M                              | 47                     |

## New vulnerabilities

The COVID-19 related measures in South Sudan such as physical distancing and increased good hygiene practices to mitigate the spread of COVID-19 are undermined by limited access to soap, which is reportedly utilized by 21 per cent of households. Access to soap or chlorinated water at the community level is extremely low. Across 27 counties in the country, less than 10 per cent of people have access to soap.<sup>12</sup> In Central Equatoria, Jonglei and Warrap, only 14 per cent of households have access to soap. Against the background of COVID-19 outbreak, the WASH response will be scaled-up, increasing handwashing stations with soap targeting public places like markets and schools, which will need additional capacities and resources.

People's access to safe water and improved sanitation services is critical in mitigating the spread and impacts of COVID-19. Across the country, 34 per cent of households reportedly have access to a safe and improved water source, less than 30 minutes distance from their home. Greater Equatoria and Greater Upper Nile have the lowest proportion of households with access to an improved water source. More than 80 per cent of households practice open defecation.<sup>13</sup> The WASH Cluster will continue to scale up water provision when viable.

Infection prevention and control also rely on access to sanitation facilities, the separation of suspected or confirmed cases from other patients and health care workers. In South Sudan, only 20 per cent of households use some form of latrine—household, communal or institutional. While latrine use is high in Western Equatoria, many states reportedly have very limited use of latrines and access to sanitation facilities. Only 3 per cent of households in Warrap, 4 per cent in Lakes and 5 per cent in Northern Bahr el Ghazal have access to latrines. This indicates that households may find it difficult to separate people suspected of having COVID-19 from others in many parts of the country.

Women, who are traditionally responsible for collecting water, are likely to have high risk of contracting COVID-19. A water point is often a congested place where transmission may occur due to the large number of people waiting to use the water pump. Limited access to water sources including a long waiting time due to social distancing may also force women to use water sources that could expose them to gender-based violence. Additionally, areas that may be at risk include areas impacted by the floods in 2019 where a

large number of people were displaced and their access to traditional sources of water were affected.

## Sectoral strategy and contribution to national plan

The WASH Cluster and partners will focus primarily on containing the spread of COVID-19 pandemic and decrease morbidity and mortality, which are outlined as the first strategic objective of the Global COVID-19 Humanitarian Response Plan. The cluster's response also contributes to the South Sudan National Response Plan's pillars on risk communication and community engagement; infection prevention and control; and points of entry.

One of the WASH Cluster objectives is to integrate WASH in health response to control outbreaks at the wider community level through a WASH-Epidemiology approach. This will address the risk factors and transmission contexts at the geographical level. To reinforce this, the cluster will conduct a large-scale response that focuses on handwashing with soap in schools, public places, health facilities, nutrition sites, point of entries and at household level, and handwashing with chlorinated water in public places like markets. Additionally, focusing on the magnitude of the COVID-19 response and country's national response plan, hygiene care kits will be provided to encourage home isolation for vulnerable people and communities at risk during contact tracing. Provision of water, minimum 15 litres per day per person, will be ensured at high risk communities during partial or complete lockdown in guidance with the national response plan.

As an important apparatus of infection prevention and control, excreta and solid waste management will be supported in public places and informal settlements, as well as in nutrition centres and point of entries. Health workers and volunteers will be orientated on the WASH minimum package which includes provision of chlorine for drinking water, chlorinated water for handwashing, safe excreta solid waste management and hygiene promotion. All response activities will be accrued out following a GBV sensitive approach including risk assessment and analysis with women and girls, continuous monitoring supported by the Protection Cluster.

Risk Communication and Community Engagement Technical Working (RCCE TWG) pillar of the National Response Plan is considered complementary with the WASH Cluster for the purposes of HRP. Its efforts aim at empowering individuals, families and communities to make informed decisions, positive behaviour change and thus maintaining trust in the response through the application of wide-ranging communication approaches and mechanisms.

More specifically, the RCCE strategy under this pillar is to disseminate timely and accurate information on COVID-19 to communities, including the most vulnerable and disadvantaged; track and mitigate rumours related to COVID-19; effectively involve communities in the response to control the outbreak and have information and advice between experts, communities and officials.

### Cluster capacity and response modalities

With the onset of the rainy season, it is difficult for the WASH Cluster and partners to reach people living in hard to reach areas and to distribute items to warehouses across the country, as roads become inaccessible. Stockpiles are also limited due to border closures and an increase in demand from neighbouring countries. Decreased access to remote areas due to impassable roads and defunct landing strips in the rainy season will have impacts on the ability of WASH Cluster and partners to reinforce activities linked to case mapping, hygiene promotion, water provision, and soap and disinfectant distribution in virus-affected areas.

Procuring and distribution of critical WASH stocks through the core pipeline have been limited due to the already planned HRP programmes. At the same time, following the 2019 flooding, stocked WASH items were depleted.

The promotion of hygiene practices and WASH programming to mitigate the spread of COVID-19 will be conducted in collaboration with the Ministry of Health and the Communication for Development programming. However, the ability to disseminate COVID-19 related hygiene promotion messages using customary practices is restricted due to the introduction of social distancing and home-based care.

The second objective of the WASH Cluster's plan under the 2020 HRP was designed to target such outbreaks through 'WASH in Health' lifesaving activities. As such, WASH programming was formulated to complement activities conducted by other sectors such as the provision of NFI kits to children with severe acute malnutrition and the provision of access to safe water and handwashing facilities to people who are vulnerable to WASH-related diseases. These activities will continue while upscaling the provision of handwashing facilities and delivery of improved water, and increasing water points to decongest overcrowded water points, particularly in targeted areas including PoC sites, informal settlements and public places.

The cluster will also provide training of operators for business continuity while ensuring response activities are conducted complying physical distancing measures. Critical stocks such as chemicals, fuel and water storage containers will be strategically positioned in hotspot locations to reach the most vulnerable in these locations with essential WASH NFIs. Response activities will be implemented in a way to mitigate WASH related gender-based violence, ensuring accountability to affected population guidelines.

### Cost of response

Additional foreseeable cost drivers include increased returnees from the PoC sites, and addressing multi-natural hazards, including disease outbreaks such as Ebola, acute watery diarrhoea, cholera, and Hepatitis E while complying with COVID-19 physical distancing measures.

WASH projects with or without CVA or a market-based approach will be more expensive due to expected increase in local prices and limited access to basic hygiene items which are primarily required to contain COVID-19 outbreak in the country. The proportion of WASH projects with market-based approaches is estimated to be minimal, thus their presence will not impact the overall WASH envelope.

WASH Cluster and partners require an additional \$43.5 million for the COVID-19 response, all of which is included in the National COVID-19 Response Plan: \$29.1 million for infection prevention and control and \$14.4 million for risk communication and community engagement. By the end of 2020, WASH partners are expected to be able to mobilize 75 per cent of \$29.1 million requested. For the 2020 HRP activities, \$20 million or 6.5 per cent of the requested \$131 million was secured in the first quarter of 2020. Costing for COVID-19 activities has been calculated to be \$50 per individual including for the provision of key supplies—household water treatment and storage, handwashing materials, bulk water treatment and storage, hand pump spare parts and tool kits, latrines materials and basic hygiene kits. The WASH costs linked to the strategic objectives are approximatively the same—on average about \$40 per person as per the 2020 HRP. The WASH costs linked to the infection prevention and control are estimated to be a bit higher—about \$50 per person.

## Additional COVID-19 monitoring

| OBJECTIVE  | INDICATOR  | IN NEED | TARGETED |
|--|--|---------|----------|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>                 |  |         |          |
| SO 1.3: Reduce excess morbidity and mortality rates from epidemic-prone diseases (malaria, diarrhoea, acute respiratory infection and measles) in priority areas |  |         |          |
| WASH in health response to control outbreaks at wider community level  | Number of people vulnerable due to WASH-related diseases provided with access to safe drinking/chlorinated water   | 3 M     | 2.8 M    |
|  | Number of people vulnerable due to WASH-related diseases provided with functional hand-washing facilities by soap or 0.05% chlorine running water  | 3 M     | 2.8 M    |
|  | Number of WASH-related diseases vulnerable population provided with a WASH minimum package of activities adapted to their vulnerabilities.)  | 3 M     | 2.8 M    |
| WASH in Health for outbreak preparedness, response, and risk reduction   | Number of functional health facilities with health workers /volunteers trained on the WASH minimum package (0.5 ml/g chlorine safe drinking water, 0.05% chlorinated handwashing, safe sanitation, and waste management) | 5.3 K   | 5.3 K    |
| WASH response mitigates GBV  | All activities implemented after GBV risk analysis with women and girls  | 3 M     | 2.8 M    |

## Risk Communication and Community Engagement

| OBJECTIVE  | INDICATOR  | IN NEED | TARGETED |
|--|--|---------|----------|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>   |  |         |          |
| SO 1.3: Reduce excess morbidity and mortality rates from epidemic-prone diseases (malaria, diarrhoea, acute respiratory infection and measles) in priority areas   |  |         |          |
| Increase the knowledge of communities on C19 through key messages using varied communication channels and approaches towards adoption of desired behaviours to prevention and protection from the pandemic | Number of people in the target population reached with C19 prevention and control messages   | 11.5 M  | 2.8 M    |
|  | Number of community mobilizers/hygiene promotors/health educators trained to sensitize the community on C19 prevention and control | 8 K     | 8 K      |
|  | Number of community stakeholders/influencers trained to sensitize the community on C19   | 8 K     | 8 K      |
|  | Number of information, education and communication materials on C19 printed and distributed  | 1.2 M   | 1.2 M    |
|  | Number of partner's organization trained to sensitize the community on C19 prevention and control                                  | 400     | 400      |
|  | Number of radio jingles aired on C19 prevention and control messages   | 60 K    | 60 K     |









# Refugee Response

| HNO PEOPLE IN NEED | PEOPLE TARGETED BY C19 ADDENDUM | ADDENDUM REQUIREMENTS (US\$) | OF WHICH, NATIONAL PLAN REQUIREMENTS | NUMBER OF C19 PARTNERS |
|--------------------|---------------------------------|------------------------------|--------------------------------------|------------------------|
| 300K               | 410K                            | \$23.3M                      | \$16.1M                              | 1                      |

## New vulnerabilities

The spread of COVID-19 to South Sudan has created additional challenges for refugees, asylum seekers, and refugee returnees in South Sudan who are often located in remote and hard-to-reach areas. Women, older people, people with disabilities and children are most at risk. An outbreak in a crowded camp would have devastating humanitarian consequences. Physical distancing is difficult, and most people do not have adequate access to health care, and water and sanitation facilities. The capacity of the government to provide basic services to refugees and asylum-seekers may also be severely undermined, with resources being reallocated to other groups.

Refugees and asylum seekers lack sufficient economic resources to access health care and are almost fully dependent on UNHCR and its partners for the provision of essential and life-saving services. Even before COVID-19, refugee partners were supporting 10 primary health facilities in refugee camps and two referral hospitals (Bunj in Upper Nile State and Pariang in Unity State), in remote areas with limited access to health care.

The economic impact of COVID-19 will have a significant implications on vulnerable groups including refugees, asylum seekers, refugee returnees and host communities due to the loss of income, restricted movement, reduced access to markets, inflation and a spike in prices. It is likely to lead to an increase in negative coping strategies.

## Sectoral strategy

UNHCR and partners will continue to protect, assist and advocate for refugees, asylum seekers, refugee returnees and host communities particularly vulnerable to COVID-19. Activities will be focused on containing the spread of the COVID-19 pandemic while decreasing morbidity and mortality in refugee-hosting areas. At the same time, UNHCR and partners will advocate to preserve unhindered access to territory to refugees and asylum seekers in South Sudan and right to return of South Sudanese refugees.

Refugee response partners will continue to work closely with South Sudanese authorities as well as the inter-agency system to ensure forcibly displaced populations are included in the country's national response plan. Support will be provided to primary health facilities and referral hospitals to be better equipped to face the situation, noting that the secondary facilities are government facilities and have been

referral hospitals for both refugees and host communities in pre-COVID-19 times. Prevention, community engagement and risk communication, including through significantly scaled up WASH interventions are key priorities in refugee-hosting areas and require significant resources. Additional needs to prepare health facilities and train frontline responders for a potential outbreak are undeniable, including in terms of expansion of in-patient capacity, equipment, drugs, medical and WASH supplies.

Contextualized messaging on COVID-19 continues in close collaboration with partners and in line with the guidance from the Risk Communication and Community Engagement Technical Working Group. Key messages are disseminated using various modes of communication such as house to house visits, local FM radios, megaphones, and loudspeakers mounted on cars. Equally important, messaging on critical hand washing practices, maintaining environmental cleaning campaigns at household level, safe water management and safe disposal of human excreta were taken into consideration with adequate measures put in place on physical distancing practice.

Advocacy with the government to ensure access to territory and asylum-procedures for refugees and asylum seekers is a priority. UNHCR is collaborating with WHO, IOM and other partners to ensure that border entry points used by asylum-seekers, refugees and refugee returnees are supported with COVID-19 preventive measures.

## Cluster capacity and response modalities

The Government of South Sudan, UNHCR, WFP, UNICEF, FAO and ICRC as well as some 15 national and international NGO partners are actively engaged in the provision of protection and assistance to refugees and their host communities in South Sudan. With additional resources to scale-up COVID-19 preparedness and response actions rapidly, there is capacity for actors on the ground to enhance their activities, with particular focus on health, WASH, protection, risk communication and core relief items. The main factor in scaling up the response will be availability of sufficient financial resources.

UNHCR is participating in the National COVID-19 Steering Committee and its various technical working groups, headed by the Ministry of Health and WHO. Refugee response partners are working to ensure that refugees, refugee returnees and other persons of concern are included in the

national response plan. In refugee hosting areas, the local COVID-19 Task Forces are co-chaired by local authorities and UNHCR.

### Cost of response

With disruptions in the global and regional supply chain, delays and transportation challenges are being experienced, in addition to the increased cost of operating and purchasing COVID-19 supplies.

The operating environment in South Sudan is expected to become more complex with COVID-19. Heightened security, hyperinflation, bureaucratic impediments and immense logistical challenges due to the remoteness of refugee and refugee return locations will make it more difficult to operate.

Logistics and transportation are challenging and expensive with the onset of the rainy season and inter-state movement restrictions. Road movements will be limited due to insecurity or seasonal rains, requiring the refugee response partners to resort to costly airlifts to pre-position COVID-19 items to refugee-hosting areas.

An estimated \$23.3 million will be required to respond the COVID-19 related needs. Refugee response partners de-prioritized some of the activities under the 2020 HRP and \$3.65 million could be reduced from the initial 2020 HRP requirement, therefore an additional \$19.6 million will be needed for the COVID-19 response.

### Additional COVID-19 monitoring

| OBJECTIVE  | INDICATOR  | IN NEED | TARGETED |
|--|--|---------|----------|
| <b>Strategic Objective 1: Reduce morbidity and mortality, as well as suffering from protection threats and incidences of the most vulnerable</b>                             |  |         |          |
| <b>Strategic Objective 2: Ensure safe, equitable and dignified access to critical cross-sectoral basic services to enable 415,000 prioritized target</b>                     |  |         |          |
| Advocate and direct provide support to ensure that refugees, asylum seekers and host communities who are particularly vulnerable to the pandemic receive COVID-19 assistance | Number of refugees, asylum seekers and host communities particularly vulnerable to the pandemic who receive COVID-19 assistance                                  | 415 K   | 415 K    |
|  | Number of refugees, asylum seekers and host communities particularly vulnerable to the pandemic who receive adequate information on risks and available services | 415 K   | 370 K    |

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# Annexes

## Annex 1: Most likely scenario developed by the Inter-Cluster Coordination Group and partners

1. Based on experiences of COVID-19 modelling from other countries, transmission in South Sudan will likely rise exponentially in May-June depending on implementation and impact of mitigation measures.
2. The mitigation measures against COVID-19 have already started reducing economic activities in South Sudan and would considerably further depress the economy. The drop in oil prices has reached a level where the cost of production is greater than the returns. Further, the loan burden on the country raises concern over the situation would change the dynamics and calculations of the political economy threatening the ability of the Transitional Government to sustain itself and to deliver meaningful services in the future.
3. While messaging to inform people living in the United Nations Mission in South Sudan PoC sites and other densely populated camp like settings and informal settlements about the risks of transmission have informed people's decisions to remain or to move voluntarily away from those sites to areas of origin or other less congested locations, very few people decided to move voluntarily. However, recent COVID-19 restrictions against inter-state movements have now affected people's ability to move and people would remain in congested areas.
4. Many villages located along the porous border areas (mainly land and river) with other countries that have registered COVID-19 cases including Sudan, the Democratic Republic of the Congo, Uganda, Kenya and Ethiopia depend heavily on commodity trade from the neighboring countries. As such, efforts to enhance the volume and quality of border screening (establishment of new screening sites, introduction of screening protocols) will have limited impact.
5. Efforts to scale up case identification and investigation, including contact tracing and testing, will continue. Government's and the Health Cluster's capacities will become quickly overwhelmed and unable to match the extent of transmission. Large-scale testing will be limited by availability of test kits and lack of sufficient qualified medical personnel, resulting in a distorted image of the outbreak. Most cases will be identified through clinical diagnosis, with people exhibiting symptoms presenting at clinics and other health facilities for consultations. As the pressure on triage capability and the safety of health workers increase, the continuation of regular health services will be increasingly put at risk.
6. Despite efforts to ensure that COVID-19 response do not compromise other life-saving humanitarian interventions, the likelihood of less funding for humanitarian partners in 2020 to deliver assistance under new ways and new modalities of working and COVID-19 mitigations measures (including the recent COVID-19 restrictions against inter-state movements) would negatively affect effective response scale up.
7. The high rates and scale of intercommunal violence continue to affect the presence of humanitarian partners in some locations making access to people in need of both life-saving assistance and COVID-19 response difficult.
8. Supply chains for key core pipeline supplies and consumables, both medical and non-medical and including essential life and routine life supplies, will be under increasing strain due to COVID-19 movement restrictions. This will affect South Sudan harder particularly in view of the country's near 100 per cent dependence on imported consumables and supplies for routine life needs as well as health care and humanitarian supplies, all of which are already facing disruption.
9. Large numbers of school children including boys and girls that remain idle due to COVID-19 restrictions, would revert to negative coping practices and at very high protection risk.
10. The response to COVID-19-related impacts could exacerbate and magnify conflict dynamics as services and incomes are disrupted, populations move or quarantines and lockdowns are imposed.



## Annex 2: COVID-19 Vulnerability Framework developed by the Needs Analysis Working Group

Annex 2 presents the vulnerability framework prepared by the inter-agency Needs Analysis Working Group, co-chaired by OCHA and REACH. The framework was endorsed in May 2020. It is currently being revised to include additional indicators, including internal displacement and COVID-19 caseloads, and will be updated regularly.

### Analysis

Each county will be given a composite score in two main areas: (1) for their assessed risk of entry and COVID-19 spread, and (2) intersectoral vulnerability. In an attempt to prioritize areas at the COUNTY level for response, two composite scores have been drafted:

#### Risk of Entry and COVID-19 Spread:

This is a composite score from 0-12 representing the risk of COVID-19 entering the country and creating potentially large spread events in areas of high population density, such as urban areas and IDP/refugee sites. The composite score is comprised of two factors:

- 1) Population movement from neighbouring countries, including the size of the flow and whether the departure location is a COVID-19 affected area (maximum weight 6)
- 2) Population density, including presence of urban centers, IDP informal or camp settings, average household size, and population density at county level (maximum weight 6)

#### Intersectoral Vulnerability to COVID-19:

Individuals with compromised immune systems, or other health vulnerabilities, are known to have a greater risk of 'severe' or 'critical' COVID-19 outcomes. This is a composite score from 0-25 comprised of food security, health, WASH and nutrition indicators which may increase the vulnerability of a population to these more serious outcomes. The composite score is derived from a number of data sources (FSNMS, IDSR, IPC, and others) and comprised of:

- Population density, including presence of urban centers, IDP informal or camp settings, average household size, and population density at county level (maximum weight 6)
- Age demographics (maximum weight 2)
- Food insecurity, including IPC Phase Classifications Acute Food Insecurity and market dependency in the lean season (Maximum Weight 6)
- IPC Phase Classifications Acute Malnutrition (Maximum Weight 4)
- Health and WASH (maximum weight 7)

Data sources, indicator thresholds, weights are summarized in the table below. Limitations of this analysis include lack of more reliable data sources on chronic illnesses in South Sudan, which has been shown to be associated with severe COVID-19 disease status, as well as access to other more relevant health datasets or more timely data in some instances. In instances where no data is available for an indicator, the weight is treated as 0.

This summary of vulnerability criteria and indicators should be considered a living document, and as the situation with COVID-19 evolves in South Sudan, or higher quality information on risk or vulnerabilities become available, indicators and results of this analysis may change.

## Proposed Vulnerability Indicators and Thresholds

| VULNERABILITY TYPE                | CATEGORY   | INDICATOR   | RATIONALE  | WEIGHT | THRESHOLD  |
|-----------------------------------|--|---|--|--------|--|
| Risk of entry and spread of virus | High levels of population movement<br><br><i>data sources: (IOM Flow Monitoring REACH PRM UNHCR Flow Monitoring; UNICEF)</i> | # of individuals reported arriving from neighboring countries/camps within the last month                             | Migration from neighboring countries with confirmed COVID-19 cases may increase the risk for cross-country transmission  | 1.5    | >= 50 and <150 individuals <sup>1</sup> arriving from neighbouring countr(ies) per month                         |
|                                   |  | # of individuals reported arriving from COVID affected district in neighboring countries/ camps within the last month |  | 3      | >= 150 individuals arriving from neighbouring countr(ies) per month  |
|                                   |  | # of individuals reported arriving from COVID affected district in neighboring countries/ camps within the last month |  | 4.5    | >= 15 and <150 individuals <sup>2</sup> arriving from COVID-affected areas in neighbouring countr(ies) per month |
|                                   |  | # of individuals reported arriving from COVID affected district in neighboring countries/ camps within the last month |  | 6      | >= 150 individuals arriving from COVID-affected areas in neighbouring countr(ies) per month                      |
|                                   | Population density   | Presence of IDP/ Refugee sites (not in host community)<br><br><i>CCCM Cluster – Camp-like settings in SSD; UNHCR</i>  | Informal camps, IDPs/Refugees not integrated in the host community.<br><br>IDPs/Refugees living in camp-like or informal settings are considered more vulnerable due to the poor and concentrated living conditions, which may increase the rate of COVID transmission in those populations. | 0.5    | >=2,000 and 5,000  |
|                                   |  |   |  | 1      | >=5,000 and <=20,000   |
|                                   |  |   |  | 1.5    | >20,000 and <=55,000   |
|                                   |  |   |  | 2      | >55,000  |
|                                   |  | Presence of large urban centres<br><br><i>European Commission Global Human Settlement Layer</i>                       | Large urban centres may lead to increased transmission given they are often key transit hubs, markets, and have high population density.   | 0      | <100,000   |
|                                   |  |   |  | 1      | >=100,000 and <=250,000  |
|                                   |  |   |  | 2      | >250,000   |
|                                   |  | Avg. # people/km <sup>2</sup><br><br><i>OCHA COD-PS</i>   | Increased population density may lead to increased transmission; consider urban centres and PoC sites  | 0.25   | >50th to 75th percentile   |
|                                   |  |   |  | 0.5    | >75 to 90th percentile   |
|                                   |  |   |  | 0.75   | >90 to 95th percentile   |
|                                   |  |   |  | 1      | >=95th percentile  |
|                                   |  | Household size<br><br><i>FSNMS Round 25<sup>3</sup></i>   | Counties with larger household size may have higher likelihood for increased transmission due to closer proximity of household members   | 0      | Avg. HH size is below the 50th percentile of national average  |
|                                   |  |   |  | 0.5    | Avg. HH size is in the 50-75th percentile of national average  |
| 1                                 | Avg. HH size is in the 75-100th percentile of national average   |   |  |        |  |

1. Median number of individual arrivals into counties in South Sudan from neighbouring countries per county was 91.5 in March 2020.

2. Median number of individual arrivals into counties in South Sudan from confirmed COVID-affected areas in neighbouring countries per county was 14 in March 2020. It is noted that this number will likely increase as COVID spreads, so this threshold may fluctuate.

3. FNSMS is representative of rural areas only

## Proposed Vulnerability Indicators and Thresholds

| VULNERABILITY TYPE  | CATEGORY                                     | INDICATOR   | RATIONALE   | WEIGHT   | THRESHOLD                |
|---|--|---|---|--|--------------------------|
| <b>Intersectoral Vulnerability</b><br>(Risk of severity of the outbreak - known factors which could increase the proportion of severe COVID cases in an area) | <b>Population density</b>                    | Presence of IDP/Refugee sites (not in host community)<br><i>OCHA – Camp-like settings in SSD; UNHCR</i>   | Informal camps, IDPs/Refugees not integrated in the host community. IDPs/Refugees living in camp-like or informal settings are considered more vulnerable due to the poor and concentrated living conditions, which may increase the rate of COVID transmission in those populations. | 0.5  | >=2,000 and 5,000        |
|   |  |   |   | 1  | >=5,000 and <=20,000     |
|   |  |   |   | 1.5  | >20,000 and <=55,000     |
|   |  |   |   | 2  | >55,000                  |
|   |  | Presence of large urban centres<br><i>European Commission Global Human Settlement Layer</i>   | Large urban centres may lead to increased transmission given they are often key transit hubs, markets, and have high population density   | 0  | <100,000                 |
|   |  |   |   | 1  | >=100,000 and <=250,000  |
|   |  |   |   | 2  | >250,000                 |
|   |  | Avg. # people/km <sup>2</sup><br><i>OCHA COD-PS</i>   | Increased population density may lead to increased transmission; consider urban centres and PoC sites   | 0.25   | >50th to 75th percentile |
|   |  |   |   | 0.5  | >75 to 90th percentile   |
|   |  |   |   | 0.75   | >90 to 95th percentile   |
|   | Household size<br><i>FSNMS Round 25 data</i> | Counties with larger household size may have higher likelihood for increased transmission due to closer proximity of household members  | 0   | Avg. HH size is below the 50th percentile of national average  |                          |
|   |  |   | 0.5   | Avg. HH size is in the 50-75th percentile of national average  |                          |
|   |  |   | 1   | Avg. HH size is in the 75-100th percentile of national average |                          |
|   | <b>Demographics</b>                          | Avg. # of elderly (60+) in the household<br><i>FSNMS Round 25 data</i>  | Due to elderly vulnerability to COVID   | 0  | <0.69                    |
|   |  |   |   | 1  | >=0.7 and <0.89          |
|   |  |   |   | 2  | >= 0.9                   |
|   | <b>High food insecurity</b>                  | % of households by IPC Phase classification from Projection 1 (Feb-April 2020)  | Greater food insecurity means a greater likelihood of reduced quantity or quality of the household diet, which could lead to a weakened immune system. Food insecurity, reliance on general food distribution can reduce immunity   | 0  | P3 < 20%                 |
|   |  |   |   | 1  | P3+ >=20% AND P3+ <50%   |
|   |  |   |   | 2  | P3+ >= 50%               |
|   |  |   |   | 3  | P3+ >= 75% OR P4+>= 20%  |
| 4   |  | P5>0 OR P4+>= 30%   |   |  |                          |
| % of households reportedly main source of food is markets in lean season  |  | Households that are dependent on markets for their main food source may be unable to access food as prices increase from border closures. Greater food insecurity may lead to weakened immune system. | 2   | 2 if >30% in lean season                                       |                          |

## Proposed Vulnerability Indicators and Thresholds

| VULNERABILITY TYPE  | CATEGORY   | INDICATOR   | RATIONALE  | WEIGHT   | THRESHOLD  |
|---|--|---|--|--|--|
| <b>Intersectoral Vulnerability</b><br>(Risk of severity of the outbreak - known factors which could increase the proportion of severe COVID cases in an area) | <b>High malnutrition</b><br><i>IPC South Sudan Jan 2020</i>                                  | IPC AMN Phase classification<br>Projection (May-August 2020)  | Acute malnutrition reduces immunity  | 1  | IPC AMN P2   |
|   |  |   |  | 2  | IPC AMN P3   |
|   |  |   |  | 4  | IPC AMN P4   |
|   | <b>WASH</b><br><i>FSNMS Round 25 data</i>  | % of population travelling 30 minutes or less to a water source and have access to soap for handwashing   | Access to clean water and soap are requisite for hand-washing practices, which is an essential preventive behavior to fight COVID-19.  | 0  | >20%   |
|   |  |   |  | 2  | <=20%  |
|   | <b>Healthcare access</b><br><i>FSNMS Round 25 data</i>                                       | % of population walking more than ½ day to a functional health facility   | Individuals may be asked to stay at home with suspected symptoms of COVID-19, but if case is critical, access to functional facility will impact mortality rate and containment.   | 0  | <=10%  |
|   |  |   |  | 1  | >10% and <=30%   |
|   |  |   |  | 2  | >30%   |
|   | <b>Infectious Disease (Non-COVID)</b><br><i>IDSR/E WARS</i>                                  | Presence of malaria 'epidemic', malaria 'alert' or other confirmed disease outbreak   | The dual burden of malaria or other infectious diseases and COVID-19 will likely increase morbidity and mortality as other illnesses become more difficult to treat due to competing health system resources. COVID will also reduce the health systems ability to deal with Areas with high burdens of disease prior to COVID may be among the heaviest hit. Especially some concerns of co-morbidity of malaria and COVID-19. Malaria is treated here is a proxy for infectious diseases. Epidemic levels of malaria: # malaria cases in the given epidemiological week > long term mean + 2 SD from the same epidemiological week in previous years Alert levels of malaria: # malaria cases in the given epidemiological week > the third quartile of cases compared to the same time in previous years. OR confirmed disease outbreak | 0  | No disease outbreak                                    |
|   |  |   |  | 1  | 'Alert' level of total morbidities or malaria specific |
| 2   |  |   |  | 'Epidemic' levels of total morbidities or malaria specific OR confirmed disease outbreak |  |
| <b>Chronic Disease</b><br><i>FSNMS Round 25 data</i>  | % of households self-reporting a household member has a chronic illness in the last 3 months | General, self-reported question for populations that may have people with chronic health issues, however some chronic health issues may not necessarily link to immune suppression or increased risk of severe/critical COVID-19 cases. | 1  | > 10% HH report family members with chronic illness in last month                        |  |



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# Endnotes

1. HSF Report, July 2019
2. SARA Survey, July 2019
3. UNFPA, Nation Wide Assessment of the Implementation of Clinical Management of Rape Services, South Sudan, December 2019
4. United Nations Mission in South Sudan and United Nations Human Rights Office of the High Commissioner, Access to Health for Survivors of Conflict-Related Sexual Violence in South Sudan, May 2020
5. South Sudan GBV Sub Cluster, GBV program coverage analysis, December 2019
6. South Sudan National Review of the Implementation of the Beijing Declaration and Platform for Action
7. Findings showed that key areas of destination for surveyed returnees coming from COVID-affected areas in neighbouring countries were; Twic, Northern Bahr El Ghazal; Rubkona, Unity State; Nzara, Yambio, Ibba, Maridi and Ezo counties, bordering Ituri (DRC); and Uganda in Central and Eastern Equatoria between Morobo and Magwi, and the urban areas of Juba, Wau, Rubkona, Aweil and Yei. The main entry points for returnees from Sudan were Renk, Upper Nile State; Pariang, Unity State; Abyei, Abyei Administrative Area and Aweil Centre, Timsah/ Ere and Delieba, Northern Bahr-el-Ghazal State. Rubkona, Unity State, Malakal, Upper Nile State and Wau, Western Bahr El Ghazal were identified as key convergence points mainly in PoCs, where returnees paused to either reunite with relatives or replenish supplies before continuing with onward return journeys. The main entry points for returnees from East Africa was mainly Nimule, Magwi County, with Juba as key convergence point, with secondary flows reported from Kampala to Kaya, Morobo County and Kajo-Keji County.
8. Out of School Children (OOSC) 2018 - conducted by MoGEI, UNESCO and UNICEF
9. FSNMS round 24 and 25
10. The Food Security and Nutrition Monitoring System (FSNMS) Round 24 conducted in the lean season 2019
11. FAO/IFAD/WORLD BANK/WFP. Joint Statement on COVID-19 Impacts on Food Security and Nutrition. Rome/Washington DC, April 2020.
12. FSNMS Round 25
13. FSNMS Round 25

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