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Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 14-Nov-2023 | Report No: PIDA0250

BASIC INFORMATION

A. Basic Project Data

Project Beneficiary(ies)	Region	Operation ID	Operation Name
South Sudan	EASTERN AND SOUTHERN AFRICA	P181385	South Sudan Health Sector Transformation Project (HSTP)
Financing Instrument	**Estimated Appraisal Date**	**Estimated Approval Date**	**Practice Area (Lead)**
Investment Project Financing (IPF)	16-Nov-2023	19-Dec-2023	Health, Nutrition & Population
Borrower(s)	**Implementing Agency**		
Ministry of Health	Ministry of Health		

Proposed Development Objective(s)

To expand access to an essential package of health and nutrition services, develop health sector stewardship, and strengthen the health system.

Components

Component 1: Provision of Essential Health Services Nationwide
Component 2: Health Systems Strengthening
Component 3: Monitoring and Evaluation and Project Management
Component 4: Contingent Emergency Response

PROJECT FINANCING DATA (US$, Millions)

Maximizing Finance for Development

Is this an MFD-Enabling Project (MFD-EP)?	No
Is this project Private Capital Enabling (PCE)?	No

SUMMARY

Total Operation Cost	**359.50**
Total Financing	**359.50**
of which IBRD/IDA	**117.00**
Financing Gap	**0.00**

DETAILS

World Bank Group Financing

International Development Association (IDA)	117.00
IDA Grant	117.00

Non-World Bank Group Financing

Trust Funds	242.50
Trust Funds	242.50

Environmental And Social Risk Classification

High

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **The Republic of South Sudan emerged as the world's youngest country in 2011 after prolonged armed conflict with northern Sudan, which ended with the Comprehensive Peace Agreement in 2005.** In 2013, the nascent country experienced a civil war, which ended with a revitalized peace agreement in September 2018. As a result of these consecutive wars, the country has had approximately fifteen years of peace (1972 – 1982, and 2005 – 2011) since 1955, resulting in systematic underdevelopment and weak institutions. The sustained instability resulted in an accumulated loss in aggregate gross domestic product (GDP), equivalent to US$81.1 billion.[1]

2. **The civil war (2013-2018) further eroded South Sudan's development potential, worsened the humanitarian situation, and deepened vulnerabilities.** Although conflict formally ended in September 2018 with the signing of the Revitalized Agreement on the Resolution of the Conflict in the Republic of South Sudan (R-ARCSS), the country remains

[1] https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=SS

fragile and beset by development challenges. While a series of encouraging reforms have been undertaken to support longer-term stability and development outcomes, the country continues to struggle with the lingering impact of prolonged conflict including widespread levels of poverty, elevated violence in several areas, weakened institutions, untapped human capital, lack of access to basic services, food insecurity and a non-diversified economy. It is estimated that 2.2 million people remain internally displaced and 2.2 million South Sudanese refugees are still residing in neighboring countries.[2]

3. **South Sudan is one of the poorest countries in the world with over 80 percent of people living in poverty.** South Sudan's real GDP contracted by 2.3 percent in FY2021/22,[3] weighed down by a fourth consecutive year of flooding, lingering impacts of the COVID-19 pandemic, violence flareups, and higher food inflation due to global crises[3]. The 2022 Household Budget Survey estimates that poverty levels in South Sudan remain persistently high – at around 80 percent of the population, with 6 in 10 South Sudanese living in extreme poverty (below the food poverty line).

4. **South Sudan has the highest level of vulnerability and lowest level of climate adaptation capacity globally**, based on the European Union's 2022 INFORM Risk Index.[4] South Sudan is the seventh most riverine flood vulnerable country in the world in an average year and is entirely composed of river basins.[5] Conversely, the Country is also vulnerable to droughts, particularly in the eastern region. Due to the country's prolonged conflicts and resulting under development, which consequently limited infrastructure and weakened governance capacity, the country lacks capacity to adapt to climate change. As a result, South Sudan's routine annual flooding, is debilitating and constrains service delivery due to the country's extremely limited infrastructure.

5. **Eighty percent of South Sudan's population lives in rural areas where infrastructure is very limited, complicating service delivery, particularly during rainy season.** South Sudan's population is extremely dispersed, with an average density of 17.7 people per square kilometer, compared to the Sub-Saharan Africa average of 47.6. As a result, distances from communities to towns, and from Juba to states and counties are extremely long. Exacerbating accessibility challenges, South Sudan's road infrastructure is minimal, with one of the lowest densities of road network per kilometer in Sub-Saharan Africa. This road network is particularly limited outside of South Sudan's main cities. The roads that do exist are largely unpaved and many become muddy and impassable in the rainy season.

6. **The history of continued conflicts – both within South Sudan and in neighboring countries – has resulted in a significant number of refugees, asylum seekers, and internally displaced persons (IDPs) and created refugee camps and IDP settlements across the country.** According to UNHCR data as of August 31, 2023, South Sudan hosted 327,546 refugees, and 71,841 households with the vast majority – over 90 percent – located in two locations: Jamjang in

[2] UNCHR. August 31,2023
[3] https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=SS
[4] Inform risk Index, 2024: https://www.worldbank.org/en/news/immersive-story/2023/04/25/water-security-and-fragility-insights-from-south-sudan; and World Bank, Global Water Security and Sanitation Partnership, Rising From the Depths: Water Security and Fragility in South Sudan; May 2023. https://www.worldbank.org/en/news/immersive-story/2023/04/25/water-security-and-fragility-insights-from-south-sudan
[5] The country is composed of the Bahr el Ghazal, Bahr el Jebel, and Baro-Akobo-Sobat River Basins, which converge into a fourth, the Upper Nile river basin, which lace the country with a network of rivers and tributaries that flood annually. World Bank, Global Water Security and Sanitation Partnership, Rising From the Depths: Water Security and Fragility in South Sudan; May 2023. https://www.worldbank.org/en/news/immersive-story/2023/04/25/water-security-and-fragility-insights-from-south-sudan

Pariang County in the Ruweng Administrative Area and Bunj Town in Maban County in Upper Nile State[6]. The Sudanese refugee population is by far the largest, with 305,628 individuals, or 93 percent of the hosted population while the rest of the refugees come from Democratic Republic of Congo, Ethiopia, Central African Republic, Burundi, and Somalia. Almost 52 percent of refugees are female, and women and children represent 81 percent of refugees. Most – 60 percent – of refugees are under 18, with 38 percent between 18 and 59 and the remainder over 60. The prospect of these refugees returning to their countries of origin in the near term is limited, and the trauma endured, assets lost, and livelihoods destroyed in fleeing conflict in their host country has created unique development challenges for refugees in reestablishing their lives in South Sudan. Despite these challenges, refugees often have better access to basic services and support like health, education, and food rations in refugee camps administered by UNHCR than members of host communities, who tend to live in isolated areas where government services and market-based opportunities are either highly lacking or non-existent. Due to these deprivations, UNHCR makes specific efforts to support host communities to the extent that resources allow. The onset of the crisis in Sudan and the large number of arrivals in northern border areas has further exacerbated the need for resources addressing interventions around forced displacement in the country.

7. **Since becoming eligible for the WHR under IDA19, the Government of South Sudan has made progress in enhancing the welfare of refugees and host communities.** The promotion of durable solutions in South Sudan require a greater focus on implementing existing rights for refugees such as the right to work, movement, and access to public services provided through national systems. In this regard, South Sudan has made progress since WHR eligibility was established including expanding equitable economic opportunities in refugee-hosting areas, steps ensuring the integration of refugees into the national education system and the development of the Durable Solutions Strategy and Plan of Action for Refugees, Internally Displaced Persons, Returnees and Host Communities that was prepared in the context of the IDA19 WHR eligibility process. Finally, but crucially South Sudan has consistently honored its commitment to protecting refugees from both longstanding and recent conflicts in the Horn of Africa by granting refuge to hundreds of thousands of Sudanese and other refugees. A baseline assessment for South Sudan under the Refugee Policy Review Framework was prepared by the World Bank, UNHCR and the Government. It promotes and monitors the design and implementation of pro-refugee policy over time. The World Bank, following consultation with UNHCR, confirms that the protection framework for refugees continues to be adequate in South Sudan', in accordance with WHR requirements[7].

Sectoral and Institutional Context

Health Sector Outcomes

8. **South Sudan's health outcomes rank among the poorest in the world.** As of 2021, life expectancy at birth is one of the lowest in the world, estimated at 54.98 years,[8] and the under-five mortality rate rwas 98.69 per 1,000 live births

[6] UNHCR Operational Data Portal https://data.unhcr.org/en/country/ssd
[7] UNHCR Refugee Protection Assessment, July 31, 2023
[8] World Bank. World Development Indicators. https://databank.worldbank.org/id/fef9176d?Report_Name=Macroeconomics-Workshop.

from 2017 to 2021.[9] The country has the highest neonatal mortality at 39.63 per 1,000 births.[10] The health system is systemically underdeveloped, with seventy-one percent of the population residing over five kilometers from the nearest health facility.

9. **South Sudan is one of the most hazardous places in the world to give birth** with the highest maternal mortality rate globally at 1,223 per 100,000 births.[11] This is driven by both demand and supply side constraints with only 41.8 percent of births taking place in facilities.[12] On the supply side, poor health facility infrastructure, limited availability of reproductive and maternal health services, lack of adequate medical supplies and pharmaceuticals, skilled health worker shortages, and inadequate arrangements for patient privacy act as barriers.[13] Notably, only 38 percent of CEmONC[14] facilities are partially functional and caesarian sections are only available in major urban areas, accounting for only 1 percent of all deliveries – much lower than the expected rate of necessary C-sections at around 10-15 percent.[15]

10. **Low demand for reproductive and maternal healthcare is a key barrier to reproductive and maternal health services**, and is attributed to limited awareness of the benefits for maternal healthcare (such as ANC and family planning), the additional unofficial cost of services, opportunity cost of time, transport conditions and safety issues, concerns about privacy at facilities, and long wait times. Consequently, approximately 86 percent of deliveries happen at home.[16,17] Cultural norms and a preference for larger families also dampen the demand for reproductive and maternal health services. Women and men both report preferences for larger families in general, but even when women show interest in family planning, they often they face barriers to access.[18] Furthermore, resistance to family planning has led to attacks against health care workers by husbands and fathers.[19]

11. **The country grapples with frequent disease outbreaks** exacerbated by conflict, persistent seasonal flooding, inadequate sanitation and water infrastructure, and a fragile health system. Preventable and curable climate sensitive diseases, such as malaria and cholera, are leading causes of death in the country. Additionally, measles poses a significant threat to the lives of the youngest and most vulnerable people. A widespread outbreak from January 2022 to February 2023 resulted in 4339 suspected cases including 388 (8.9%) laboratory-confirmed cases and 46 deaths (case fatality ratio: 1.06%).[20]

Health system and service delivery challenges

[9] World Bank. World Development Indicators. https://databank.worldbank.org/id/fef9176d?Report_Name=Macroeconomics-Workshop.
[10] World Bank. Mortality Rate – Neonatal: South Sudan. https://data.worldbank.org/indicator/SH.DYN.NMRT?locations=SS
[11] World Bank. Maternal Mortality Ratio. https://data.worldbank.org/indicator/SH.STA.MMRT?locations=SS
[12] UNICEF. USAID, UNICEF, and the United Kingdom Recommit to Preventing Child and Maternal Deaths in South Sudan. March 2023. https://www.unicef.org/southsudan/press-releases/usaid-unicef-and-united-kingdom-recommit-preventing-child-and-maternal-deaths-south.
[13] World Bank. Service Delivery ASA. 2022.
[14] World Bank. Empowering Girls and Women in South Sudan. 2022.
[15] WHO. n.d.
[16] Lawry et al. 2017
[17] Wilunda et al. 2016
[18] Lawry et al. 2017
[19] World Bank. Empowering Girls and Women in South Sudan. 2022.
[20] World Health Organization. Measles – South Sudan. 2023. https://www.who.int/emergencies/disease-outbreak-news/item/2023-DON440.

12. **Poor health outcomes are underlined by weak health service delivery.** Core health service delivery indicators are lagging. For example, based on data from a 2020 Lot Quality Assurance Survey, only 28.8 percent of expectant mothers received four antenatal care visits and 39.7 percent of mothers delivered with skilled birth attendants. Moreover, a mere 8.1 percent of mothers received postnatal care, essential for preventing newborn and maternal deaths. Similarly, only 11.5 percent of children received the diphtheria, tetanus, and pertussis vaccine before their first birthday, based on vaccination records, although this number increases to 43 percent when relying on reports from parents.

13. **South Sudan's health system is characterized by fragmentation and minimal Government engagement**. Since 2013, health service delivery in South Sudan has been supported through external financing from the World Bank through UNICEF and ICRC, the European Union (EU), GAVI through a consortium led by Crown Agents and bilateral donors, including the United Kingdom (UK), United States, Canada, and Sweden . While donors have strengthened coordination between the two geographical coverage areas, including delivering the same package of services and harmonizing monitoring along with the HRH incentive scheme, the two areas have separate management structures creating inefficiencies and coordination challenges. The Government's limited involvement has failed to fulfill its essential role as the steward of the health sector, including the critical coordination and facilitation role of financing and implementing partners exacerbating fragmentation in the sector.

14. **The Government contributes a mere 4 percent of its budget to health demonstrating its minimal commitment to the sector.** Low government contributions to the health sector since 2013 have led to the sector's chronic underfunding and undermine the system's sustainability. Household out-of-pocket expenditures on health exceed government expenditure, potentially reaching as high as 79 percent of total health expenditure. Robust data on household health-related expenditure is unavailable, but estimates suggest that the amounts are high, especially in urban areas. High out-of-pocket health expenditures are a significant constraint to accessing healthcare, also reinforcing inequities across socioeconomic groups, increasing household vulnerability to catastrophic expenditure, and undermining the principles of universal health coverage.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To expand access to an essential package of health and nutrition services, develop health sector stewardship, and strengthen the health system.

Key Results

- Number of health facilities providing at least 75 percent of the essential package of health services
  - Number of health facilities providing at least 75 percent of the essential package of health services in refugee / host community areas
- Percentage of Bomas covered by the Boma Health Initiative
  - Percentage of Bomas covered by the Boma Health Initiative in refugee / host community areas
- Increase in average health sector national level budget execution rate
- Composite health systems strengthening index (HSSI; measuring blood banks, laboratories, and supervision

structures) by project end

D. Project Description

15. **Component 1: Provision of Essential Health Services Nationwide (UNICEF and Competitively selected pharmaceutical procurement and logistics; US$ 320.77 million: US$100.71 million IDA (US$10.22 million IDA Grant and US$90.49 million WHR IDA and US$220.06 million Trust Funds (US$23.14 million SDTF and US$196.92 million MDTF)**. Component 1 will enhance delivery of essential health services nationwide through the CERHSPP and HPF, with a focus on improving service availability. It will deliver a selection of prioritized services from the Country's Basic Package of Health and Nutrition Services (BPHNS) including: child health; nutrition; maternal and neonatal health; Basic and Comprehensive Emergency Obstetric and Newborn Care (BEmONC and CEmONC); family planning and sexual and reproductive health services; Sexual and Gender Based Violence Services (SGBV); mental health; disability; infectious and noncommunicable diseases; emergency and surgical services; and Behavior Change Communication (BCC), health promotion, and education.
    The project will aim to expand access to health services for host communities and refugees, remote and rural populations, women, and other marginalized groups.

16. **Subcomponent 1.1: Delivery of high impact essential health and nutrition services Nationwide through Health Facilities (UNICEF; US$263.73 million: US$62.67 million IDA (US$0.0 million IDA Grant and US$62.67 million WHR IDA) and US$201.06 million Trust Funds (US$21.14 million SDTF and US$179.92 million MDTF)).** This subcomponent will deliver cost effective, high impact essential health and nutrition services through health facilities. The subcomponent will also support strengthened supervision, management, and on-the-job coaching for implementing partners and service providers through an integrated supervisory approach in which IPs develop CHD capacity, inclusive of health service delivery planning, supervision, and data entry into DHIS2. The sub-component will include planning and execution of outreach service with close attention to seasonal population movement patterns and access, using different forms of outreach (village visits, mass campaigns, etc.) and transportation (vehicle, boat, foot) based on these dynamics. Climate sensitive health service delivery and planning will be integral to the approach under this sub-component.

17. **Subcomponent 1.2: Boma Health Initiative (UNICEF; US$12.41 million: US$3.41 million IDA (US$0.0 million IDA Grant and US$3.41 million WHR IDA) and US$9.0 million Trust Funds (US$0.95 million SDTF and US$8.05 million MDTF)).** This subcomponent will invest in expanding and strengthening the BHI to deliver basic health services at the community level, in the context of South Sudan's extremely rural, climate vulnerable, conflict impacted, and dispersed population with limited road access. The focus on community-based interventions and health education activities have been identified among the priorities for refugees and host communities. Continuity of service delivery during the intense annual flooding and high heat in the country, is a primary impetus for this activity.

18. **Subcomponent 1.3: Pharmaceutical and Last Mile Delivery (UNICEF to a subcontracted competitively selected pharmaceutical procurement and logistics agency; US$13.41 million: US$3.41 million IDA (US$0.0 million IDA Grant and US$3.41 million WHR IDA and US$10.0 million Trust Funds (US$1.05 million SDTF and US$8.95 million MDTF)).** This subcomponent will finance a pharmaceutical supply agent (PSA) with the aim of improving the availability of essential medicines at health facilities through strengthened supply systems. The PSA will be responsible for: i)

country-wide pharmaceutical and medical supply distribution; and ii.) last mile logistics including delivery of medical supplies and pharmaceuticals. Implementing partners will be responsible for the storage, stock management, cold chain management, and rational use of pharmaceuticals at health facilities.

19. **Subcomponent 1.4: Climate Resilient Health Service Delivery (UNICEF; US$31.22 million: US$31.22 million IDA (US$10.22 million IDA Grant and US$21.00million WHR IDA) and US$0.0 million Trust Funds (US$0.0 million SDTF and US$0.0 million MDTF)).** The subcomponent will enable broad climate change adaptation through the project with the aim of minimizing the impact of climate change on the population, health system, and project in light of the immense impact of climate change on South Sudan's population and health system, through targeted investments. The sub-component will be closely coordinated with the Water Global Practice Climate Resilient Flood Management Project (P179169) and the South Sudan Energy Sector Access and Institutional Strengthening Project (P178891) and will be in coordination with through other UN agencies and partners.

20. **Component 2: Health Systems Strengthening (WHO; US$15.00 million: US$5.50 million IDA (US$1.78 million IDA Grant and US$3.72 million WHR IDA) and US$9.50 million Trust Funds (US$1.0 million SDTF and US$8.50 million MDTF))**.This component will undertake activities to strengthen South Sudan's health system to facilitate health service access and capacity improvements. The component will be implemented by the World Health Organization (WHO) and will focus on strategic mechanisms to strengthen services in South Sudan, given the low-infrastructure, conflict-impacted context.

21. **Sub-component 2.1: Health emergency preparedness and response, laboratory strengthening, and disease control (WHO; US$5.5 million: US$2.04 million IDA (US$0.66 million IDA Grant and US$1.38 million WHR IDA) and US$3.46 million Trust Funds (US$0.36 million SDTF and US$3.10 million MDTF))**. This subcomponent will improve the health system's ability to prepare for and respond to health emergencies and control diseases by strengthening emergency preparedness, laboratory, and disease control systems. It will build on the work conducted through the CERHSPP and needs identified in the National Action Plan for Health Security (NAPHS) 2020-2024.

22. **Sub-component 2.2: Blood Banking and Transfusion (WHO; US$2.50 million: US$0.93 million IDA (US$0.29 million IDA Grant and US$0.64 million WHR IDA) and US$1.57 million Trust Funds (US$0.17 million SDTF and US$1.40 million MDTF))**. This subcomponent will focus on strengthening the country's blood banking and transfusion system, which currently has very limited reach, impairing access to CEmONC and safe surgical services. It will: (i) develop guidelines for the proper collection, storage, transport, and use of blood for transfusions; (ii) build or strengthen existing blood banking services; (iii) develop systems and protocols for the transfer of blood products for transfusion; (iv) conduct community and donor sensitization on the collection use of blood products and develop low literacy visual tools and protocols for oral behavior change communication on the collection use of blood products to be used by health workers, emphasizing community level communication activities.

23. **Sub-component 2.3: Health Service Quality Improvement (WHO; US$2.5 million: US$0.83 million IDA (US$0.30 million IDA Grant and US$0.53 million WHR IDA) and US$1.67 million Trust Funds (US$0.17 million SDTF and US$1.50 million MDTF)).** This activity focuses on improving health service quality in South Sudan by addressing the challenges of very remote health facilities, shortage of qualified health workers, and a long history of low health service quality.

24. **Sub-component 2.4: Health Management Information Systems (WHO; US$2.50 million: US$0.93 million IDA (US$0.30 million IDA Grant and US$0.63 million WHR IDA) and US$1.57 million Trust Funds (US$0.17 million SDTF and US$1.40 million MDTF)).** This sub-component will focus on developing systems and procedures for the national Health Information System (HMIS) to standardize data collection, entry and cleaning, as well as instituting data quality improvement practices.

25. **Subcomponent 2.5: Health Sector Stewardship and Financing (WHO; US$2.00 million: US$0.77 million IDA (US$0.23 million IDA Grant and US$0.54 million WHR IDA) and US$1.23 million Trust Funds (US$0.13 million SDTF and US$1.10 million MDTF)).** This sub-component aims to enhance the health sector stewardship and financing capacities of the National and State level MoHs.
26. **Component 3: Monitoring and Evaluation and Project Management (Competitively selected TPM Agencies, PMU; US$23.73 million: US$10.79 million IDA (US$0.0 million IDA Grant and US$10.79 million WHR IDA) and US$12.94 million Trust Funds (US$1.36 million SDTF and US$11.58 million MDTF)).**Component 3 will finance costs related to monitoring and evaluation, and management of project activities. The project will ensure that independent and credible data on health service delivery, health service coverage, and commodities are generated and that the data are usable and used. This is critical to enable the World Bank, Government, and development partners to verify that resources are reaching the intended beneficiaries and potential harm is minimized.
27. **Subcomponent 3.1: Third Party Monitoring** (**Competitively selected TPM Agencies; US$13.75 million: US$6.15 million IDA (US$0.0 million IDA Grant and US$6.15 million WHR IDA) and US$7.6 million Trust Funds (US$0.8 million SDTF and US$6.8 million MDTF)).** The project will finance third-party monitoring of delivery of essential health services under subcomponent 1.1, and will build on arrangements through the CERHSPP, incorporating lessons learned from the project. The TPM arrangements will incorporate quarterly and periodic reporting at the frequencies described below:

    (a) Quarterly TPM Visits. All data collection methods will be administered during the same visits, at the frequency indicated. A phased approach will be used to support the expansion of TPM in the country, with initial sampling for quarterly and bi-annual assessments moving to a bi-annual census of health facilities once monitoring capacity is established, anticipated in year two.

    (b) Periodic TPM data collection:

    (i) Household coverage surveys every other year, planned as a baseline and endline survey in the project's three year timeframe[21]

    (ii) Citizen engagement survey collected at the household level, along with the coverage survey every other year.

28. **Subcomponent 3.2: Data analysis and visualization platform (Competitively selected TPM Agency; US$0.73 million: US$0.30 million IDA (US$0.0 million IDA Grant and US$0.30 million WHR IDA) and US$0.43 million Trust Funds (US$0.05 million SDTF and US$0.38 million MDTF)).** To facilitate data sharing and use, the sub-component will develop a data visualization and use platform focusing on visual representations of TPM and routine data. Linking of platforms, including DHIS2 and the Health Service Functionality (HSF) platform will be integral to the work.

[21] Given the planned project length of three years, this is a baseline and an endline survey. Potential timeframe changes would include interim surveys, which are planned to be light surveys focusing on key indicators.

29. **Subcomponent 3.3: Contract and program management capacity development (PMU; US$3.44 million: US$1.54 million IDA (US$0.0 million IDA Grant and US$1.54 million WHR IDA) and US$1.9 million Trust Funds (US$0.20 million SDTF and US$1.7 million MDTF)).** This sub-component will develop the capacity of the PMU to manage health service delivery contracts focusing on monitoring health service delivery performance and taking actions; resolution of disputes related to health service contracts; review and feedback on contractor deliverables; liaising with and coordinating with other relevant departments within the MoH to provide technical guidance to contractors; providing field-level supervision to contractors; and developing a contract management manual. The sub-component will also provide capacity development support for day-to-day and strategic program management of the PMU along with capacity development for specific technical areas as needed. The capacity development support will include developing systems, processes, and tools, needed for effective functioning of the unit. This sub-component will finance: (i) technical assistance and capacity development on contract, environmental and social risk, and program management; and (ii) the development of the contract management manual. Specialized experts will be recruited by the PMU to conduct capacity development activities.

30. **Subcomponent 3.4: Project management (PMU; US$5.81 million: US$2.80 million IDA (US$0.0 million IDA Grant and US$2.80 million WHR IDA) and US$3.01 million Trust Funds (US$0.31 million SDTF and US$2.7 million MDTF)).** This sub-component will finance the day-to-day operations of the PMU including project supervision, management and oversight. The subcomponent will support: i) PMU staff costs; ii) PMU project supervision and oversight; iii) environmental and social safeguards activities; iv) PMU office equipment, stationary, and other day-to-day operating costs; v) State MoH project supervisory visits; vi) costs of specialists needed to support the project; and vii) operational costs of the project steering committee.

31. **Component 4: Contingent Emergency Response (US$0 million).** The objective of this component is to improve the country's response capacity in the event of an emergency, following the procedures governed by Paragraph 12 of the World Bank Investment Project Financing (IPF) Policy. During the implementation of the CERHSPP, the CERC has been instrumental in responding to the nutrition and food insecurity crisis in South Sudan in a timely manner. There is a moderate to high probability that during the life of the project, South Sudan will experience a disease outbreak or health emergency with the potential to cause a major adverse economic and/or social impact which would result in a request to the World Bank to support mitigation, response, and recovery in the region(s) affected by such an emergency. In anticipation of such an event, this CERC provides a mechanism for the project to support mitigation, response, and recovery in the areas affected by such event. The CERC would allow the contracted agencies through the PMU to receive support by reallocating funds from other projects or other funding sources for eligible emergencies to mitigate, respond and recover from the potential harmful consequences arising from the emergency situation. Disbursements under this component will be subject to the declaration of emergency and the preparation of an "Emergency Response Operational Manual" by the contracted agencies / PMU, agreed upon by the World Bank.

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Area OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts

E. Implementation

Institutional and Implementation Arrangements

32. **The World Bank will set up a free-standing, multi-donor trust fund (MDTF).** Donor grant financing will be pooled to co-finance the WB IDA grant using IPF instrument though the MDTF. The timing and use of funds from donors will be governed by Administrative Agreements between the Bank and the donors. The WB will manage the program (IDA+TFs) through its operational policies, procedures, and safeguards.

33. **The World Bank will sign a Financing Agreement with the MOF for the IDA and TF resources.** This agreement, along with the program package will set out clearly the government responsibilities and contribution under the program.

34. **The MoH will contract UNICEF and WHO as management organizations. UNICEF will sub-contract NGOs to deliver the identified package of health services** and will provide robust, day-to-day supervision of the NGOs. UNICEF will be in place to maintain service delivery if conflict resumes/intensifies in the country. The sub-contracted NGOs will deliver the identified package of health services nationwide as per the required standards. WHO will implement health system strengthening activities to facilitate health service access and capacity improvements at national and state level.

35. **Third Party Monitoring agency/ies** will be contracted by the PMU, with WB oversight. The TPM conduct household and health facility surveys along with surveys to solicit community and patient feedback. TPM will submit quarterly monitoring reports to the PMU/WB.

36. **Flow of fund**. The funds for the project interventions and procurement of supplies will flow directly from the Bank to UNICEF, WHO, and the TPM agency/ies while the fund required for PMU salaries and operating expenses will flow from the Bank to the project designated account managed by the government.

37. **Establishment of a Project Management Unit (PMU) at the Ministry of Health** to manage health service contracting and the day-to-day engagement with the government, management organization, and donors. This PMU will include qualified and capacitated government and non-government staff covering the skill mix required including project

management, financial management, procurement and contract management, monitoring and evaluation and environmental and social safeguards. The PMU will be contracted by MoH, and reporting directly to the Undersecretary and will establish clear coordination mechanisms with the relevant departments at the national and State Ministries of Health. The PMU will be responsible for managing health service contracts, supervising project implementation, monitoring progress on results, and submitting quarterly Interim Financial and progress reports as per the WB templates. In addition, the PMU will contract, under WB supervision, technical assistance for capacity building activities based on needs assessment.

38. **A High-level Steering committee** (HSC) will be established to provide strategic direction, overall coordination and policy guidance on the sectoral challenges and future steps on service delivery, health financing, human resources for health, information system and medicines and supplies. The HSC will meet on a bi-annual basis and will consist of MoH, MOF, Donors, State level health ministers, UNICEF and WHO Senior management, and the WB.

39. **An operational steering committee (OSC) will be established** to provide routine oversight and technical guidance during project implementation. the OSC will be responsible for ensuring that the implementation of the project is carried out efficiently and with the necessary technical quality. The OSC will meet on a quarterly basis and will include MoH, PMU, Donors, UNICEF, WHO, TPM, and WB. Representatives of line ministries and relevant stakeholders will participate in meetings, as necessary. The PMU will serve as the Secretariat to the SCs, and it will be responsible for organizing meetings of the SCs based on directions received from the chairs.

40. **PMU capacity:** The current CERHSPP project is financing institutional capacity development at MoH through customized capacity building activities in the core areas of effective project management. These areas include: (i) financial management; (ii) procurement; (iii) monitoring and evaluation, contract management, and reporting; and (iv) social and environmental risk management. A PMU of 15 qualified members has already been established at the MoH and started engaging in oversight of core aspects of project activities including support for the DHIS2 system, supporting IPs with implementation of safeguard standards, developing social media platforms, supporting pharmaceutical distribution, review of reports, and participating in quarterly IP meetings. Along with on-the-job training, an individual training plan was developed, and successfully implemented. For the HSTP, a new PMU will be established through open and competitive recruitment process. MoH will carry out the recruitment process under close supervision of the bank team. Current PMU team will provide good candidates for the new PMU. A Project Implementation Manual (PIM) will be prepared, describing the main activities - to be carried out by the PMU - and implementation modalities.

CONTACT POINT

World Bank

Amr Elshalakani
Senior Health Specialist

Abeyah A. Al-Omair
Senior Public Health Specialist

Moustafa Mohamed ElSayed Mohamed Abdalla
Senior Health Specialist

Borrower/Client/Recipient

Ministry of Health
Yolanda Awel Deng Awel Deng, Minister of health , anyezam.ad@gmail.com

Implementing Agencies

Ministry of Health
Yolanda Awel Deng, Minister of Health , anyezam.ad@gmail.com

FOR MORE INFORMATION CONTACT

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

APPROVAL

Task Team Leader(s):	Amr Elshalakani, Abeyah A. Al-Omair, Moustafa Mohamed ElSayed Mohamed Abdalla

Approved By

Practice Manager/Manager:		
Country Director:		