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Report No: 84176-SS

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL GRANT
IN THE AMOUNT OF SDR 16.3MILLION
(US$ 25 MILLION EQUIVALENT)

AND

PROPOSED ADDITIONAL CREDIT
IN THE AMOUNT OF SDR 6.6 MILLION
(US$10 MILLION EQUIVALENT)

TO THE

REPUBLIC OF SOUTH SUDAN

FOR A

HEALTH RAPID RESULTS PROJECT

February 28, 2014

Human Development Sector Unit
AFCE4
AFRICA

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CURRENCY EQUIVALENTS

(Exchange Rate Effective January 31, 2014)

Currency Unit	=	SSP
SSP 3.5	=	US$ 1
SDR 0.6518055	=	US$ 1

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
ANC	Antenatal Care
BPHS	Basic Package of Primary Health Services
BSF	Basic Services Fund
CHD	County Health Department
CHW	Community Health Workers
CIDA	Canada International Development Agency
CPA	Comprehensive Peace Agreement
CSDO	Coordination and Service Delivery Organization
DFID	Department for International Development
DPs	Development Partners
DPT3	Diphteria, Pertusis and Tetanus 3
EC	European Community
EHD	Environmental Health Directorate
EPI	Expanded program on Immunization
ESIA	Environmental and Social Impact Assessment
ESSAF	Environmental and Social Screening Assessment Framework
FBO	Faith Based Organization
FM	Financial Management
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GNI	Gross National Product
GOSS	Government of South Sudan
GoSSHA	Government of South Sudan Health Assembly
HCW	Health Care Waste
HFS	Health Facility Survey
HIV/AIDS	Human Immunodeficiency Virus- Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System

HNCG	Health and Nutrition Consultative Group
HPF	Health Pooled Fund
HR	Human Resources
HRITF	Health Results Innovation Trust Fund
HRRP	Health Rapid Results Project
HSDP	Health Sector Development Plan
IAS	International Accounting standards
ICB	International Competitive Bidding
IDA	International Development Association
IDSR	Integrated Disease Surveillance and Response
IFR	Interim Financial Report
IMA	Interchurch Medical Association
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPF	Investment Project Financing
IPSAS	International Public Sector Accounting standards
IPT	Intermittent Preventive Treatment
ISN	Interim Strategy Note
ITN	Insecticide Treated Nets
JAM	Joint Assessment Mission
JICA	Japan International Cooperation Agency
LA	Lead Agencies
LATH	Liverpool Associates in Tropical Health
LLIN	Long Lasting Insecticidal Nets
LQAS	Lot Quality Assurance Survey
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MDTF-SS	Multi-Donors Trust Fund for South Sudan
MOFCIEP	Ministry of Finance, Commerce, Investment and Economic Planning
MOH	Ministry of Health
MWMP	Medical Waste Management Plan
NGO	Non-Governmental Organizations
NPV	Net Present Value
OPCS	Operation Policy and Country Services
OPRC	Operational Procurement Review Committee
ORAF	Operational Risk Assessment Framework
PAD	Project Appraisal Document
PBC	Performance Based Contracting
PBF	Performance Based Financing
PDO	Project Development Objective
PEFA	Public Expenditure and Financial Accountability Assessment
PFMU	Project Financial Management Unit
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PIM	Project Implementation Manual

PMT	Project Management Team
RoSS	Republic of South Sudan
SHHS	Sudan Household Survey
SHTP2	Sudan Health Transformation Project -2
SIDA	Swedish International Development Cooperation Agency
SOE	Statement of Expenses
SMOH	State Ministries of Health
SP	Sulfadoxine-Pyrimethamine
SPLM	Sudan People's Liberation Movement
SSDP	South Sudan Health Sector Development Plan
SSHS	South Sudan Household Survey
SSP	South Sudanese Pound
SSTF	South Sudan Transitional Trust Fund
TB	Tuberculosis
TFR	Total Fertility Rate
TOR	Teams of Reference
U5MR	Under 5 Mortality Rate
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WDR	World Development Report
WHO	World Health Organization

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REPUBLIC OF SOUTH SUDAN

HEALTH RAPID RESULTS PROJECT

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REPUBLIC OF SOUTH SUDAN

HEALTH RAPID RESULTS PROJECT
ADDITIONAL FINANCING DATA SHEET

Basic Information - Additional Financing (AF)	
Country Director: Bella Bird Sector Manager: Olusoji Adeyi Team Leader: Anne Bakilana Project ID: P146413 Expected Effectiveness Date: June 13, 2014 Lending Instrument: Investment Project Financing Additional Financing Type: Scale Up	Sectors: Health Themes: Human Development, Health Environmental category: B-partial assessment Expected Closing Date: October 31, 2015 Joint IFC: - Joint Level: -
Basic Information - Original Project	
Project ID: P127187 Project Name: Health Rapid Results Project Joint Level:- Lending Instrument: Investment Project Financing	Environmental category: B-partial assessment Expected Closing Date: October 31, 2014 Joint IFC: - Fragility or Capacity Constraints [ ] Financial Intermediary [ ] Series of Projects [ ]
AF Project Financing Data	
[ ] Loan [x] Credit [x] Grant [ ] Guarantee [ ] Other: Proposed terms:	
AF Financing Plan (US$ 35m)	
Source	**Total Amount (US $m)**
Total Project Cost:	**US$35.00 million equivalent (SDR 22.9 million)**
Co-financing:	
Borrower:	
Total Bank Financing:	
IBRD	
IDA:	**US$35.00 million equivalent (SDR 22.9 million)**
New	
Recommitted	
Client Information	
Recipient: Republic of South Sudan **Responsible Agency:** Ministry of Health Contact Person: Dr. Makur Matur Kariom Telephone No.: +211977166249 Fax No.: - Email:mkariom@talktalk.net	

AF Estimated Disbursements (Bank FY/US$m)						
FY	**2014**	**2015**	**2016**			
Annual	**9.2m**	**18.4m**	**7.4m**			
Cumulative	**9.2m**	**27.6m**	**35.0m**			

Project Development Objective and Description

Original project development objective: The objectives of the original project are: (i) to improve the delivery of High Impact Primary Health Care Services in Upper Nile and Jonglei states; and (ii) to strengthen the coordination, monitoring and evaluation capacities of the Ministry of Health.

Revised project development objective: PDOs remain the same.

Project description: The project will support activities under two components. Component 1: Delivery of high impact Primary Health Care Services (US$ 31.2 million) will extend MOH performance-based contract with IMA – the Coordination and Service Delivery Organization (CSDO) to improve the delivery, throughout the assigned state(s), of high impact PHC services, including maternal and child health services such as vaccination, prenatal care, skilled birth attendance and curative services. Component 2: Capacity development of MOH at the national level (US$ 3.8 million): The AF will provide further support to: i) Strengthen Grant and Contract Management, specifically, the project will support the strengthening of the MOH's capacity to plan, manage, and monitor grants and contracts; and ii) continue Monitoring and Evaluation functions by ensuring that there is a steady stream of independent and credible data on health sector performance. This will involve building on recent experience of financing Health Facility Survey (HFS) and Lot Quality Assurance (LQAS) household surveys.

Safeguard and Exception to Policies	
Safeguard policies triggered:	
Environmental Assessment (OP/BP 4.01)	[x] Yes [ ] No
Natural Habitats (OP/BP 4.04)	[ ] Yes [x] No
Forests (OP/BP 4.36)	[ ] Yes [x] No
Pest Management (OP 4.09)	[ ] Yes [x] No
Physical Cultural Resources (OP/BP 4.11)	[ ] Yes [x] No
Indigenous Peoples (OP/BP 4.10)	[x] Yes [ ] No
Involuntary Resettlement (OP/BP 4.12)	[ ] Yes [x] No
Safety of Dams (OP/BP 4.37)	[ ] Yes [x] No
Projects on International Waterways (OP/BP 7.50)	[ ] Yes [x] No
Projects in Disputed Areas (OP/BP 7.60)	[ ] Yes [x] No

Question	Response
Is approval of any policy waiver sought from the Board (or MD if RETF operation is RVP approved)?	[ ] Yes [x] No
Has this been endorsed by Bank Management? (*Only applies to Board approved operations*)	[ ] Yes [x] No
Does the project require any exception to Bank policy?	[ ] Yes [ ] No
Has this been approved by Bank Management?	[ ] Yes [] No

Conditions and Legal Covenants:		
Financing Agreement Reference	Description of Condition/Covenant	Date Due
FA, Schedule 2, Section IV (B.1.b)	Each of the two Contract Management Agreements has been entered into by the parties thereto, and all conditions precedent to the effectiveness of each such contract has been met.	Disbursement condition linked to withdrawal of funds under the project.
FA, Schedule 2, Section II (B.5)	The Recipient shall engage, not later than six months after the Effective Date, the external auditor referred to in Section 4.09 (b) of the General Conditions in accordance with Section III of Schedule 2 of this Agreement and pursuant to terms of reference satisfactory to the Association.	Not later than six months after the Effective Date.

I. INTRODUCTION

1. This Project Paper seeks the approval of the Executive Directors to provide an Additional Financing (AF) consisting of a grant in the amount of US$25 million equivalent and credit in the amount of US$10 million equivalent to the Republic of South Sudan for the Health Rapid Results Project (P127187, Trust Fund 12272) to extend project activities and scale up project impact and effectiveness. The Project Paper does not propose changes to the original Project Development Objectives, technical design or implementation arrangements. The Project Paper proposes extending the project closing date to October 31, 2015; and to modify the results framework by adjusting end of project targets to reflect a longer period of implementation.

2. The proposed AF will support activities under Component One which focus on improving the delivery of high impact Primary Health Care services in the two states of Jonglei and Upper Nile. The proposed AF will extend the Ministry of Health (MOH) performance-based contract with a Coordination and Service Delivery Organization (CSDO) to improve the delivery of high impact primary health care services in the two states. The primary health care services to be supported include maternal and child health services such as vaccination, prenatal care, skilled birth attendance and basic curative care. Under the supervision of the MOH and State MOHs, the CSDO will supervise service delivery, mobilize human resources, procure and distribute pharmaceuticals and other inputs, and help to determine the need for additional health facilities. The CSDO will also play an overall coordination function to ensure that there are no gaps in service delivery and that duplication of effort is minimized.

3. The proposed additional financing will also support activities under Component Two which aim to strengthen grant and contract management capacity of the MOH. It will also support monitoring and evaluation functions by strengthening routine Health Management Information System (HMIS); the Quantitative Supervisory Checklists, and will ensure timely health facility surveys and household surveys. The component will also support the strengthening of the capacity of the MOH‘s Department of Planning in M&E so that they can effectively analyze the data to track the progress made towards health sector targets. The proposed AF will continue the support that aims to strengthen the technical skills through training and south-south visits.

4. The AF is being sought in accordance with the policies described in: (1) OP 10.00, paragraph 11 on Projects in Situations of Urgent Need of Assistance or Capacity Constraints; and (2) OP/BP 10.00 on Investment Project Financing (IPF) which provides for a financing gap and the implementation of additional or expanded activities that scale up the Project's impact and effectiveness. OP 10.00 paragraph 11 applies when the borrower/beneficiary is deemed by the Bank to: (i) be in urgent need of assistance because of a natural or man-made disaster or conflict; or (ii) experience capacity constraints because of fragility or specific vulnerabilities (including for small states). Thus, Paragraph 11 is applicable to this proposed AF because: (i) remaining recovery and reconstruction challenges in South Sudan are numerous; (ii) due to history of many decades of war and conflict government capacity remains extremely weak; (iii) inter-tribal clashes means security remains tenuous in specific counties in Jonglei and difficult relations along South Sudan’s border with Sudan remain, with frequent disruption of revenues; (iv) recent eruption of fighting between government forces under the control of the President

and factions loyal to the former Vice President have emphasized the urgent need for continued efforts to consolidate peace and provide assistance for vulnerable populations affected by conflict; and (v) The UN Peace-keeping Mission in the Republic of South Sudan became operational on July 9, 2011 and remains operational in the country.

II. BACKGROUND AND RATIONALE FOR ADDITIONAL FINANCING

Country Context

5. In 2005, SPLM/A signed a Comprehensive Peace Agreement (CPA) with Sudan; and in July 2011 South Sudan celebrated its independence. The country emerged from five decades of a civil war that took a heavy toll on human life, displaced populations, destroyed infrastructure and stalled investment in its people. South Sudan is still characterized by high incidence of poverty, inadequate access to basic services, very limited access to economic opportunities, poor infrastructure, high mortality and morbidity rates and food insecurity. More than half of the population of South Sudan (51%) lives below the poverty line and income disparity is high. Oil revenues account for more than 90% of GDP and approximately 98% of the national budget. Turbulent relations with Sudan have continued to affect oil transit fee arrangements over the past year, which in turn greatly affected government revenues and its ability to keep a stable macroeconomic environment.

6. The fighting that erupted on December 15, 2013 between forces loyal to the current Government and those supporting the former Vice President has underscored the repeated cycles of violence and disruption that usually affect countries emerging from conflict. The fighting highlights the nonlinear path to sustained security and the effects of violence on the most vulnerable in society as highlighted in the 2011 World Development Report on Conflict, Security and Development. Even prior to recent fighting, South Sudan had some of the worst human development indicators in the world; but signs of progress in some areas were beginning to emerge, albeit very slowly. The recent fighting has already impacted the population of South Sudan at various levels, not only in the states at the epicenter of fighting (i.e. Unity, Jonglei and Upper Nile), but in other states not directly involved in the conflict. Just prior to the current crisis, oil revenues had begun to flow again after a couple of years of an unstable macroeconomic environment caused by oil transfer fees disagreements with Sudan. There was anticipation that the economy would gradually rebound and enable the government's return to a non-austerity budget and hence increase expenditures and investments in social sectors. The fighting that started in December 2013 is likely to stall the path to economic recovery. It has already led to massive internal displacement of populations (an estimated 750, 000 IDPs); it has worsened food security and further constrained access to health services. It is unlikely that anticipated increased allocations to social sectors will be realized in the current environment.

Sector Challenges

7. Health is always placed among the top in the list of priorities for the Government; however, the sheer challenge of improving outcomes for a population that has been affected by

decades of conflict; destruction of basic health services infrastructure and exposure to multiple health risks is overwhelming. Health services cover a small proportion of the population; only 40% of the population is able to access healthcare within a 5 km radius square. South Sudan's burden of maternal morbidity is among the highest in the world. Maternal mortality ratio is estimated to be 2,054 per 100,000 live births (2006 SSHS; no updated estimate is available). Few women receive care during pregnancy as reflected in the small proportion of women who had four or more Ante-Natal Care (ANC) visits (17%: SSHS 2010; 20% LQAS 2011); few women are attended by skilled health personnel during labor (10%) and most deliveries occur at home (81% of births: SSHS 2010; 78%: 2011 LQAS).

8. Childhood mortality and morbidity remain unacceptably high, and though latest (albeit highly unreliable) data suggest that U5 mortality is declining, it is currently estimated at 105 per 1000 live births (2010 SSHS), a decline from 135 per 1000 live births (2006 SSHS). Infant mortality is estimated to be 75 per 1000 live births (SSHS 2010); a decline from 102 per 1000 live births (2006 SSHS). High rates of childhood malnutrition, with underweight prevalence of 28% (2010 SSHS) down from 33% (2006 SHHS), and low coverage of immunization rates approximated at 17% of under-fives fully immunized (SHHS 2010), all contribute to high rates of infant and child mortality. In comparison, under-five mortality levels for South Sudan are 25% higher than those in Sudan and 78% higher than the global average.

9. In addition to dismal maternal and child health outcomes, other illnesses constitute a heavy burden of disease. Rates of malaria morbidity and mortality are high. Malaria was estimated to account for 20-40% of all health facility visits and 30% of hospitalizations (MIS 2009). There is a positive trend in household ownership of Insecticide Treated Nets (ITNs) which expanded rapidly between 2006 and 2010 from 27 to 42 percent. A number of preventable or treatable Neglected Tropical Diseases (NTDs) are endemic to South Sudan, including Onchoceriasis, Trachoma, Lymphatic Filariasis, Schistosomiasis, Leprosy, Buruli Ulcer and Kalar Azar are prevalent in South Sudan. Various partners are working on mapping their prevalence and mounting efforts to prevent and treat these debilitating diseases. HIV/AIDS prevalence is believed to be low due to past isolation of South Sudan from neighboring high prevalence regions but could increase given low rates of awareness about the infection and prevention.

10. The fighting that erupted in December 2013 has magnified the challenges the country faces in improving access to essential primary health care services (South Sudan Health Cluster, 2014). Poor access to health services has been further constrained by health facilities closure in locations in close proximity to fighting as populations and health care staff flee violence. The fighting has also limited access to health services for populations displaced by the fighting. There has also been disruption of the medicines supply chain, including supplies for treatment of trauma, obstetric care, and infectious diseases such as malaria, tuberculosis, leprosies, and treatment of chronic conditions. There is an increased burden of communicable diseases such as pneumonia, and diarrhea, especially in Internally Displaced People's (IDPs) camps. There is also increase in malaria morbidity due to increased exposure as populations flee their homes and seek refuge out in the elements.

11. It is estimated that the fighting has resulted in an estimated 750,000 IDPs who are seeking refuge from the fighting and have moved to UN compounds and other locations. It is estimated that Unity state has 180,000 IDPs; Jonglei 133,600; Upper Nile 157,300 and Central Equatoria 93,500 IDPs. Displaced people, especially young children and pregnant women, are at particularly high risk of contracting communicable diseases due to poor sanitation, shortage of water, crowded living conditions and lack of vaccination coverage. Not only is the risk of outbreaks elevated, especially of diseases such as measles, but in addition the UN reports that food shortage is affecting about a third of the population (UN 2014). There are concerns that, as a result, malnutrition especially in infants and young children, could lead to increased and more severe disease as immunity declines. There are also concerns that reproductive health needs of expectant mothers especially those related to complications of pregnancy, safe delivery and acute newborn care are not being met under the current environment.

12. In addition to increased demand for health and other services, the first few weeks of violence saw a decline in actual provision of services due to closure of some facilities. NGOs are still the main providers of health care services in South Sudan, and due to the sudden surge in demand from the influx of IDPs from neighboring states/counties, a number of them are overstretched. Some NGOs are likely to be drawing from their normal pool of development health workers to respond to the crisis. One of the greatest concerns is that facilities are experiencing drugs and medical supplies stock-out and this will impact service delivery even in areas unaffected by conflict. Looting, theft and damage to facilities and equipment is another worrying concern. A number of NGOs have reported looting of their offices, stolen vehicles and damaged property. The three major referral hospitals in Jonglei, Upper Nile and Unity, namely Bor, Malakal and Bentiu suffered damage and are not operational (Health Cluster, 2014). In addition to much reduced hospital care facilities, there are concerns that due to reduced availability of health care staff, there could be poor infection prevention and control in health care facilities, and lack of care for increased wounds and injuries as a direct result of violence.

Sector Policy

13. The signing of the CPA in 2005 paved the way for initiatives targeting better health for the population. The Government's efforts to improve health outcomes are guided by the Health Sector Development Plan (HSDP) (2012-2016) whose mission is to improve the health status of the population and provide quality health care to all, especially the most vulnerable women and children. Since the signing of the CPA in 2005, a number of donors have assisted the GRSS in addressing challenges in the sector, mostly with a priority to provide PHC services. In an agreement reached in 2011, the World Bank has focused its support to the two most challenging states of Jonglei and Upper Nile while USAID and the Health Pooled Fund support the remaining eight states. The Health Pooled Fund's (DFID, CIDA, SIDA, EU, and Spain and Australia Aid agencies) Basic Services Fund supports the regions of Western Bahr el Ghazal, Northern Bahr El Ghazal, Warrap, Lakes, Unity and Eastern Equatoria; while the Sudan Health Transformation Project funded by USAID supports Western Equatoria and Central Equatoria.

14. Despite support received since the CPA, South Sudan's health sector has yet to attain the desired pace towards meeting health MDGs. There is still uncoordinated and inequitable

distribution of health services, international and national NGO's remain the major players in the sector. Health services are run mainly by NGOs and faith-based organizations funded from international sources. Coordination is improving, and there is now an agreement on geographical areas that specific donors and partners focus on, though services are still delivered through short term health interventions that do not reach a high proportion of the population.

15. **Lack of qualified human resources at all levels of the health system**: Most of the staff running health facilities are Community Health Workers (CHWs) who have limited technical skills. It is estimated that only about 10% of the staffing norms needed to deliver the Basic Package of Health services are met. Moreover, an unstable economic environment has meant that salaries of health care workers are very low and often go unpaid for months. Concentration of health personnel in urban areas remains, with limited success in relocating staff to areas with pressing needs.

16. **Significant challenges in management of pharmaceuticals**: The MOH has tangible achievements in framing policies and guidelines and in expanding pharmaceutical and medical supply management by introducing: (i) The Drug and Food Control Authority mandated to regulate pharmaceuticals licensing; and (ii) The Central Medical Supply Store as an independent body to regulate pharmaceuticals supplies. Still, the MOH faces a serious challenge in ensuring patients' access to essential drugs. This is due to: (i) Lack of qualified personnel to implement policies especially at SMoH (State Ministries of Health) and the level of CHDs (County Health Departments); (ii) Lack of trained personnel to implement the new pharmaceuticals pull system; (iii) Lack of effective supply chain management and storage facilities at all levels; (iv) A weak pharmaceuticals information system to inform decision makers in planning and financing; and (v) Insufficient budget allocations to cover pharmaceutical needs.

17. **Ineffective financing and budgeting processes**: Health planning and budgeting remains top down, neither operational nor evidence based. Financial disbursements to SMOHs are slow, funds for salaries and other recurrent costs at state and county level are scarce. A significant portion of the limited budget is allocated away from PHC; and leaves SMOHs and CHDs unclear about budget allocations and availability.

18. **Low capacity in supervision, monitoring and evaluation**: Since donors directly fund NGOs to deliver services, the MOH and SMOHs are usually not part of the contracting process. This contributes to reduced capacity to supervise delivery of services by implementers. Even when the MOH is closely involved in negotiating donors funding to NGOs, its capacity to monitor and supervise is hindered by lack of human resources, logistics and operational costs.

19. **Limited Data on Health Services Delivery**: This is a major constraint for development and implementation of evidence based planning. There has been extensive improvement in the amount of data available, e.g. the routine Health Management Information System (HMIS) and District Health Information System (DHIS) achieved through the MDTF–SS and other surveys financed through the Umbrella Health Program (e.g. Health Facility Survey, Lot Quality Assessment Household Survey, etc.). The use of available data remains limited and the quality of data, especially routine HMIS data, needs further improvement.

20. **Large health care infrastructure needs**: The legacy of decades of war has left the country with large infrastructure needs, due to lack of investment, disrepair and unequal distribution of resources; and the minimum budget allocated to the social sectors has not allowed for much needed capital investments. Given the competing priorities within the sector, investment in infrastructure has continued to lag behind the large needs.

The Original Project

21. The original grant for the Health Rapid Results Project (HRRP) in the amount of US$ 28 million was approved on April 20, 2012, and became effective on August 2, 2012, with an original closing date of October 31, 2014; though support for service delivery activities implemented through a MOH-CSDO contract was expected to close on December 31, 2013.

22. The objectives of the original Project are to: (a) to improve delivery of high impact primary health care services in Upper Nile and Jonglei states; and (b) to strengthen coordination and monitoring and evaluation capacities of the MOH. The original Project consists of the following two components: Component 1: Delivery of high impact Primary Health Care services; and Component 2: Capacity development of MOH at the national level, which had two sub-components as follows: (i) Strengthening Grant and Contract Management; and (ii) Bolstering the monitoring and evaluation function.

23. The HRRP is consistent with the Bank's assistance in the sector which has focused on improving service delivery, building systems and the capacity of the MOH in grant management, monitoring and evaluation, financial management and procurement. Together with other sectoral projects, the Multi-donor Trust Fund for South Sudan (MDTF-SS) financed the South Sudan HIV/ AIDS Project in 2007 which closed in June 2012; and the two phases of the Umbrella Project for Health System Development which closed in December 2012. In providing support to the Government through these projects, the Bank has further built its credibility and comparative advantage in working in fragile states specifically in systems development. The Bank has played a key role in helping the Government of South Sudan purchase services through contracts thereby strengthening the Government's stewardship role in purchasing services and grant management.

24. The ongoing project is one of the projects funded by the South Sudan Transitional Trust Fund (SSTTF) approved by the Bank's Executive Directors to support South Sudan in the interim period between its independence and becoming a member of IMF and IDA. The ongoing project has so far successfully met the criteria set for SSTTF funded projects by being quick starting, quick disbursing and quick in showing results. Currently, the project has disbursed about 72%, and has committed more than 90% of available resources.

Project Performance

25. Overall Project performance is rated as satisfactory; and progress towards the achievement of PDOs is rated satisfactory. Ratings for progress in implementation and towards

achievement of objectives are reflected in the November 2013 Implementation Status Report (ISR) following the results of the implementation support mission that ended September 18, 2013. The project is expected to disburse the remaining funds for service delivery activities at the end of March 2014; hence, there is an urgent need for additional resources to ensure the delivery of basic services in Jonglei and Upper Nile after this date.

26. Progress under Component 1 is satisfactory. The MOH has reviewed and approved the first, second and third quarter progress reports (for the period January-September 2013) on services delivered by the CSDO. The services provided by the CSDO have been verified by the monitoring and evaluation firm contracted by the MOH for this purpose under Component 2 of the Project. In Jonglei, the project has supported the delivery of high impact primary health care services through 151 primary health care facilities and has undertaken activities to strengthen the capacity and function of County Health Departments (CHDs) in 11 counties across the state. Services are delivered by sub-contracted NGO partners in each of the 11 counties that support CHDs and all Primary Health Care Centers (PHCCs) and Primary Health Care Units (PHCUs). In addition, the CSDO also supports three NGOs that support county hospitals in Boma, Akobo, and Duk.

27. Results in Jonglei state show that the project is making a difference by making basic services available to the population. Data show that the proportion of children that received DPT3 vaccine before twelve months of age has increased from 23% in 2012 to 32% at the end of September 2013. The proportion of pregnant women going for first antenatal care visits has also seen a significant improvement from 18% to 30%. The project's support has also improved availability of essential drugs in health facilities, and data show that the proportion of facilities with essential drugs at the time of supervision visits has improved from 48% to 56%. Data also show that services to those aged under five has increased, from 40% of visits to 70% of visits. The number and proportion of women who deliver in a health facility fluctuates between the seasons, though the overall trend shows that it ranges between 10% and 14% suggesting a number of factors that might include accessibility during the rainy season (Annex 1 on Results Framework).

28. The CSDO supported the MOH in a similar set of activities in Upper Nile where services are delivered through 132 primary health care facilities. In addition, the CSDO supports the strengthening of the capacity and function of CHDs in 13 counties across Upper Nile. The CSDO directly supports five counties (Malakal, Akoka, Manyo, Melut, and Renk) in collaboration with the State Ministry of Health (SMOH) by direct subcontracting of the CHDs. The CSDO provides materials and funding to carry out essential functions such as monitoring and reporting, supply of materials and drugs, and supervision. In the other eight counties, the CSDO subcontracts NGO partners to support CHDs and all PHCCs, PHCUs, and County Hospitals.

29. Results for Upper Nile also show positive impact of the project. Data show that the proportion of children that received DTP3 before twelve months of age has increased from 21% in 2012 to 48% at the end of September 2013. The proportion of pregnant women receiving ANC first visits has also seen a significant improvement from 26% to 42%. The project's support has also improved availability of essential drugs in health facilities, and data show that the proportion of facilities with essential drugs at the time of supervision visits has improved from

40% to 55%. Data also show that the proportion of outpatient services, that is, to those aged under five, has increased, and that women comprise more than 55% of all project beneficiaries (Annex 1 on Results Framework).

30. Progress under Component 2 is also satisfactory. Working with the consultant independent monitoring and evaluation firm, the MOH has already undertaken a DHIS initiation and refresher course for 30 SMOH M&E Coordinators and other MOH staff. A Health Facility survey covering all states began in November 2013 and data are expected in early 2014; and a Household Survey is planned for early 2014. The monitoring and evaluation firm has also provided assistance to the MOH and SMOH to verify implementation progress and ensure results and targets are achieved by the CSDO in Jonglei and Upper Nile. The firm has verified that the targets reported by the CSDO have been met and surpassed in certain areas. The project has successfully supported the strengthening of the capacity of the central MOH to manage grants, and direct observation shows that the capacity of MOH has improved over the last year of implementation. MOH-CSDO discussions on budget allocations have become richer; they have increasingly focused on details of implementation and delivery of results. In addition, close working relationship between the Department of Planning and the independent monitoring and evaluation firm has resulted in transfer of skills in methods of data collection and field work supervision. Capacity improvement to provide and manage services at the local level is also observed in a select number of CHDs that have received close supervision and mentoring from both the CSDO and other subcontracted international NGOs.

31. The Project also supported a Performance Based Contracting pilot for county hospitals, County Health Departments (CHDs) and facilities and results are promising. All 24 CHDs and approximately half of the 283 health facilities (MOH supported), have the opportunity to earn monthly incentives based on the attainment of 5-6 key project indicators. Incentives are given as block grants to institutions (not to personnel) and paid out monthly on a sliding scale based on performance. Maximum amounts attained and paid in local currency are approximately $1200 per month for county hospitals, $900 per month for county health departments, $500 per month for PHCCs and $200 per month for PHCUs. Over the course of the past six months, approximately $380,000 has been paid out to such facilities. There are some early lessons in implementing the PBC pilot, these are: (i) there is a need to increase overall understanding of the concept of performance based incentives to ensure that incentives are paid upon verification of targets reached; and (ii) ensuring that reported data is correct and not inflated to receive higher payment. Thorough facility-by-facility analysis is planned to determine the relationship between payment and performance over the previous period, but early results show that there is a relationship between incentives paid and performance in delivery of ANC and curative care for children under five.

Implementation Environment

32. The two states supported by the project are among the most challenging to work in, even before the latest fighting. The project has had to respond flexibly to tough implementation conditions including access constraints and the importance of addressing needs of populations

affected by conflict. Security, tribal clashes, IDPs and returnees from Sudan continue to be a concern for some counties in Jonglei state. Between January and July 2013, conflicts in Akobo, Pibor, Nyirol, Duk, and Pochalla counties resulted in loss of life, displacement and evacuation of one subcontracted international NGO delivering services in the state. Security incidences also disrupted access on key access roads and reduced EPI and LLIN mass campaigns and outreach. One of the counties in Jonglei, Pibor County, had its capacity to provide services significantly reduced due to facility damage and staff dispersing due to conflict. For these particular cases, the MOH-CSDO contract had inbuilt flexibility for the CSDO to reallocate supplies to areas with urgent need and to change dates of outreach campaigns. It also necessitated working even closer with the UN and other partners to meet medical care needs and use of mobile clinics and other mechanisms to move the injured and supplies necessary to address trauma related injuries.

33. The December 15, 2013 outbreak of fighting between government forces and sections of the army loyal to the former Vice President has required that the project swiftly respond to increases in demand for health services as well as healthcare needs of populations that have fled the violence. Reports suggest loss of life of approximately 10, 000 people; close to 750, 000 IDPs as well as destruction of infrastructure and property, including some health facilities. Through the support of the project in these two states, the MOH has responded to an increase in demand for services caused by an inflow of IDPs; increase in casualties and an increased sense of urgency to immunize children in order to prevent outbreaks of diseases such as measles. Given the flexibility built in project design, the CSDO, working with the MOH project management team and other partners, have identified specific needs from IDPs in both Upper Nile and Jonglei; and responded by ensuring that medicines are airlifted to areas of urgent need; and readjusting work plans for the next few months to focus on ensuring availability of health care workers and medical supplies.

34. Despite the challenging environment within which the original project provides its support, the project is making a real difference in changing people's lives for the better. The project's innovative design is cognizant of the need to work with the limited capacities of MOH while gradually strengthening capacity at all levels. In an innovative way, the project supports a performance based contract with a service delivery organization which is tasked with delivering a specific set of results, and must do so within an agreed timeframe. For the first time in their lives, women in some of the most remote areas of the country that are accessible for only part of the year, have a chance to deliver in a health facility that is staffed by trained birth attendants. Children are immunized in facilities with a cold chain supported by the project; they receive treatment for basic illnesses and medication for malaria from a pharmacy supported by the project. The remote areas that the project reaches are accessible for only a few months a year, poor roads make transport of medical supplies or of patients impossible. Transport via the river is time consuming and infrequent; and demands that a health facility secures sufficient resources for boat hire and fuel which are usually not available because health care facilities budget usually do not cover either. In most cases, women and their families must pay out of pocket unless they can access a nearby health facility for services.

35. The project design ensures that strategic planning and flexibility allow for immunization of children to occur in the dry season where community outreach campaigns provide the platform to educate the population and create demand for not only immunization but also other

health services. Through the project, health care workers in Asosa in Upper Nile have a pharmacy with medications needed to handle the needs of their community and for the first time women in Kodok can deliver in a health facility and returnees from Sudan can receive much needed nutrition supplementation for their children. It is with the support of the project that 80% of health facilities in the two states now send reports to their County Health Departments who send electronic reports to the State MOH. This has been made possible through training in HMIS; investment in IT equipment including V-sat equipment and hands-on support of the CSDO in the county. Most importantly, not only is this data transmitted to the central MOH, training is being provided so that there is sufficient capacity for data cleaning, analysis and use. The capacity of the MOH in monitoring project activities has increased, and its involvement in coordinating the various partners working in the sector has also grown resulting in improvements in distribution of partner support across geographical areas. While the bulk of health care is still provided by NGOs, there is improved capacity of some County Health Departments which are increasingly working independently to manage care in their counties.

Risk

36. The overall operating environment and implementing agency risks were already high for the ongoing project. The team assesses that the same applies to the proposed AF which might be implemented during a period of increased insecurity and deepening fragility. In addition to the risks that had been identified, such as possible lack of commitment, lack of technical capacity as well as lack of fiduciary management capacity, the recent eruption of fighting will not only exacerbate these risks but could also present new ones. One of these new risks is the possible capture of resources or restriction of access to health services by one side of the dispute. This is partly mitigated by the fact that services that will be supported by the proposed AF are very basic health services that are unlikely to attract the attention of the elite. The risk of restricted access to health services is partially mitigated by the fact that the Government has remained fully committed throughout the preparation of the proposed AF and has made a firm commitment to ensure that the population of these two states has access to health services as do populations of other states not affected by the fighting.

37. Continued dialogue between not only the Bank and the Government, but also between the Government and all actors in the sector who as a group have leverage to influence decision making in the sector, is critically important. Coordination between the Bank, DFID, USAID, UN agencies and other partners is critical in order to ensure that the needs of the population continue to be met. This will also mean even closer coordination between the three Coordinating and Service Delivery Agencies funded through contracts by the Bank, DFID and USAID. Exchange of information through the Health Cluster (which brings together MOH with all partners in the sector) is active in coordination and sharing of information relevant to the sector.

38. The team has identified the following risk management strategies to ensure that project activities remain on track and that any necessary change of course is identified and acted on in a timely manner: (i) the need to hold more frequent portfolio reviews of all projects being implemented in the country under similar environment; and (ii) identifying emerging risks and appropriate corrective responses during a period of anticipated deepening fragility. Together with

the Government, the Bank team has also identified the following as alternative or additional activities that could be supported by the project should it not be possible to implement the current range of proposed activities. These include: i) Purchase and distribution of pharmaceuticals for the ten states; ii) In collaboration with the IFC, strengthening the national pharmaceuticals system; and iii) Further activities to strengthen the capacity of the Central MOH to manage grants, and improving the capacity of SMOH and CHDs to manage local service delivery including training in financial management.

Fiduciary Management

39. The Project's financial management is satisfactory, Financial Management (FM) arrangements are adequate and project FM risk is moderate. The last FM field supervision in April 2013 as well as continuous desk reviews did not indicate any significant internal control or accountability issues. There are no outstanding reports and the Interim Financial Report (IFR) for the period ended September 30, 2013 has been received and reviewed by the Financial Management Specialist. Following the closure of the Project Financial Management Unit that was responsible for financial management of projects under the MDTF-SS, ongoing projects under the SSTTF jointly fund a Financial Management Consultant who, in addition to FM consultants based in the Ministries and working directly on the project, oversees all FM issues for projects under implementation. The first audit for the project was due on December 31, 2013 and was completed. Procurement performance is satisfactory and procurement arrangements will remain the same under the proposed additional financing.

40. The performance of the project management team is also satisfactory. The project team is in place and comprises the Project Manager, Financial Management Specialist, Procurement Officer, Health Planner, and Monitoring and Evaluation Specialist. To build the capacity of State MOHs, the project is supporting a State Health Advisor for Upper Nile State. Due to insecurity, recruitment of a State Health Advisor for Jonglei has been more challenging and MOH efforts to recruit for this position are ongoing. It must be noted that 80% of the project management team is South Sudanese, and the team works closely with the international CSDO and the independent monitoring and evaluation firm contracted by the MOH. The aim is to ensure that local skills and capacity to manage programs and implement policies are improved through learning by doing and skills transfer.

Rationale for Additional Financing

41. Consistent with the World Bank Guidelines for Additional Financing under OP 10.00, Investment Project Financing, The AF is intended to address both a financing gap and for scaling up the development effectiveness of the project. The financing gap has resulted from drastic changes in the budget after the project was approved. Following the shutdown of oil production in 2012, the country adopted austerity measures, which have had significant ramifications on project cost and its effective duration. Before the austerity measures, about 50% of primary health care facilities in project supported states were to be financed by the Government, and the project was designed and costed in such a way that project funds could fill gaps and would be

additional to Government resources. Changes in Government financing resulted in faster than projected expenditures under the Project, therefore, there is a need for additional resources to ensure the delivery of basis services in those states after January 2014. The AF is also intended to extend coverage of a select range of activities under the Project from January 1, 2014 to October 31, 2015 in the same geographical areas in the two states. Thus, another justification for the AF it that it would support the "implementation of additional or expanded activities that scale up a project's impact and development effectiveness". The AF is a better mechanism to maximize the development impact and results of the project compared to a repeater project, a completely new operation or non-lending instruments. This is mainly because the AF would rely on the existing well performing implementation and institutional arrangements and capacity of the Ministry of Health (MOH), which would ensure speedy disbursement and timely achievement of the development objectives. The Borrower is highly committed to extending project activities since these are crucial for ensuring continuity in the delivery of quality health services to the most vulnerable women and children.

42. The proposed AF is aligned with the Bank's Interim Strategy Note (FY 2013-2014) for the Republic of South Sudan. The additional financing is consistent with the ISN's accompanying work program's Cluster 1 which focuses on improving economic management and governance for effective local service delivery. The original project and this AF are also aligned with the 2011 World Development Report on Conflict, Security and Development. The original project and this additional financing will continue the Africa Region Strategy whose focus includes: (i) fragile states, (ii) increasing household resilience and decreasing their vulnerability to health shocks (pillar 2); (iii) public sector capacity and use of ICT to improve accountability; and (iv) strengthening monitoring and evaluation. The additional financing is in line with the Government's Health Sector Development Plan (HSDP) (2012-2016) whose mission is to improve the health status of the population and provide quality health care to all, especially the most vulnerable women and children. The proposed AF is fully consistent with the Bank's twin goals to end extreme poverty and promote shared prosperity. It will make a direct contribution to reduce maternal morbidity and mortality; reduce childhood illness and reduce vulnerability to economic shocks arising from high household spending on health care.

43. The original project, and the proposed AF, is part of the Bank's multi-pronged response to long term needs of building structures that can deliver health services while at the same time responding to the basic health needs of the population. Jonglei and Upper Nile were two of the most challenging states to work in even before the recent fighting. The two are also the most affected by recent fighting. The original project and this AF proposal are aligned with activities of other donors who prioritize PHC services; and respond to the request by the Government to focus on these two states in order to ensure equity in distribution of donor resources. The Health Pooled Fund's Basic Services Fund (a pool funded by DFID; EC; CIDA, SIDA, Australia and Spanish Aid Agency) focuses on Western Bahr El Ghazal; Northern Bahr El Ghazal; Warrap, Lakes, Unity and Eastern Equatoria states; while the Sudan Health Transformation Project funded by USAID supports Western Equatoria and Central Equatoria. The proposed AF will continue to support these two states of Upper Nile and Jonglei as requested by the MOH in 2011, and as agreed by all other partners channeling assistance to the health sector.

Sustainability

44. When South Sudan gained independence in July 2011, the new nation began a new chapter facing numerous challenges, comparably more resources but with weak institutions to manage its wealth, ensure peace and stability, and drive its development agenda. Despite health being a priority for the Government, budget allocations to the health sector have been low, and realistically, prospects for improvements in allocation to the sector are poor. Sustainability risk is high. Recently erupted fighting, just at the time when the macroeconomic environment was improving, has reduced the prospect that the sector would at last begin to receive a larger proportion of the budget. It is clear that support to the sector, both from the Bank and other partners, will be needed for a longer period while capacity is built and with support targeting service delivery. The proposed AF will ensure the continuity of basic health services in the two states of Upper Nile and Jonglei, and in addition will continue to provide the support needed to strengthen the Government's ability to be a steward of the sector. Strengthening of the Government's abilities to manage service delivery at all levels is a critical area in order to ensure sustainability, value for money and quality of services. Without the proposed AF, basic services in the two states will be disrupted and health outcomes will worsen as the Bank is the main source of support for the two states following an agreement with other partners. In addition to the proposed AF, the Bank is also working with the Government on a health sector Public Expenditure Review in order to better understand budget setting and expenditure in the sector. This is part of the technical and analytical support that will provide tools needed to begin dialogue on sustainability of basic health services for the population.

III. PROPOSED CHANGES

45. The original PDOs would remain unchanged under this AF. However, the outcome indicator target values would be adjusted to track progress during the extended period of implementation between 1st January 2014 and 31 October 2015[1]. Implementation arrangements will remain the same as under the original project; and will build on the capacity of the Ministry of Health (MOH), which has so far ensured speedy disbursement and timely progress towards the achievement of development objectives. Given the longer period of implementation, a Mid-Term Review will be undertaken by May 2015.

46. The AF will continue to support the same activities as the ongoing HRRP. The AF will support activities under Component 1 (Delivery of High Impact Health Services in Jonglei and Upper Nile State US$23 million, revised amount with AF is US$54.2 million), in particular the Ministry of Health (MOH) performance-based contract with a Coordination and Service Delivery Organization (CSDO) to improve the delivery of high impact primary health care services in Upper Nile and Jonglei. The primary health care services to be supported include maternal and child health services such as vaccination, prenatal care, skilled birth attendance and basic curative care. The CSDO will also extend the current design of the performance based

[1] A Project Preparation Advance of US$4.0 Million became effective in December 2013 and is financing a performance based service delivery contract between the Government and the Coordination and Service Delivery Organization for services to be delivered between January 2014 and March 2014.

contracting model to more counties and cover wider geographical areas within Jonglei and Upper Nile states.

47. Under Component 2, Capacity development of MOH at the national level (original amount US$ 5 million, revised amount with AF is US$8.8 million) the AF will continue to support Strengthening Grant and Contract Management: The project will support the strengthening of the MOH's capacity to plan, manage, and monitor grants and contracts. The grant and contract management function will be housed in the Directorate of International Health and Coordination at the MOH which will be strengthened by: (i) continuing to support qualified South Sudanese staff to work with the MOH; (ii) providing the logistical and office support for the unit; and (iii) strengthening the technical skills of the unit through training and south-south visits. It will also support some activities bolstering the Monitoring and Evaluation Function. The Project will ensure that there is a steady stream of independent and credible data on health sector performance. This will involve building on recent experience and financing a health facility survey (HFS) and a household survey using lot quality assurance sampling (LQAS) every year. These surveys are nationwide in scope but provide estimates that are robust at state level, as well as strengthening the capacity of the MOH's Directorate of Policy, Planning and budgeting so that they can effectively analyze the data to track the progress made towards health sector targets.

48. Monitoring and Evaluation strategy for the project and AF will be adapted to monitor progress and track project achievements during the longer period of implementation. Outcome indicator target values will be adjusted to track progress during the extended period of implementation between 1st January 2014 and 31 October 2015. The table in Annex 1 summarizes proposed changes for PDO indicators. The project will also continue to support verification of activities of the CSDO in the extended period of implementation and will support an additional household survey to capture data at that level following 18-24 months of implementation. These data collection activities will be coordinated with other surveys that are planned, including those supported by other partners. Data collection activities, including the frequency of verification visits, will be adjusted to take on board lessons learnt from implementation under this component. This will include paying close attention to seasonality, access, costs and value for money.

Fiduciary Management

Procurement

49. The arrangements for procurement management under the original Project will remain unchanged. Procurement for the proposed project will be carried out in accordance with the World Bank's Guidelines: Procurement of Goods, Works and Non Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers, dated January 2011 and Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers, dated January 2011. The flexibilities in the procedures described in OP 10.00, will be used especially during the current crisis in order to ensure that service delivery and monitoring strategies are nimble and can respond as required. The MOH has developed a procurement plan at negotiations; this was reviewed and agreed by the Bank and

will be updated by the MOH annually or as needed throughout the duration of the project and all such updates will be subject to the Bank's prior review. The procurement plan for the use of PPA amount of $ 4.0 Million has already been prepared by the MOH and reviewed and cleared by the Bank. The procurement plan will be updated in agreement with the Bank Project team on an annual basis or as needed to reflect the actual project implementation needs. Due to limited procurement capacity, the support of the procurement officer will continue during the AF period. Keeping in view the overall country procurement environment due to the security condition in the country, the overall procurement risk is considered as High.

Financial Management

50. The financial management arrangements for the AF are similar to that of the original Project. The FM for the grant will be managed by the Project Management Unit (PMU) in the MOH. The Financial Management Specialist in MOH will continue to work closely with the Lead consultant at the smaller scale Project Financial Management Unit (PFMU) in the Ministry of Finance, Commerce, Investment and Economic Planning who also supports other projects under the SSTTF. The FM capacity in the MOH is being developed with support from the project by attaching two accounting staff in the MOH to work with the Project for on-the-job training and capacity development. The audit of the original project has been completed and was carried out by the Audit Chamber with support of an External Audit Agent. The audit arrangements will remain, and not later than six months after the Effective Date, the external auditor will be hired pursuant to terms of reference satisfactory to the Bank. Audits will be conducted in accordance with International Standards on Audit issued by the International Auditing and Assurance Board of the International Federation of Accountants (IFAC). The Financial Procedures Manual used for the PFMU will be updated and included in the Project Implementation Manual (PIM) for the project. The FM on-site supervision of the project was carried out in April 2013. The report, in addition to subsequent desk review of the IFRs did not indicate any major accounting or internal control issues. It also indicates that the financial management arrangement is sufficient for the project implementation. The Project FM risk is Moderate.

Disbursement

51. Disbursement arrangements under the original project have been found to be adequate and have ensured smooth disbursements to date. The Project FMS shall continue to submit payment requests to the Bank based on Direct Payment, Advances, and Reimbursements. Detailed disbursement arrangements as documented in the original Disbursement Letter will remain the same. Funds Flow and Banking Arrangements will remain the same under the AF; working with the FM Specialist under the project, the Lead FM Consultant in the Project Financial Management Unit (PFMU) in Ministry of Finance, Commerce, Investment and Economic Planning (MOFCIEP), will provide the day to day oversight of funds through the project's designated bank account denominated in US$ and located in a commercial bank. The funds flow process will continue to require that the Management Team in MOH carries out its due diligence on the activities of the Lead Agencies in accordance with criteria set under the grant and credit Agreements.

52. The proposed AF to the ongoing HRRP will be provided on a grant and credit basis; and will finance 100% of project expenditures, including taxes. There are no conditions of effectiveness.

Table 1: Financing Table and Project Costs by Component

Component	**Costs (USD million)**					**Costs (USD million)**				
	Original					**Revised**				
	FY12	**FY13**	**FY14**	**FYI5**	**Total**	**FY13**	**FY14**	**FY15**	**FY16**	**Total**
1. Delivery of high impact Health services	***2.3***	***11.2***	***8.4***	***1.1***	***23.00***	***12.65***	***19.79***	***20.67***	***1.09***	***54.20***
Service Delivery – *Upper Nile*	1.0	4.9	3.6	0.5	10.00	5.50	8.87	9.74	0.51	24.62
Service Delivery – *Jonglei*	1.3	6.3	4.8	0.6	13.00	7.15	10.92	10.93	0.58	29.58
2. Capacity Development of MOH at Central Level	***0.75***	***2.4***	***1.44***	***0.41***	***5.00***	***2.27***	***2.95***	***3.06***	***0.52***	***8.80***
Salaries	0.05	0.66	0.48	0.06	1.25	0.53	0.78	0.60	0.20	2.12
Equipment & Vehicles	0.30	0.09	0.05	0.00	0.45	0.00	0.00	0.00	0.00	0.00
Vehicles	0.00	0.00	0.00	0.00	0.00	0.13	0.07	0.00	0.00	0.20
IT Equipment	0.00	0.00	0.00	0.00	0.00	0.22	0.16	0.06	0.00	0.44
Workshops and Training costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.28	0.00	0.28
Training (PBC workshop)	0.00	0.12	0.12	0.00	0.24	0.12	0.12	0.00	0.00	0.24
M&E consulting firm	0.4	1.5	0.75	0.35	3.00	1.27	1.24	0.56	0.00	3.07
M&E activities	0.00	0.00	0.00	0.00	0.00	0.00	0.38	1.07	0.11	1.56
Audit	0.00	0.03	0.03	0.00	0.06	0.00	0.06	0.05	0.05	0.16
Operating Costs	0.00	0.00	0.00	0.00	0.00	0.00	0.14	0.44	0.16	0.74
3. Total cost	***3.05***	***13.6***	***9.84***	***1.51***	***28.00***	***14.92***	***22.74***	***23.73***	***1.61***	***63.00***

Summary of Proposed Changes

Change in Implementing Agency	Yes [ ] No [X]
Change in Project's Development Objectives	Yes [ ] No [X]
Change in Results Framework	Yes [X] No [ ]
Change in Safeguard Policies Triggered	Yes [X] No [ ]
Change of EA category	Yes [ ] No [X]
Other Changes to Safeguards	Yes [ ] No [X]
Change in Legal Covenants	Yes [ ] No [X]
Change in Loan Closing Date(s)	Yes [X] No [ ]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [ ] No [X]
Reallocation between Disbursement Categories	Yes [ ] No [X]
Change in Disbursement Estimates	Yes [X] No [ ]
Change to Components and Cost	Yes [ ] No [X]
Change in Institutional Arrangements	Yes [ ] No [X]
Change in Financial Management	Yes [ ] No [X]
Change in Procurement	Yes [ ] No [X]
Change in Implementation Schedule	Yes [X] No [ ]
Other Change(s)	Yes [ ] No [X]

Finance

Grant and Credit Closing Date - Additional Financing (South Sudan Health Rapid Results Project - Additional Financing - P146413)

Source of Funds	**Proposed Additional Financing Grant Closing Date**
International Development Association	31 October 2015

Allocations - Additional Financing (South Sudan Health Rapid Results Project - Additional Financing - P146413)

Source of Fund	**Currency**	**Category of Expenditure**	**Allocation**	**Disbursement % (Type Total)**
			Proposed	**Proposed**
IDA	USD	(1) Goods, works, consultants' services, non-consulting-services, Workshops and Training, and Operating Costs for the Project	31.00	100%
		(2) Refund of Preparation	4.00	100%

		Advance		
		Total	35.00	100%

IV. APPRAISAL SUMMARY

Economic and Financial Analysis
Explanation: ***Economic Analysis.*** The AF has the same economic rationale as the original Project. Given its current difficulty in generating and sustaining revenues from its main source (oil), the Government faces a challenge in making sufficient investments in health services. Compared to other countries in Africa, South Sudan is spending relatively little on health which has impeded its ability to ensure adequate access to even basic services for its predominantly rural population. In this context, the project and AF focus on those activities and interventions that are the most cost-effective focusing on provision of high impact interventions such as immunization, safe delivery; insecticide-treated bed nets, Vitamin A, tuberculosis treatment etc. and these remain the focus of the proposed AF. These interventions are the most cost-effective interventions available and are of singular importance in a country which has a disease profile like South Sudan‘s. In addition to focusing on the most efficient interventions, the proposed project will use approaches to service delivery that are low cost and thus more likely to be sustained. The value of the contracts under the project with the CSDOs was US$5 per capita per year; and for the proposed AF the value of the contracts with the CSDO per capita per year are even lower at approximately US$4.5. This is substantially less than what international NGOs are currently receiving for their work in South Sudan. It is comparable to the historical standard for such contracts with NGOs in low income countries even though South Sudan, and especially Upper Nile and Jonglei, is a particularly expensive environment to work in, at least partly due to high transportation costs and accessibility constraints.
Technical Analysis
Explanation: The technical design and fiduciary arrangements would remain the same as under the original project. Project supervision has shown that the technical basis of the Project is sound. The investment priorities would continue to focus on improving access to basic health services. The experience of implementation so far shows that contracting works and the Government has requested that the contracting of service delivery through the CSDO be continued because it recognizes the modest managerial capacity at local levels. Rationale for having one CSDO covering the whole state is sound. Since 2011, the Government has opted for using one CSDO per state recognizing that current large gaps in service delivery in all states are partly due to a large number of small grants and contracts that existed previously, as NGOs worked only in those areas they wanted to and were not held accountable for a coherent geographic area. The Government feels that contracts for a whole state have helped to eliminate the gaps in service delivery. A large number of

contracts would be more challenging for the MOH to manage. The institutional arrangements will remain the same as under the original Project. As such, activities to be undertaken as a result of this AF will be executed under the direction of the MOH and its Project Management Unit. The Project management team is comprised of the Project Manager, Financial Management Specialist, Procurement Officer, Health Planner, and M&E Specialist. To build the capacity of State MOHs, the Project is supporting a Planning Officer for the Upper Nile State. Due to security issues, recruitment for Jonglei State has been more challenging and MOH efforts to recruit for this position are ongoing. The team works closely with the international CSDO contracted by the MOH and the independent monitoring and evaluation firm contracted by the MOH. The aim is to ensure that local skills and capacity to manage programs and implement policies are improved through learning by doing and skills transfer.
Social Analysis
Explanation: The project will continue to meet the health needs of South Sudanese especially women and children who are very vulnerable by providing primary health care services such as vaccination, prenatal care, and skilled birth attendance. In addition to the resident population, the project will not only meet the needs of returning IDPs and refugees to Jonglei and Upper Nile states that have immense unmet health needs, but also respond to injuries and trauma arising out of conflict where required in order to save losses and lives. A key challenge at the implementation level is the potential risk of elite capture of key services especially given the operating environment which is characterized by low capacity and weak accountability mechanisms. The recent conflict has further limited the access to basic health services to populations rendered vulnerable due to ethnic identity, insecurity, inaccessibility, and information asymmetry. The mass campaign and outreach activities supported under the project will take these specific risks into consideration and make concerted efforts to reach the more vulnerable among the communities, to ensure benefits flowing to a larger population irrespective of location and ethnicity. The CSDO staff will be sensitized and made aware of these challenges, and equipped to seek greater participation of communities in mobilizing the more vulnerable to seek health services and also in monitoring delivery. The project will contribute to reducing the vulnerability of the poor to health related shocks but also influence positively the maternal and infant morbidity and mortality rates. OP 4.12 on Involuntary Resettlement is not triggered since minor renovations and upgrades are expected to be undertaken in existing facilities and there will be no taking of land under the project. Social impacts of proposed activities under the project will be addressed in accordance with the Environmental and Social Screening Assessment Framework (ESSAF) that was prepared for the original project. OP/BP 4.10 on Indigenous Peoples is triggered and is applicable to the project as analysis by World Bank and other experts confirms that the overwhelming majority of people in the project area are expected to meet the requirements of OP 4.10. The approach and implementation process of the proposed Project embeds the basic principles of OP 4.10 and ensures that benefits will flow to all households, and the campaign and outreach activities enables support for the project and participation of the entire community.
Environmental Analysis

Explanation: The original project only triggered World Bank Safeguard Policy OP/BP 4.01 (Environmental Assessment) and was assigned to environmental Category B-Partial assessment. Environmental issues pertaining to safe water supply, sanitation, waste disposal were expected to come up as minor renovation of existing functioning health facilities and health care activities. Since the proposed AF retains the same PDO and components as the original project, it is also an EA Category B project and OP 4.01 remains the only safeguards policy triggered. The original project only performed minor rehabilitation of existing functioning health facilities in both states, and there was no new construction. The main environmental safeguard issues relate to health care waste management, in view of the risks associated with the handling and disposal of medical waste. The Government of Republic of South Sudan has already prepared a Medical Waste Management Plan (MWMP) prepared in October 2011 and valid for a five-year period (2011-2016) which focuses on existing waste generation, as well as segregation, storage, collection, transport, and final disposal practices; technologies for waste disposal; public awareness programs; and relevant national legislation. During the original project implementation period no significant environmental impacts were identified and no safeguards non-compliance recorded and all the issues were managed by the best practice method stated in the ESSAF and MWMP. The MWMP has since been approved by the Bank and has been disclosed at Bank's Infoshop on February 10, 2014. An Environmental and Social Screening Assessment Framework (ESSAF) was prepared for the original project. This project-specific ESSAF explains the OPs triggered, safeguard screening and mitigation based on the possible types of sub-projects, responsibilities for safeguards screening and mitigation, capacity-building and monitoring of safeguards framework implementation, and consultation and disclosure. No long term risks or impacts were anticipated and no project alternatives have been identified during implementation and none are required for the AF. The anticipated impact will be addressed through this project-specific ESSAF and national Medical Waste Management Plan. The Environmental Health Directorate (EHD) under the MOH is a safeguard implementing body and still has a very limited capacity to take care of environmental and social safeguards issues. However, the Ministry, particularly the Environmental Health Directorate, has been supported through training and capacity building activities to strengthen available capacity for managing the environmental and health issues. This Directorate (EHD) has received and will continue to receive required technical expertise from the project for implementing the MWMP and preparation of ESMP, as required.
Risk
Explanation: The attached ORAF (Annex 2) assesses the overall rating of the ongoing HRRP and AF as High due to overall substantial operating environment risks and implementing agency risks. Under the ongoing project, the team has taken a number of measures to mitigate these risks as described in the ORAF. Mitigating factors are Government's strong commitment, the PMU demonstrated capacity to fulfill Bank's fiduciary requirements, and the satisfactory progress in the implementation of the ongoing HRRP. Project stakeholders' risks are being mitigated by continuous involvement of authorities at local level and from community beneficiaries. Implementing agency risks are shaped by continued shortage of qualified professional staff at central and state level. These will be

mitigated by continuing support for institutional capacity by filling key positions and providing technical assistance, especially in the areas of planning, management, and M&E. FM risks remain substantial, the country's FM system remains very weak. This is mitigated by the presence of a Lead international financial management expert supporting the Financial Management system of the project as well as others supported by the SSTTF. The Lead Consultant under the PFMU will continue to support the MOH in efforts to strengthen the Financial Management system. Two FM accountants from the Ministry of Health will also be assigned to work with the project.

Delivery monitoring and Sustainability risk: There continues to be lack of data collection and analytical capacity, though data availability will improve under the support of the project. Use of available data will probably remain a concern, and this will likely continue to affect decision-making during project preparation or implementation. This is being mitigated by hands on participation of MOH staff in design of surveys supported by the project and direct involvement of the Department of Planning in data collection, and analyses efforts. In fact, the project's strong focus on results and payment on the basis of results has created demand for reliable data not just for project monitoring but for policy planning overall. Sustainability risk remains high as the Government of South Sudan investments in the sector remain low. Originally, the project was designed to support health services in two states for a period of 31 months (though service delivery was for only 12 months given austerity measures adopted as a result of weakening macroeconomic environment). The AF of US$35 million will extend service delivery support for 18 additional months. It is expected that the Government of South Sudan will require significant donor support in the health sector for the foreseeable future. South Sudan is now a full member of the World Bank; and as a member, it will benefit from IDA 17 funds part of which could be allocated to continue the support of the health system.

ANNEX 1: RESULTS FRAMEWORK AND MONITORING

SOUTH SUDAN: HEALTH RAPID RESULTS PROJECT

Results Framework

Revisions to the Results Framework		Comments/ Rationale for Change
PDO		
Current (PAD)	*Proposed*	
(i) to improve delivery of high impact primary health care services in Upper Nile and Jonglei states; and (ii) to strengthen coordination and monitoring and evaluation capacities of the MOH.	No proposed changes.	N/A
PDO indicators		
Current (PAD)	*Proposed change**	
1. Number and Percentage of children who received DPT3 before 23 months of age	Number and Percentage of children who received DPT3 before 12 months of age. Added an end of project target.	This is the indicator that the MOH tracks, and has requested that all projects supporting services delivery in the states adopts the 12 months reference period. Extended period of implementation.
2. Number and Percentage of pregnant women receiving ≥1 antenatal care;	Added an end of project target.	Extended period of implementation.
3. Percentage of health facilities submitting standardized HMIS monthly reports within one month of the reporting month	Added an end of project target.	Extended period of implementation.
4. Number of out-patient visits per capita per year	Added an end of project target.	Extended period of implementation.
5. Number of direct	Added an end of project target.	Extended period of

Revisions to the Results Framework		Comments/ Rationale for Change
project beneficiaries of which female (%)		implementation.
Intermediate Results indicators		
Current (PAD)	*Proposed change**	
6. Number and percentage of children 12 to 59 months who received a Vitamin A supplement in the previous 6 months	Added an end of project target.	Extended period of implementation.
7. Number and percentage of children who received measles before 59 months of age	Number and percentage of children who received measles before 12 months of age. Added an end of project target.	This is the indicator that the MOH tracks, and has requested that all support in the states follows. Extended period of implementation.
8. Number and percentage of births attended by skilled health workers	Added an end of project target.	Extended period of implementation.
9. Contraceptive prevalence rate (modern);	Added an end of project target.	Extended period of implementation.
10. Pregnant women living with HIV who received antiretroviral to reduce the risk of MTCT (number)	Added an end of project target.	Extended period of implementation.
11. Percentage of children aged 0-59 months sleeping under an insecticide-treated net (LLIN) the night before the survey	Added an end of project target.	Extended period of implementation.
12. Percentage of health centers with at least two skilled health workers	Added an end of project target.	Extended period of implementation.
13. Percentage of facilities having essential drugs at the time of supervisory visit	Added an end of project target.	Extended period of implementation.
14. Percentage % of health facilities with structured supervision	Added an end of project target.	Extended period of implementation.

Revisions to the Results Framework		Comments/ Rationale for Change
visit (using QSC) within a month before the verification visit		
15. Average score of quality of care –QSC	Added an end of project target.	Extended period of implementation.

*** Indicate if the indicator is Dropped, Continued, New, Revised, or if there is a change in the end of project target value**

REVISED PROJECT RESULTS FRAMEWORK[2]

PDO Level Results Indicators	Core	Unit of Measurement	Baseline Original Project Start (2012) UN	Progress To Date (Sept 2013) UN	Baseline Original Project Start (2012) Jonglei	Progress To Date (Sept 2013) Jonglei	EOP Cumulative Target Values				Freq.	Responsibility for Data Collection/ Comments	Data Source/ Methodology
							2014 Original UN	2015 Revised UN	2014 Original Jonglei	2015 Revised Jonglei			
1. i. % of children who received DPT3 before 12 months of age ii. Children immunized (number)	X		20.8% 7134	48% 19275	22.7% 9852	32% 17454	28% 14943	28% 14943	30% 21513	30% 21513	Annual	MOH SMOH CHD	HMIS HHS
2. i. % of pregnant women receiving ≥1 antenatal care ii. Pregnant women receiving antenatal care during a visit to a health provider (number)	X		41.4% 14200	42% 16913	25.3% 10980	31% 16938	45%	40% 21347	30%	36% 25816	Annual	MOH SMOH CHD	HMIS HHS
3. % of functional health facilities submitting standardized HMIS monthly reports within one month of the reporting month	☐		62%	94%	67%	83%	75%	75%	75%	75%	Annual	MOH SMOH CHD	HMIS, QSC, HHS
4. Outpatient visits per capita per year	☐		0.1	0.3 400250	0.1	0.3 537834	0.4	0.4 533666	0.4	0.4 717112	Annual	MOH SMOH CHD	QSC, HFS
5. Direct Project Beneficiaries (number), of which female (%)	X		TBD	430402 55.9%	TBD	572256 55.3%	TBD	572256 56.2%	TBD	772330 55.9%	Annual	MOH SMOH CHD	QSC HFS

[2] Targets under the AF period are modest and are kept at original levels due to current crisis.

PDO Level Results Indicators	Core	Unit of Measurement	Baseline Original Project Start (2012) UN	Progress To Date (Sept 2013) UN	Baseline Original Project Start (2012) Jonglei	Progress To Date (Sept 2013) Jonglei	EOP Cumulative Target Values				Freq.	Responsibility for Data Collection/ Comments	Data Source/ Methodology
							2014 Original UN	2015 Revised UN	2014 Original Jonglei	2015 Revised Jonglei			
INTERMEDIATE INDICATORS													
6. Number and percentage of Children 12 to 59 months who received a Vitamin A supplement in the previous 6 months	X		34.6% 11868	40% 104438	14.3% 6206	40% 104339	50% 126746	50% 126746	50% 170314	50% 170314	Annual	MOH SMOH CHD	HMIS HHS
7. Number and percentage of children who received measles before 12 months of age	☐		32.8%	66% 26352	22.3%	47% 25141	28% 14943	45% 24015	30% 21513	37% 26533	Annual	MOH SMOH CHD	HMIS HHS
8. Number and percentage of births attended by skilled health workers*	☐		31.2% 10702	4% 2199	7.2% 3125	5% 2438	35% 12005	7% 3736	10% 4340	7% 5020	Annual	MOH SMOH CHD	HMIS HHS
9. Contraceptive prevalence rate (modern)	☐		5.5%	1.1%	3.5%	0.6%	6%	1.5%	4%	0.8%	Annual	MOH SMOH CHD	HMIS HHS
10. Pregnant women living with HIV who received antiretroviral to reduce the risk of MTCT (number)	X		28	-	36	-	50	TBD**	60	TBD	Annual	MOH/SMOH/CHD	HMIS
11. Percentage of children aged 0-59 months sleeping under an insecticide-treated net (LLIN) the night before the survey	☐		32.4%	-	37.0%		40%	TBD	45%	TBD	Annual	MOH/SMOH/CHD	HMIS, HHS

PDO Level Results Indicators	Core	Unit of Measurement	Baseline Original Project Start (2012) UN	Progress To Date (Sept 2013) UN	Baseline Original Project Start (2012) Jonglei	Progress To Date (Sept 2013) Jonglei	EOP Cumulative Target Values				Freq.	Responsibility for Data Collection/ Comments	Data Source/ Methodology
							2014 Original UN	2015 Revised UN	2014 Original Jonglei	2015 Revised Jonglei			
12. Percentage of health centers with at least two skilled health workers	☐		TBD	84%	TBD	60%	TBD	70%	TBD	60%	Annual	MOH SMOH CHD	QSC HFS
13. Percentage of facilities having essential drugs at the time of supervisory visit	☐		50.0%	68%	70.0%	56%	55%	55%	56%	56%	Annual	MOH SMOH CHD	QSC HFS
14. Percentage % of health facilities with structured supervision visit (using QSC) within a month before the verification visit	☐		TBD	92%	TBD	60%	60%	60%	60%	60%	Annual	MOH SMOH CHD	HMIS HHS
15. Average score of quality of care –QSC	☐		TBD	73%	TBD	60%	+12%	64%	+12%	60%	Annual	MOH SMOH CHD	QSC HFS

* The original baseline were based on household survey which is likely to capture skilled birth attendance in communities; the progress to date is from HMIS which only captures skilled births attendance in facilities only. **The next household survey is planned for 2014 and will provide more information.

Notes:

1. **Due to the current crisis, targets under the AF period are modest and have been kept at original target levels. According to United Nations Office for Humanitarian Affairs (7-10 February 2014) an estimated 723, 900 people are internally displaced. Approximately 145,000 people have fled to neighboring countries; 84, 000 people from Jonglei are in Minkaman and 3,000 in Yirol Lakes State. 2013 population figures have been used. Data source for Population figures is the National Bureau of Statistics (NBS). These have been projected to 2013, Jonglei has a total population of 1,792,781 and Upper Nile 1,334,166. Of these 4% are under 1; 21% under the age of 5 years, 19% are aged 6-59 months and 4% are pregnant women. This has been used to calculate coverage; progress to date and targets. Note that calculation of progress the denominator takes into account the quarter (e.g. for 3rd quarter the denominator is (population *0.75).**
2. **Indicator 2 - HMIS data collects ANC1 and ANC4 data.**
3. **Indicator 4 - Outpatient visit is available from HMIS.**
4. **Contraceptives prevalence and number of births attended by skilled attendant to be obtained from HMIS and planned surveys.**
5. **Number of mothers provided PMTCT to be tabulated from HMIS.**
6. **Number of under five children sleeping under net night before survey to be obtained from surveys.**
7. **Values to be determined after detailed analyses of DHIS HMIS data in 2014.**

ANNEX 2: OPERATIONAL RISK ASSESSMENT FRAMEWORK (ORAF)

South Sudan : Additional Financing to Health Rapid Results Project

<table>
<tr><td colspan="7">Project Stakeholder Risks</td></tr>
<tr><td>Stakeholder Risk</td><td>Rating</td><td colspan="5">Moderate</td></tr>
<tr><td rowspan="2">Description:
The primary stakeholders are governments at national, state and county levels, the citizens and development partners. There could be a risk of lack of ownership, interest and involvement from health authorities at all levels. This could adversely affect sustainability in the medium to long term.</td><td colspan="6">Risk Management:
i) Obtain total commitment of health authorities at all levels: national, state and county; and (ii) adopt a participatory approach to program design and implementation. The service delivery component of the project comprises activities aiming at community empowerment and participation in the design, delivery, and evaluation of the high impact PHC services. It will also help create the demand for key services (e.g., EPI, family planning, use of LLINs, etc.) in the community through appropriate behavior change communication.</td></tr>
<tr><td>Resp: Client</td><td>Stage: All stages</td><td>Recurrent: ☐</td><td>Due Date :</td><td>Frequency: Continuous</td><td>Status: In progress</td></tr>
<tr><td colspan="7">Implementing Agency Risks (including fiduciary)</td></tr>
<tr><td>Capacity</td><td>Rating:</td><td colspan="5">High</td></tr>
<tr><td rowspan="2">Description:
At the MOH central level, lack of skilled personnel in both administrative and technical positions has been hindering the MOH's full budget execution capacity and fulfillment of stewardship functions (coordination, monitoring and evaluation, technical supervision, and fund raising). At the state MOHs, most of the key positions are not yet staffed and the lack of communication tools between state MOHs and central MOH makes it difficult for effective communication and coordination.</td><td colspan="6">Risk Management :
At the MOH-central level, the project will continue to support the project management team (project coordinator, procurement, FM, monitoring and evaluation and health planner) with the task to support the management of the project and to provide support to the MOH to fulfill the stewardship function of the sector. At the State MOH and County Health Department levels, the CSDO Lead Agency and the project will continue to support the position of a health adviser to assist the state MOH in both project supported states.</td></tr>
<tr><td>Resp: GOV. supported by partner</td><td>Stage: Implementation</td><td>Recurrent: ☐</td><td>Due Date :</td><td>Frequency:</td><td>Status: In progress</td></tr>
<tr><td>Governance</td><td>Rating:</td><td colspan="5">High</td></tr>
<tr><td>Description :
Ownership and commitment is evolving and expected to strengthen as project implementation progresses. The management contract with the lead agency may lead to misinterpretation of expected results and targets to be achieved and as a consequence, disagreements on the incentives.</td><td colspan="6">Risk Management :
The Task Team will continue to support the MOH's procurement, FM, M&E, primary healthcare delivery and policy setting, and coordination functions. For better contract management and coordination with external donors, the planning Department and the M&E Department will be strengthened.
(i) In addition to the existing Southern Sudan Anti-Corruption Strategy, 2010-2014 and Anti-Corruption Action Plan 2010-2014, which is being utilized in the country, the program will implement major surveys and strengthen HMIS to ensure value for money of services and results of interventions in the states. At the central level, Procurement and FM specialists recruited under the program will ensure the compliance of all contracts to the WB guidelines.
The reported results by implementing agencies will be verified by an independent entity and endorsed by a</td></tr>
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<tr><td></td><td colspan="6">steering committee. In case of disagreement, the implementing agency will be able to introduce a complaint. The project will continue to use the implementation manual which describes the modality of results verification as well the complaint mechanism.</td></tr>
<tr><td>Project Risks</td><td colspan="6">Resp: Client</td></tr>
<tr><td>Design</td><td>Rating:</td><td colspan="5">Moderate</td></tr>
<tr><td rowspan="2">Description :
Technical complexity: The design of the MDTF-SS funded health projects were overly ambitious in South Sudan’s extremely disadvantaged operating environment (no social and physical infrastructures due to civil wars, and limited data).

In the context of South Sudan with highly rural population and with badly developed road network, access and use of health services for majority of the population will remain challenging.</td><td colspan="6">Risk Management :
The original project incorporated lessons from projects implemented under the MDTF and has very simple PDOs (i.e., improving coverage of high impact PHC interventions and strengthening the stewardship function of the MOH) and specific result indicators. The project will further improve flexibility of implementing partners’ operation while adhering to the WB guidelines. The program also created more focus on M&E, capacity strengthening, with major surveys to measure performances of health service providers and improvement of HMIS.

In response to low levels of access and utilization, the project includes the organization of regular outreach services in every village especially during the dry season to rapidly increase availability and use of high impact PHC services such as vaccination, vitamin A supplementation, de-worming, distribution of Insecticide Treated Nets, and health promotion.</td></tr>
<tr><td>Resp: Client</td><td>Stage: Implementation</td><td>Recurrent: ☐</td><td>Due Date :</td><td>Frequency: Quarterly</td><td>Status: In Progress</td></tr>
<tr><td>Social and Environmental</td><td>Rating:</td><td colspan="5">Moderate</td></tr>
<tr><td rowspan="2">Description :
The project will support implementation of minor rehabilitation works for health facilities in target states and the project is rated category B. The legal and institutional frameworks in the country are not adequate to ensure compliance with the WB safeguard policy triggered.

Potential risk of elite capture of key services especially given the operating environment which is characterized by low capacity and weak accountability mechanisms.</td><td colspan="6">Risk Management :
The draft project specific Environmental and Social Screening Assessment Framework (ESSAF) was finalized within three months after the original project’s effectiveness. It will be used in tandem with the Medical/ Healthcare Waste Management Plan already prepared and will serve as guideline for mitigation measures.

Mass campaign and outreach activities supported under the project will take these specific risks into consideration and make concerted efforts to reach the more vulnerable among the communities,

CSDO staff will be sensitized and made aware of these challenges, and equipped to seek greater participation of communities in mobilizing the more vulnerable to seek health services and also in monitoring delivery.</td></tr>
<tr><td>Resp: GOV</td><td>Stage: Preparation</td><td>Recurrent: ☐</td><td>Due Date :</td><td>Frequency:</td><td>Status:</td></tr>
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<tr><td></td><td>and Partner</td><td>and Implementation</td><td></td><td></td><td>Quarterly</td><td></td></tr>
<tr><td>Program and Donor</td><td>Rating:</td><td colspan="5">Moderate</td></tr>
<tr><td rowspan="2">Description :
No co-financing, Other donors supporting the delivery of health services will be coordinated by the MOH. The additional financing to the project is 100% IDA financed and as much as possible the project will coordinate with other donors supporting a similar package of services in the remaining 8 states.</td><td colspan="6">Risk Management :
No co-financing from donors is envisaged in this proposal. The Task Team and the MOH will continue ongoing efforts to build on coordination mechanisms under the ongoing project.</td></tr>
<tr><td>Resp: MoH and the Bank</td><td>Stage: Implementation</td><td>Recurrent: ☐</td><td>Due Date :</td><td>Frequency:</td><td>Status: In Progress</td></tr>
<tr><td>Delivery Monitoring and Sustainability</td><td>Rating:</td><td colspan="5">Substantial</td></tr>
<tr><td rowspan="2">Description :
The original project was designed to support health services in two states for a period of 31 months. This short duration was due to the limited funds and it is expected that the Government of South Sudan will require significant donor support in the health sector for the foreseeable future.

Lack of data collection and analytical capacity. Lack of reliable data may affect decision-making during project preparation or implementation</td><td colspan="6">Risk Management :
South Sudan has become a full member of the World Bank and will likely benefit from additional IDA funds part of which could be allocated to continue the support of health system.

(i) Baseline data were established as part of project preparation; (ii) The program’s strong focus on results and its monitoring will continue to create the evidence on which the MOH can seek continuous funding on service delivery and institutional strengthening after the closure of the project; (iii) an independent monitoring firm has been hired to verify results</td></tr>
<tr><td>Resp: Both</td><td>Stage: Implementation</td><td>Recurrent: ☐</td><td>Due Date :</td><td>Frequency:</td><td>Status: Implementation</td></tr>
<tr><td colspan="7">4. Overall Risk</td></tr>
<tr><td>Overall Implementation Risk</td><td>Rating</td><td colspan="5">High</td></tr>
<tr><td colspan="7">A High risk rating was selected for implementation, due to the multiplicity of challenges associated with the implementation of the project in volatile political environment and lack of capacity of the client. This framework has identified the risk management tasks and processes that different stakeholders will undertake to reduce and manage these risks.</td></tr>
</table>