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Report No: PAD00197

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A
PROPOSED GRANT
IN THE AMOUNT OF SDR 89.1 MILLION
(US$117 MILLION EQUIVALENT)
OF WHICH
SDR 80 MILLION
(US$105 MILLION EQUIVALENT)
FROM THE WINDOW FOR HOST COMMUNITIES AND REFUGEES

TO THE
REPUBLIC OF SOUTH SUDAN

FOR A
SOUTH SUDAN HEALTH SECTOR TRANSFORMATION PROJECT
DECEMBER 6, 2023

Health, Nutrition and Population Global Practice
Eastern and Southern Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective Oct 31, 2023)

Currency Unit =	South Sudanese Pound (SSP)
SSP 1,040.00 =	US$1
US$1 =	SDR 0.76
SDR 1 =	US$1.31

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Victoria Kwakwa
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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
BHI	Boma Health Initiative
BHW	Boma Health Worker
BHT	Boma Health Team
BPHNS	Basic Package of Health and Nutrition Services
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CEN	Country Engagement Note
CERC	Contingent Emergency Response Component
CMR	Clinical Management of Rape
COVID-19	Coronavirus Disease 2019
CRA	Commission for Refugee Affairs
DHIS2	District Health Information Software 2
ESF	Environmental and Social Framework
ESMAP	Energy Sector Management Assistance Program
ESMF	Environmental and Social Management Framework
EU	European Union
FCDO	Foreign, Commonwealth and Development Office
FCV	Fragility, Conflict and Violence
FM	Financial Management
Gavi	Gavi, the Vaccine Alliance
GBV	Gender-based Violence
GCP	Global Challenges Program
GDP	Gross Domestic Product
GEMS	Geo-Enabling for Monitoring and Supervision
GRM	Grievance Redress Mechanism
HCI	Human Capital Index
HEIS	Hands-on Extended Implementation Support
HMIS	Health Management Information System
HNP	Health, Nutrition, and Population
HPF	Health Pooled Fund
HRH	Human Resources for Health
HSC	High-Level Steering Committee
HSF	Health Service Functionality
HSSP	Health Sector Strategic Plan
HSTP	Health Sector Transformation Project
ICRC	International Committee of the Red Cross
IDP	Internally Displaced People
IDSR	Integrated Disease Surveillance and Response
IEC	Information. Education, and Communication
IMF	International Monetary Fund
IMNCI	Integrated Management of Neonatal and Childhood Illness
IP	Implementing Partner
IPC	Integrated Food Security Phase Classification
IPF	Investment Project Financing

IPV	Intimate Partner Violence
M&E	Monitoring and Evaluation
MDTF	Multi-Donor Trust Fund
MoH	Ministry of Health
MoFP	Ministry of Finance and Planning
MPA	Multiphase Programmatic Approach
NCD	Noncommunicable Disease
NDC	Nationally Determined Contribution
NGO	Non-governmental Organization
NTD	Neglected Tropical Disease
OSC	Operational Steering Committee
PDO	Project Development Objective
PIM	Project Implementation Manual
PMU	Project Management Unit
PSA	Pharmaceutical Supply Agent
SDTF	Single-Donor Trust Fund
SEA/SH	Sexual Exploitation and Abuse/Sexual Harassment
SEP	Stakeholder Engagement Plan
SGBV	Sexual and Gender-Based Violence
SMoH	State Ministry of Health
SRH	Sexual and Reproductive Health
ToR	Terms of Reference
UNHCR	United Nations High Commissioner for Refugees
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WHR	Window for Host Communities and Refugees

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DATASHEET

BASIC INFORMATION

Project Beneficiary(ies)	Operation Name		
South Sudan	South Sudan Health Sector Transformation Project (HSTP)		
Operation ID	Financing Instrument	Environmental and Social Risk Classification	Process
P181385	Investment Project Financing (IPF)	High	Track II

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[✓] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[✓] Fragile State(s)
[ ] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[✓] Conflict
[ ] Deferred Drawdown	[✓] Responding to Natural or Man-made Disaster
[ ] Alternative Procurement Arrangements (APA)	[✓] Hands-on Expanded Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date
20-Dec-2023	31-Jul-2027
Bank/IFC Collaboration	
No	

Proposed Development Objective(s)

To expand access to a basic package of health and nutrition services, improve health sector stewardship, and strengthen the health system.

Components

Component Name	Cost (US$)

Component 1: Provision of Basic Health Services Nationwide	100,710,000.00
Component 2: Health Systems Strengthening	5,500,000.00
Component 3: Monitoring and Evaluation and Project Management	10,790,000.00
Component 4: Contingent Emergency Response Component	0.00

Organizations

Borrower:	Republic of South Sudan
Implementing Agency:	Ministry of Health

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	**369.50**
Total Financing	**127.00**
of which IBRD/IDA	**117.00**
Financing Gap	**242.50**

DETAILS

World Bank Group Financing

International Development Association (IDA)	117.00
IDA Grant	117.00

Non-World Bank Group Financing

Counterpart Funding	10.00
Borrower/Recipient	10.00

IDA Resources (US$, Millions)

	Credit Amount	Grant Amount	SML Amount	Guarantee Amount	Total Amount
National Performance-Based Allocations (PBA)	0.00	12.00	0.00	0.00	12.00
Window for Host Communities and Refugees (WHR)	0.00	105.00	0.00	0.00	105.00
Total	**0.00**	**117.00**	**0.00**	**0.00**	**117.00**

Expected Disbursements (US$, Millions)

WB Fiscal Year	2024	2025	2026	2027
Annual	30.00	60.00	27.00	0.00
Cumulative	30.00	90.00	117.00	117.00

PRACTICE AREA(S)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

CLIMATE

Climate Change and Disaster Screening

Yes, it has been screened and the results are discussed in the Operation Document

SYSTEMATIC OPERATIONS RISK- RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	High

2. Macroeconomic	High
3. Sector Strategies and Policies	Substantial
4. Technical Design of Project or Program	High
5. Institutional Capacity for Implementation and Sustainability	High
6. Fiduciary	Substantial
7. Environment and Social	High
8. Stakeholders	High
9. Other	Substantial
10. Overall	High

POLICY COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

ENVIRONMENTAL AND SOCIAL

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
ESS 1: Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10: Stakeholder Engagement and Information Disclosure	Relevant
ESS 2: Labor and Working Conditions	Relevant
ESS 3: Resource Efficiency and Pollution Prevention and Management	Relevant
ESS 4: Community Health and Safety	Relevant
ESS 5: Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Relevant
ESS 6: Biodiversity Conservation and Sustainable Management of Living Natural Resources	Relevant

ESS 7: Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Relevant
ESS 8: Cultural Heritage	Relevant
ESS 9: Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

LEGAL

Legal Covenants

Sections and Description
Schedule 2, Section I.A.1. The Recipient shall, not later than thirty (30) days after the Effective Date, establish and thereafter maintain, throughout the Project implementation period, with composition, mandate and resources satisfactory to the Association, a high level steering committee, to be chaired by the Ministry of Health and co-shared by the Ministry of Finance and comprised of representatives of key stakeholders to be responsible for providing overall guidance and strategic support to the Project.
Schedule 2, Section I.A.2. The Recipient shall establish, not later than thirty (30) days after the Effective Date, an Operational Steering Committee with a composition, mandate, resources and functions satisfactory to the Association, and thereafter maintain such OSC at all times during the implementation of the Project, to be responsible for, inter alia, providing advice on technical aspects of Project activities, follow up the progress in achieving the targets identified in the results framework and monitoring and evaluation plans, as detailed in the Project Implementation Manual (PIM).
Schedule 2, Section I.A.3.(d). Without limitation to Section I.A.3 (a) of Schedule 2, the environmental specialist and social specialist shall be appointed and recruited not later than sixty (60) days after Effective Date.
Schedule 2, Section I.B.1. The Recipient shall, no later than thirty (30) days after the Effective Date, through the Ministry of Health, prepare in accordance with terms of reference acceptable to the Association and furnish to the Association for prior review a Project Implementation Manual for the Project
Schedule 2, Section I.B.2.(a). The Recipient shall, no later than thirty (30) days after the Effective Date, through the Ministry of Health, prepare in accordance with terms of reference acceptable to the Association and furnish to the Association for prior review a Project Procurement Manual for the Project, which shall include provisions on the procurement management procedures
Schedule 2, Section I.B.3.(a). The Recipient shall, not later than thirty (30) days after the Effective Date, (and thereafter by February 15 of each subsequent FY) prepare and furnish to the Association, a work plan and budget containing all activities proposed for implementation in the following calendar year.
Schedule 2, Section I.C. Within one hundred eighty days (180) days from the Effective Date, or such later date as agreed by the Association, the Recipient shall recruit and maintain throughout Project implementation, the Third-Party Monitoring Agent, in accordance with terms of reference satisfactory to the Association, to monitor and review performance of the Project.
Schedule 2, Section I.D. The Recipient shall, not later than sixty (60) days after the Effective Date, establish and thereafter maintain at all times during the implementation of the Project, a Grievance Mechanism, under terms and structure satisfactory to the Association.

Schedule 2, Section I.E.1.(a)(i) Without limitation upon the provisions of Section I.A of this Schedule 2, the Recipient shall, through its PMU, not later than sixty (60) days after the Effective Date, make part of the proceeds of the Financing allocated from time to time to Category (1) of the table set forth in Section III.A of this Schedule, available to UNICEF under an output arrangement on terms and conditions approved by the Association, as further elaborated in the PIM
Schedule 2, Section I.E.1.(b)(i) Without limitation upon the provisions of Section I.A of this Schedule 2, the Recipient shall, through its PMU, not later than sixty (60) days after the Effective Date, make part of the proceeds of the Financing allocated from time to time to Category (2) of the table set forth in Section III.A of this Schedule, available to WHO under an output arrangement on terms and conditions approved by the Association, as further elaborated in the PIM.
Schedule 2, Section II.1. The Recipient shall furnish to the Association each Project Report (i.e., a progress Project Report providing for a summary of activities covering a period of six (6) calendar months, and a detailed annual Project Report), not later than forty-five (45) days after the end of the period covered by such report.
Schedule 2, Section II.2. The Recipient shall ensure that each Third-Party Monitoring Report from the Third-Party Monitoring Agent, prepared in accordance with terms of reference acceptable to the Association is furnished to the Association within sixty (60) days of the end of the period covered by said report

Conditions

Type	Citation	Description	Financing Source
Effectiveness	Article V, 5.01.(a)	The MDTF Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled.	IBRD/IDA
Effectiveness	Article V, 5.01.(b)	The Association is satisfied that the Recipient has an adequate refugee protection framework.	IBRD/IDA
Effectiveness	Article V, 5.01.(c)	The Recipient has established the Project Management Unit in accordance with the provisions of Section I.A.3 of Schedule 2 to this Agreement and recruited its key staff, namely (i) a Project Manager, (ii) a financial management specialist, and a (iii) a	IBRD/IDA

		procurement specialist; each on the basis of terms of reference, qualification, integrity, and experience acceptable to the Association.	
Effectiveness	Article V, 5.01.(d)	the Recipient has prepared, disclosed, consulted upon and adopted the ESMF, LMP, RF, SRAMP all under terms satisfactory to the Association and in accordance with the ESCP.	IBRD/IDA

I. STRATEGIC CONTEXT

A. Country Context

1. **The history of South Sudan has been marked with bouts of conflict and efforts for peace and stability.** After prolonged armed conflict with northern Sudan and the Comprehensive Peace Agreement in 2005, the Republic of South Sudan emerged as the world's youngest country in 2011. In 2013, a civil war erupted in the nascent country, which ended with the signing of the Revitalized Agreement on the Resolution of the Conflict in the Republic of South Sudan (R-ARCSS). As a result of consecutive wars, the country has experienced only about 15 years of peace since 1955, specifically during 1972–1982 and 2005–2011. 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.

2. **South Sudan is one of the poorest countries in the world with over 80 percent of people living in poverty.** South Sudan's GDP is estimated to have contracted by 0.4 percent in FY 2022/23,[1] 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). Nearly 80 percent of South Sudan's population lives in rural areas where infrastructure is limited, complicating service delivery, particularly during the rainy season.

3. **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.[2] South Sudan, composed entirely of river basins, ranks as the seventh most vulnerable country to riverine flood in the world in an average year.[3] Between 2019 and 2022, the flooding reached record levels with climate change affecting weather patterns, destroying already scarce infrastructure, displacing populations, and decreasing movement throughout the country. It is estimated that 1 million people were affected by flooding and 300,000 people were displaced in 2021. South Sudan also experiences an intense annual hot season and cyclical drought. This extreme vulnerability to flooding and drought, coupled with the primarily rural landscape has made the delivery of services very difficult.

4. **Women and girls face a disproportionate burden of poverty, poor access to services, and insecurity**. Just over 51 percent of women are married by age 18[4] and the total fertility rate is 4.47 births per woman[5]. Additionally, around one-third of girls become pregnant before the age of 15. Women and girls also face a disproportionate burden of violence. While violence takes multiple forms, intimate partner violence (IPV) is significant with 26.7 percent of ever-partnered women having experienced IPV in the past year.[5]

[1]World Bank. Macro Poverty Indicator, October 2023.
[2] 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.
[3] 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.
[4] UNICEF. (2020, October). Some things are not fit for children – marriage is one of them. South Sudan. Retrieved from https://www.unicef.org/southsudan/press-releases/some-things-are-not-fit-for-children
[5]UNFPA. South Sudan. https://southsudan.unfpa.org/en/topics/family-planning-20

5. **More resources need to be mobilized to meet the immediate needs of refugees arriving in South Sudan.** With hundreds of thousands of South Sudanese already internally displaced due to other conflicts, flooding, and food insecurity, many northern border areas receiving Sudanese refugees were already under stress before the Sudan conflict broke out on April 15, 2023. According to the United Nations High Commissioner for Refugees (UNHCR) data as of September 30, 2023, South Sudan hosted 333,300 refugees and 74,576 households with the vast majority–89 percent–in two locations: Jamjang in 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 311,160 individuals, or 93 percent of the hosted population while the rest come from the Democratic Republic of Congo, Ethiopia, the Central African Republic, Burundi, and Somalia. Almost 52 percent of the refugees are female, with women and children representing 81 percent of the refugee population. About 60 percent of refugees are under 18 years, with 38 percent between 18 and 59 years and the rest over 60 years.

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.** 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 the host country have created unique development challenges for refugees in reestablishing their lives in South Sudan. For instance, refugees are at much higher risk of infectious diseases and malnutrition. In Renk alone, a measles outbreak has left 59 children dead as of September 15, 2023. Malaria cases are also on the rise, accounting for 40 percent of all medical consultations in Renk. It is estimated that acute malnutrition rate among refugees in South Sudan is as high as 31.1 percent for children under the age of 5, and 63.4 percent for pregnant and lactating women[7].

7. **Despite these challenges, refugees often have better access to basic services and support such as 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 limited or non-existent. For this reason, 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 have further exacerbated the need for resources addressing interventions around forced displacement in the country. With most of the humanitarian agencies scaling down their support in the country, the project will need to play a more significant role to fill the gap.

8. **The Government of South Sudan has maintained an open-door policy and reaffirmed its commitment to address vulnerabilities and respond to shocks for both refugees and host communities.** South Sudan is recognized as having one of the most progressive refugee policy frameworks in Eastern Africa. It has acceded to the 1951 Refugee Convention and its 1967 Protocol, as well as the 1969 Organization of African Union Convention Governing the Specific Aspects of Refugee Problems in Africa. South Sudan is also a state party to several other international and regional human rights instruments relevant to the protection of refugees and has adopted the draft East African Community Refugee Management Policy. The Refugee Act of 2012, which provides the central legal framework for refugee protection in South Sudan, incorporates provisions that are in line with international and regional treaties. The Government has also maintained a policy of granting refugees access to its territory, land for cultivation and livelihoods, and practical arrangements for their initial reception and registration. Refugees are granted freedom of movement and, in principle, are free to settle anywhere in the country. The Commission for Refugee Affairs (CRA) plays the leading role in developing government policy on refugee issues,

[6] UNHCR Operational Data Portal https://data.unhcr.org/en/country/ssd.
[7] UNHCR. September 2023. Health and Nutrition Update. Sudan Situation.

including protection and coordinating government and external support for refugees. The CRA is present in all refugee-hosting areas, even as capacity limitations impede its ability to fulfill its designated responsibilities.

B. Sectoral and Institutional Context

Health Sector Outcomes

9. **South Sudan faces significant challenges that adversely affect its human capital with one of the lowest Human Capital Index (HCI)[8] scores at 0.31** (2020)[9] In the country, 31 out of every 100 children are stunted, increasing the risk of physical and cognitive impairment, which can ultimately affect the adult survival rate. 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, and the under-five mortality rate was 98.69 per 1,000 live births from 2017 to 2021.[10] The country has the highest neonatal mortality globally at 39.63 per 1,000 live births.[11] About 71 percent of the population residing over 5 km from the nearest health facility. South Sudan has the highest maternal mortality ratio globally at 1,223 per 100,000 live births.[12] Notably, only 38 percent of facilities offering Comprehensive Emergency Obstetric and Newborn Care (CEmONC)[13] 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 caesarian sections at around 10–15 percent.

10. **Cultural norms and a preference for larger families dampen the demand for reproductive and maternal health services.** Even when women show interest in family planning, they often encounter barriers to access.[14] The combination of a contraceptive prevalence rate of only 6 percent,[15] persistent high fertility rates, and challenges like early marriage precipitate adolescent childbearing. One in three adolescent girls in South Sudan have begun childbearing, which increases the risk of maternal mortality and childbirth injuries like obstetric fistula.[16]

11. **Acute malnutrition remains a major public health emergency in South Sudan**. As of November 2023, 5.8 million people,[17] or over half of South Sudan's population, experienced high levels of acute food insecurity, classified as crisis (Integrated Food Security Phase Classification, IPC Phase 3). Of those, 1.6 million people are experiencing emergency condition (IPC Phase 4) acute food insecurity and an estimated 35,000 people in catastrophe (IPC Phase 5) acute food insecurity in Fangak, Canal/Pigi and Akobo of Jonglei State; Pibor County in the Greater Pibor Administrative Area.

12. **The country grapples with frequent disease outbreaks** exacerbated by conflict, persistent seasonal flooding, inadequate sanitation and water infrastructure, a fragile health system, and low vaccination coverage. Preventable and curable climate sensitive diseases, such as malaria and cholera, are leading causes of death in the country. WHO and the United Nations Children's Fund (UNICEF) estimate that only 76 percent of children receive the Pentavalent 3 vaccine.[18] The country also has one of Africa's lowest measles immunization coverage

[8] World Bank. Human Capital Index, 2020.
[9] The HCI uses two primary health indicators: the stunting rate in children under the age of 5; and the adult survival rate.
[10] World Bank. World Development Indicators. https://databank.worldbank.org/id/fef9176d?Report_Name=Macroeconomics-Workshop.
[11] World Bank. Mortality Rate – Neonatal: South Sudan. https://data.worldbank.org/indicator/SH.DYN.NMRT?locations=SS.
[12] World Bank. Maternal Mortality Ratio. https://data.worldbank.org/indicator/SH.STA.MMRT?locations=SS.
[13] World Bank. Empowering Girls and Women in South Sudan. 2022.
[14] Lawry et al. 2017; World Bank. Empowering Girls and Women in South Sudan. 2022.
[15] UNFPA. 2023. Family Planning. https://southsudan.unfpa.org/en/topics/family-planning-
[16] World Bank. Empowering Girls and Women in South Sudan. 2022.
[17] IPC. November 6, 2023. IPC Acute Food Insecurity and Malnutrition Analysis for September 2023—July 2024 for South Sudan.
[18] Draft South Sudan Health Sector Strategic Plan 2023-2027.

estimated at 49 percent for the first dose of the measles vaccine,[19] while a 95 percent coverage rate is needed to substantially reduce transmission.[20] Additionally, the 2017 EPI coverage survey estimated that only 18.9 percent of children are fully immunized, contributing to the high levels of vaccine preventable diseases.[21]

Health System and Service Delivery Challenges

13. **Substantial supply- and demand-side health service delivery challenges persist across all health services.** Supply-side issues include limited physical infrastructure, supply stock-outs, severe health service delivery capacity gaps, and a long history of suboptimal health service delivery. While historically, the focus has been on supply-side challenges, demand-side issues require equal attention. The Boma[22] Health Initiative (BHI),[23] is a community health worker program, targeting these issues by improving community-level interventions and bridging the gap between health service supply and demand.

14. **Health and health service delivery in South Sudan are intertwined with climate change and the country's climatic patterns.** The heavy annual flooding in the country disrupts ground transportation annually, rendering road transport to most rural areas impossible and severely restricting air transport. As a result, supply lines are cut off and staff movements are difficult. Patient travel to facilities, which is by foot in most areas year-round, is further hampered. Simultaneously, transmission of waterborne and vector-borne diseases increases annually during this period, causing spikes in diarrheal diseases and malaria, which account for 8.59 and 8.07 percent of the country's burden of disease, respectively.[24]

15. **The overall response to sexual and gender-based violence (SGBV) remains inadequate in reach, quantity and quality**. There is a severe shortage of medical personnel trained in Clinical Management of Rape (CMR) and basic psycho-social support is insufficient. Across the country health professionals seldom receive training in counseling and psycho-social care. Specialized mental health expertise is virtually non-existent, with currently only one South Sudanese psychiatrist working for the entire country.

16. **South Sudan's health system is characterized by fragmentation and minimal Government engagement**. Since 2013, health service delivery has been supported through external financing from the World Bank through UNICEF and the International Committee of the Red Cross (ICRC) covering three states[25] and the European Union (EU), Gavi the Vaccine Alliance through a consortium led by Crown Agents and bilateral donors including the United Kingdom (UK), the United States, Canada, and Sweden covering seven states. While donors have strengthened coordination between the two areas in delivering the same package of services and harmonizing monitoring and the human resources for health (HRH) incentive scheme, the two areas had separate management structures creating inefficiencies and coordination challenges.

17. **The Government contributes a mere 4 percent of its budget to health, far below the 15 percent target pledged by the African Union countries in 2001.** The health sector has been chronically underfunded since 2013, which undermines the system's sustainability. Estimates suggest that household out-of-pocket expenditures on health account for as high as 79 percent of the total health expenditure. As per the MoFP letter to the World Bank dated November 23, 2023, the Government of South Sudan will commit USD$ 20 million in support of the proposed

[19] World Health Organization. Measles – South Sudan. 10 February 10, 2023. https://www.who.int/emergencies/disease-outbreak-news/item/2023-DON440#:~:text=South%20Sudan%20is%20one%20of,were%20estimated%20to%20be%2049%25.
[20] Gavi. South Sudan launches major push on measles vaccination. 2023. https://www.gavi.org/news/media-room/south-sudan-launches-major-push-measles-vaccination.
[21] Draft South Sudan Health Sector Strategic Plan 2023-2027.
[22] A boma is the lowest-level administrative division in South Sudan. Bomas vary in size and typically contain many individual villages.
[23] BHI is a national scale community health program that aims to strengthen the health system in South Sudan.
[24] UNICEF. Malaria Season: https://www.unicef.org/southsudan/stories/malaria-season.
[25] The Republic of South Sudan now has 10 states and 3 administrative areas.

reforms under the HSTP. This includes: (i) a US$10 million budgetary allocation as a direct co-financing into HSTP; and (ii) an additional US$10 million provided under the food shock window of the IMF program with South Sudan that has been disbursed to MoH to procure pharmaceuticals, medical consumables, and equipment. The World Bank will provide to the Government through an independent Third-Party Monitoring (TPM) a report outlining the execution and utilization of the funds supported by the IMF program. The MoFP and MoH will provide the required access and documentation to facilitate the TPM validation.

C. Relevance to Higher Level Objectives

18. **The proposed South Sudan Health Sector Transformation Project (HSTP) is aligned with the World Bank's goals and regional and global strategies and is poised to contribute to IDA20 policy commitments.** Specifically, the HSTP contributes to the World Bank's vision to create a world free of poverty on a livable planet, the World Bank Evolution, and the Eastern and Southern African regional priorities by investing in improved water and sanitation and energy efficiency in health facilities, strengthening national and state level capacity for climate and health emergency preparedness and response, and critical nutrition interventions for children and pregnant women. The IDA20 commitments place special priority on improving overall human capital focus on improving pandemic prevention and preparedness support building resilient health systems that have the capacity to prevent, detect, and respond to disease outbreaks and other health emergencies. The project is also fully aligned with the 2023 Dar es Salaam declaration on human capital.

19. **The project is consistent with the World Bank Group Country Engagement Note (CEN) for South Sudan for FY2021—2023 (Report No. 158008-SS).** The project is aligned with the first and second focus areas of the CEN: (a) lay groundwork for institution building; and (b) continue support for basic public service delivery. In addition, the project is in line with the Fragility, Conflict and Violence (FCV) Strategy Pillar 2 on remaining engaged during conflict and crisis situations, with a direct link to its first high priority area of investing in human capital, as well as Pillar 4, which centers on mitigating the spillovers of FCV, given that the project will facilitate provision of vaccines to refugees and IDPs in South Sudan.

20. **The project is fully aligned with South Sudan Health Sector Strategic Plan (HSSP 2023—2027)** which aims to improve the health status of people by effective delivery of a basic package of health and nutrition services (BPHNS) and highlights partnership with donors to support key health sector programs as one of its strategic objectives. The upcoming National Immunization Strategy will be part of the HSSP.

21. **The project is consistent with South Sudan's Second Nationally Determined Contribution (NDC) and National Adaptation Plan (NAP), both issued in 2021.**[26] The NDC details specific health goals while the NAP identifies health as a priority sector for climate adaptation in South Sudan. Both documents outline activities supported by and embedded in the project including strengthening surveillance and early outbreak warning systems for climate-sensitive diseases and climate and health emergencies, building community capacity for climate emergency preparedness and response, and developing climate resilient health systems.

22. **The project complements both World Bank and development partner investments in health systems' strengthening, disease control and surveillance, interventions to change individual and institutional behavior, and citizen engagement**. The project also supports the attainment of Universal Health Coverage and of the Sustainable Development Goals, and the promotion of a One Health approach.

[26] South Sudan's Health Sector Strategic Plan (HSSP) 2023-2027, with which the project is aligned and is considered the Long-Term Strategy (LTS) relevant to the project, includes one reference to climate change along with several to the impacts of flood and droughts and no climate change specific actions. Therefore, the project is considered consistent with the HSSP for Paris Alignment.

23. **The project is in line with the Remaining Engaged in Conflict Allocation (RECA) criteria for direct financing to third parties** demonstrated by; (a) the Government of South Sudan's requests to the World Bank dated August 14, 2018 and January 27, 2020 to provide financing directly to organizations to carry out operations for the benefit of the people in South Sudan, due to capacity constraints of the Government to effectively manage and implement operations; (b) the World Bank's value proposition and strategic focus on laying the foundations for institutional building in areas such as financial management (FM), procurement, and environmental and social risk management and building the humanitarian development nexus through sustaining the provision of health services while investing in core aspects of the health system; (c) the planned institutional capacity development at the Ministry of Health (MoH) to support a gradual transition towards government-led project management modality through customized capacity building activities in the core areas of effective project management; and (d) contributing to sustainability of the project activities through supporting community-based approach of health service delivery, and strengthening disease surveillance and information systems, allowing the country to be more responsive to the emerging diseases and more resilient to public health threats.

II. PROJECT DESCRIPTION

24. The project will operate in all ten states and three administrative areas of South Sudan and is designed to expand access to a basic package of health and nutrition services for the people in South Sudan, including refugees, with financial support available and future financing over the immediate- and short-term. The project design outlines project activities that will be implemented with an initial funding envelope that comprises an IDA grant of US$12 million equivalent and a grant from the IDA20 WHR of US$105 million equivalent. Additional resources totaling US$242.5 million are expected to be mobilized as donor funding through a Multi-Donor Trust Fund (MDTF) and a Single-Donor Trust Fund (SDTF) during the period of January to September 2024. The project will provide US$16 million in retroactive financing to cover the advanced procurement and staffing costs incurred by UNICEF for project preparation.

25. **The project is being processed under the World Bank Policy for IPF, paragraph 12.** The Government of South Sudan requested the World Bank, in letters dated August 14, 2018, and January 27, 2020, to provide financing directly to organizations to carry out operations for the benefit of the people in South Sudan, due to capacity constraints of the Government to effectively manage and implement operations. The project seeks to build the MoH's institutional capacity to pave the way for the future World Bank-financed projects in South Sudan to transition toward a fully government-led implementation modality where the MoH's role in service delivery will be to contract and manage service providers.

A. Project Development Objective

PDO Statement

The Project Development Objective (PDO) is to expand access to a basic package of health and nutrition services, improve health sector stewardship, and strengthen the health system.

PDO-Level Indicators

- Percentage of bomas covered by the Boma Health Initiative
    - Percentage of bomas covered by the Boma Health Initiative in refugee areas
    - Percentage of bomas covered by the Boma Health Initiative in host communities' areas

- Percentage of MoH budget executed
- General service availability score (Percentage)
    - General service availability score for refugees (Percentage)
    - General service availability score for host community areas (Percentage)

B. Project Components

26. **Component 1: Provision of Basic Health Services Nationwide (UNICEF and competitively selected pharmaceutical procurement and logistics will implement; US$330.77 million: US$10 million equivalent from Government contribution; US$100.71 million equivalent IDA [including US$90.49 million WHR] and US$220.06 million Trust Funds [US$23.14 million SDTF and US$196.92 million MDTF])**. Component 1 will deliver basic health services nationwide, guided by the MoH's HSSP and building on the experiences obtained under the COVID-19 Emergency Response and Health System Preparedness Project (CERHSPP-P176480) and the Health Pooled Fund (HPF), with a focus on improving service availability including to refugees and host communities. It will deliver a selection of prioritized services from the BPHNS: 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; SGBV services; mental health; disability; infectious and noncommunicable diseases; emergency and surgical services; Social and Behavior Change Communication (SBCC), health promotion, and education; and strengthened referral systems. Special emphasis will be given to improving childhood vaccination and malaria prevention, diagnosis and treatment, with targeted services to refugees and host communities.

27. The project will expand access to health services for host communities and refugees (in addition to Maban and Jamjang which received support under previous WHR-funded health projects), remote and rural populations, women, and other marginalized groups.[27] The project will implement several mechanisms to target refugees and host communities (HC) and address their unique challenges in accessing health services, including strengthening community health programs and health promotion activities in refugee and host communities areas. It will incorporate climate-sensitive planning and service delivery to mitigate the health impacts of climate change and climatic shocks. Conflict-sensitive approaches will be used to ensure equitable access to services.[28] Expanded access to the package of health services will be delivered at the community level through the BHI and primary care facilities along with strategically identified secondary and tertiary hospitals, complemented with community outreach and mobile health services to increase, and expand equitable service access for the population. The component will also strengthen the health system by enhancing the pharmaceutical supply chain, improving health management information system (HMIS) data collection, quality improvement at the facility and county level, climate-sensitive health facility rehabilitation, and health worker training.

28. Through Subcomponents 1.1 and 1.2, UNICEF will contract implementing partners (IPs) to deliver health services across designated geographic areas, or Lots. Contracting national non-governmental organizations (NGOs) directly, reducing reliance on consortiums to maximize fund flows for health service delivery, will be emphasized. The two subcomponents will be executed in collaboration with and under the leadership of the MoH, State Ministries of Health (SMoHs), and County Health Departments (CHDs). To build the capacity of SMoHs and CHDs, an integrated approach will be taken to management and supervision, whereby IP staff will be co-located within CHDs and engage in on-the-job capacity development with the CHDs, primarily through a twinning approach.

[27] Other marginalized groups are anticipated to include the people with disabilities (including mental), and in terms of health service access, adolescents.
[28] Conflict sensitivity is woven into the project design.

UNICEF will station staff at (a) the county level to provide supervision and support for IPs, CHDs, and project activities; and (b) the state level within the SMoHs to provide on-the-job capacity development for SMoH staff.

29. **Subcomponent 1.1: Delivery of High Impact Basic Health and Nutrition Services Nationwide through Health Facilities (implemented by UNICEF; US$273.73 million: US$10 million equivalent from Government contribution, US$62.67 million equivalent IDA [WHR] 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 basic health and nutrition services through health facilities nationwide, including to refugees and host communities. The subcomponent aims to cover 1,158 health facilities throughout the life of the project using a phased approach beginning with 600 health facilities, including 135 in refugee and host community areas, and will expand based on population coverage and health facility readiness. The subcomponent will also support strengthened supervision, management, and on-the-job coaching for IPs 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 District Health Information Software 2 (DHIS2). The subcomponent will include planning and execution of outreach (village visits, mass campaigns, and so on) and transportation (vehicle, boat, and foot) modalities paying close attention to seasonal population movement patterns and access. Climate sensitive health service delivery and planning will be integral to the approach under this subcomponent.

30. Subcomponent 1.1 will channel resources through UNICEF to sub-contract national and international NGOs for health service delivery and coordination.[29] In collaboration and through the leadership of the MoH, SMoHs, and CHDs, UNICEF will be responsible for (a) oversight and coordination of health services and DHIS2 data collection and entry systems; (b) supervision and quality assurance of IPs and health facilities in line with national plans and guidelines; (c) coordinating and conducting in-service training; (d) through an integrated approach, developing the capacity of SMoHs to plan, supervise, and oversee service delivery and the DHIS2 system; and (e) integrated pharmaceutical procurement, quantification, and forecasting. Contracted IPs will be responsible for: (a) delivering quality health services; (b) quality improvement activities; (c) supervision of health facilities (d) recording of HMIS data, provision of HMIS data to CHDs, and support for entry of DHIS2 data into DHIS2 and data use; (e) in-service training complementing UNICEF's training activities; (f) health facility stock management, recording, and rational use; (g) through an integrated approach, developing the capacity of CHDs to plan, supervise, and oversee service delivery and the DHIS2 system; and (h) sustain the support of the innovation activities under CERHSSP and expand using the digital health technology to address service delivery and supply chain issues.

31. **Subcomponent 1.2: Boma Health Initiative (implemented by UNICEF; US$12.41 million: US$3.41 million equivalent IDA [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 including to refugees and host communities, in the context of South Sudan's extremely rural, climate vulnerable, conflict impacted, and dispersed population with limited road access. The subcomponent will be executed by UNICEF through contracted IPs, in coordination with the leadership of the MoH, SMoH, and CHDs. The focus on community-based interventions and health promotion activities have been identified as 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. Specifically, the subcomponent will: (a) finance the delivery of health services through the BHI; (b) increase the coverage of the BHI based on a needs assessment and timed

[29] Subcomponent 1.1 will finance costs related to: (a) health service delivery at health facilities and outreach activities; (b) operational costs of health facilities including staff incentives, utilities, waste management, and transportation; (c) technical supervision, support, monitoring and oversight by UNICEF of sub-contracted NGO implementing partners; (d) health worker in-service training conducted by UNICEF and NGO implementing partners (IPs); (e) quality assurance and improvement activities (f) health facility supervision and reporting for sub-contracted IPs; (g) development of IP capacity through an integrated approach; and (h) project management costs (e.g. transport costs, information technology support, monitoring and reporting) for UNICEF.

plan, with commensurate increases in the number of Boma Health Supervisors and strengthening of Boma HW management and training; (c) increase the number of female Boma health workers; (d) develop visual/low-literacy tools for BHWs; and (e) strengthen supervision, training, supply chain, and support for BHWs. BHWs will deliver basic preventative and curative services, health education, and refer/ accompany patients to higher levels of care when needed. Core services to be delivered by BHWs include: health promotion and SBCC; maternal health, child health including vaccine preventable diseases, family planning, and gender-based violence (GBV); control of malaria, pneumonia, and diarrhea including diagnostics and treatment for uncomplicated cases; identification and referral of malnutrition; referral and, as needed, accompaniment for immunization, antenatal care (ANC), and postnatal care services; and outbreak surveillance, prevention; and response. Multi-level health promotion interventions will be tailored to the specific needs of vulnerable and hard-to-reach groups particularly refugees and host communities through increased outreach activities and access to health education by BHI workers, and will be designed to be understood by all, including women, girls, and other disadvantaged populations who are illiterate or lack access to information sources. Resources for Subcomponent 1.2 will be channeled through UNICEF; agencies contracted to deliver health services under Subcomponent 1.1 will also deliver services through the BHI in the same geographic areas.

32. **Subcomponent 1.3: Pharmaceutical and Supply Last Mile Delivery (implemented by UNICEF through a subcontracted and competitively selected pharmaceutical procurement and logistics agency; US$13.41 million: US$3.41 million equivalent IDA [WHR] 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: (a) country-wide pharmaceutical and medical supply distribution of supplies for health facilities and BHWs, including to refugees and host community areas; and (b) last mile logistics, including delivery of medical supplies and pharmaceuticals to health facilities. IPs will be responsible for the storage, stock management, cold chain management, rational use of pharmaceuticals at health facilities, and distribution of supplies to BHWs. This subcomponent will incorporate the use of technology to improve the tracking, quantification, and accountability of pharmaceutical delivery to the last mile. Close attention will be paid to climate sensitive supply chain, including prepositioning of pharmaceuticals for the rainy season, ensuring all pharmaceuticals are in the country ahead of the rainy season, ensuring pharmaceuticals and medical supplies are protected from climate shocks, and acquiring buffer stocks of pharmaceuticals.

33. **Subcomponent 1.4: Climate Resilient Health Service Delivery (implemented by UNICEF; US$31.22 million equivalent IDA [including US$21.00 million WHR]).** 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 subcomponent will be closely coordinated with the Climate Resilient Flood Management Project (P179169) and the South Sudan Energy Sector Access and Institutional Strengthening Project (P178891) as well as with UN agencies such as UNICEF. The subcomponent will finance: (a) water and sanitation improvements in facilities to improve infection prevention and control, with a focus on reducing the transmission of climate sensitive (water and vector borne) diseases and addressing the impacts of flooding on water and sanitation in health facilities; (b) minor rehabilitation[30] to health facilities selected based on their exposure to climate shocks to reduce the impact of these shocks, primarily flooding and high heat, and implement energy efficiency improvements; (c) minor rehabilitation of pharmaceutical stores to effectively and securely preposition pharmaceuticals for rainy season; (d) limited solar electrification of health facilities to complement to

[30] Minor civil works and rehabilitation in the context of the HSTP means the construction work that will be undertaken in existing structures of project-supported health care facilities and pharmaceutical stores, which will not in any way alter the structural designs of the facilities and stores. These works also require no prior municipality or planning approval. They will result in little to no environmental or social impact.

those financed by the South Sudan Energy Sector Access and Institutional Strengthening Project(P178891); (e) the development and dissemination of climate adaptive and energy efficient health facility and pharmaceutical store rehabilitation guidelines to inform current and future climate sensitive rehabilitation; (f) the development and dissemination of multi-hazard climate emergency preparedness and response plans for each county with an emphasis on climate emergency preparedness and response plans that consider planning for climate shocks, including annual flooding and high heat, coordinated with National and State level plans; and (g) trainings for health facility, CHD, and State MoH staff on climate emergency preparedness and response as well as climate and health adaptation.

34. **Component 2: Health Systems Strengthening (WHO will implement; US$15.00 million: US$5.50 million equivalent IDA [including US$3.72 million WHR] and US$9.50 million Trust Funds [US$1.0 million SDTF and US$8.50 million MDTF])**. This component is aligned with the MoH's HSSP and will undertake activities to strengthen South Sudan's health system to facilitate health service access and capacity improvements, with an emphasis on developing the stewardship capacity of the MoH, SMoHs, and CHDs. The component will be implemented by WHO and will focus on strategic mechanisms to strengthen services in South Sudan, given the low-infrastructure and conflict-affected context. Component 2 activities will be closely aligned with and complementary to health service delivery activities under Component 1, through close coordination between UNICEF and WHO with leadership from the MoH.

35. **Subcomponent 2.1: Health Emergency Preparedness and Response, Laboratory Strengthening, and Disease Control (WHO will implement; US$5.5 million: US$2.04 equivalent million IDA [including US$1.38 million WHR] 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 COVID-19 Emergency Response and Health System Preparedness Project (CERHSPP-P176480) and needs identified in the National Action Plan for Health Security (NAPHS) 2020-2024. Specific activities will include: (a) training and operational support for Integrated Disease Surveillance and Response (IDSR); (b) operational and rehabilitation costs for three Public Health Emergency Operations Centers (PHEOCs); (c) development, dissemination, and training of trainers on multiphaser emergency preparedness and response plans, with an emphasis on climate shock emergency preparedness and response; (d) training and staff costs for Point of Entry (PoE) surveillance; (e) update and disseminate laboratory guidelines; (f) procure laboratory equipment, consumables, reagents, and test kits; (g) develop a national laboratory quality accreditation program and scale up laboratory quality management; (h) Neglected Tropical Disease (NTD) program management training and training of trainers for health service delivery, review of NTD indicators, and execution of community based drug distributions; (i) development of noncommunicable diseases (NCD) guidelines and training of trainers for NCD health service delivery; and (j) viral hepatitis, sexually transmitted disease (STD), and tuberculosis (TB) and HIV training of trainers, diagnostic equipment procurement, and development and dissemination of guidelines.

36. **Subcomponent 2.2: Blood Banking and Transfusion (WHO will implement; US$2.50 million: US$0.93 million equivalent IDA [including US$0.64 million WHR] 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: (a) develop guidelines for the proper collection, storage, transport, and use of blood for transfusions; (b) build or strengthen existing blood banking services; (c) develop systems and protocols for the transfer of blood products for transfusion; (d) conduct community and donor sensitization on the collection and use of blood products; and (e) develop low literacy visual tools and protocols for oral SBCC on the collection of blood products to be used by health workers, emphasizing community-level communication activities.

37. **Subcomponent 2.3: Health Service Quality Improvement (implemented by WHO; US$2.5 million: US$0.83 million equivalent IDA [including US$0.53 million WHR] and US$1.67 million Trust Funds [US$0.17 million SDTF and US$1.50 million MDTF]).** This subcomponent focuses on improving health service quality in South Sudan by addressing the challenges of remote health facilities, shortage of qualified health workers, and a long history of low health service quality. This subcomponent will: (a) develop an HRH policy, strategy, and manual; (b) implement the national Human Resources for Health Information System; (c) review and update the health worker training curriculum; (d) review and update the essential medicines list and standard treatment guidelines, including rational use of medicines; strengthen the capacity of the Drug and Food Control Authority (DFCA) at the State and National levels through training, development of tools and guidelines, and operational support for testing and supervision; (e) review and update the national quality of care policy and strategy; (f) review and update the BPHNS; and (g) establish a quality of care system through development of guidelines, tools, and standards, training of trainers on quality of care, piloting quality of care teams and supporting national scale up, and support for National and State level quality improvement supervision.

38. **Subcomponent 2.4: Health Management Information Systems (WHO; US$2.50 million: US$0.93 million equivalent IDA [including US$0.63 million WHR] and US$1.57 million Trust Funds [US$0.17 million SDTF and US$1.40 million MDTF]).** This subcomponent will focus on developing systems and procedures for the national HMIS, with an emphasis on supporting the collection of routine data through DHIS2, to standardize data collection, entry and cleaning, as well as instituting data quality improvement practices. This will enhance targeting and data tracking for refugees and provide regularly updated information to understand the evolving needs on the ground that will aid further in the decision-making process. The subcomponent will: (a) finance procurement of information communication technology equipment at the national level and train staff on data entry and use; (b) train trainers to develop health facility staff data entry, management, and use capacity; (c) create interoperability and integration between data systems and ensure data sharing, storage and backup; (d) develop, print, and disseminate Standard Operating Procedures for HMIS data entry, cleaning, quality improvement, and use at all levels; (e) conduct data review meetings and generate data use tools; (f) establish and operate the National and State level HMIS and Monitoring and Evaluation (M&E) Technical Working Groups; (g) conduct data quality improvement activities at the facility and national level; (h) operationalize a national and state level research committee, building on existing structure; (i) conduct an annual health sector review meeting; and (j) maintain and institutionalize the Health Service Functionality (HSF) Database.

39. **Subcomponent 2.5: Health Sector Stewardship and Financing (WHO implemented; US$2.00 million: US$0.77 million equivalent IDA [including US$0.54 million WHR] and US$1.23 million Trust Funds [US$0.13 million SDTF and US$1.10 million MDTF]).** This subcomponent aims to enhance the health sector stewardship and financing capacities of the national and state level MoHs. Core activities will include: (a) train national and state MoH managers and leaders on leadership, management, policy formulation, operational planning, data use for decision making, and budgeting; (b) develop annual operational plans at the national and state levels, aligned with the MoH's HSSP; (c) establish health sector coordination units at the national and state MoHs by setting up offices; (d) conduct intersectoral and inter-ministerial advocacy on the determinants of health through the development of materials and health communication activities; (e) develop a Public Private Partnership framework; (f) conduct a National Health Accounts (NHA); (g) develop, validate, and disseminate a national Health Financing Strategy; and (h) develop MoH capacity for FM, with a focus on improved budget execution, and intersectoral advocacy for health sector budget allocations.

40. **Component 3: Monitoring and Evaluation and Project Management (competitively selected third party monitoring [TPM] agencies and the Project Management Unit [PMU] will implement; US$23.73 million: US$10.79 million equivalent IDA [WHR] 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 M&E and management of project activities. The project

will ensure that independent and credible data on health service delivery and coverage and commodities are generated and that the data are usable and used to enable the Government, the World Bank, and development partners to verify that resources are reaching the intended beneficiaries and minimize potential harm. The monitoring entities' roles will include working with the PMU, UNICEF, the World Bank, and IPs to explain results, providing guidance on improved methods, proposing context-appropriate solutions, and conducting ex-post fact verification of results provided by project reporting mechanisms.

41. **Subcomponent 3.1: Third Party Monitoring (Competitively selected TPM agencies; US$13.75 million: US$6.15 million equivalent IDA [WHR] and US$7.6 million Trust Funds [US$0.8 million SDTF and US$6.8 million MDTF]).** The project will finance TPM of delivery of basic health services under Subcomponent 1.1 and will build on arrangements through the COVID-19 Emergency Response and Health System Preparedness Project (CERHSPP-P176480), incorporating lessons learned from the project. TPM will provide critical assessment and survey data, in complement to routine data through DHIS2, in support of the country's overall HMIS. The TPM arrangements will incorporate quarterly health facility functionality assessments and data quality verification; biannual health service quality assessments, patient feedback, and BHI performance visits; and baseline and endline household coverage and citizen engagement surveys. The TPM agent will be selected for the full project period through a competitive process, with close attention to their capacity to scale up nationwide. To facilitate nationwide scale-up, multiple agencies may be recruited with an anticipated geographic division of labor using standardized data collection, entry, analysis, and reporting tools nationwide. TPM arrangements are outlined in detail in Annex 2. Along with monitoring and survey activities, the TPM will develop Government capacity for the design of data collection tools, data use, and oversight of health service monitoring.[31]

42. **Subcomponent 3.2: Data Analysis and Visualization Platform (Competitively selected TPM Agency; US$0.73 million: US$0.30 million equivalent IDA [US$0.0 million IDA Grant and US$0.30 million WHR] 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 subcomponent will develop a data visualization and use platform (software) focusing on visual representations of TPM and routine data, inclusive of BHI data. Linking of platforms, including DHIS2 and the HSF platform will be integral to the work. The data visualization platform will include visualization of Results Framework data and other core indicators from the HSSP, linking TPM and DHIS2 data using maps, charts, and graphs and will incorporate HSF data along with the overlay of health and meteorologic data to better understand the impact of climatic patterns on health. The platform will include analysis of health service delivery in refugee and host community areas to facilitate improved health service delivery among the critical underserved populations. The development of an integrated, institutionalized, and sustainable platform which will strengthen MoH systems will be emphasized. Annex 2 provides further details on the platform.

43. **Subcomponent 3.3: Contract and Program Management Capacity Development (PMU; US$3.44 million: US$1.54 million equivalent IDA [WHR] and US$1.9 million Trust Funds [US$0.20 million SDTF and US$1.7 million MDTF]).** This subcomponent will develop the capacity of the PMU (through consultancy work) to manage health service delivery contracts focusing on monitoring health service delivery performance and taking actions; resolve disputes related to health service contracts; review and provide feedback on contractor deliverables; liaise and coordinate with other relevant departments within the MoH to provide technical guidance to contractors; provide field-level supervision to contractors; and develop a contract management manual. The subcomponent will also provide capacity development support (training activities) 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

[31] Geocoded technology will be used to track TPM data collection activities and facilitate near-real-time reporting of field data. All data will be shared directly with the World Bank and PMU. The World Bank reserves the right to request changes to the TPM process, data collection tools, and so on to ensure TPM is meeting project needs.

include developing systems, processes, and tools, needed for effective functioning of the unit. This subcomponent will finance: (a) technical assistance and capacity development on contract, environmental and social risk, and program management; and (b) the development of the contract management manual. Specialized experts will be recruited by the PMU to conduct capacity development activities.

44. **Subcomponent 3.4: Project Management (PMU; US$5.81 million: US$2.80 million equivalent IDA [WHR] and US$3.01 million Trust Funds [US$0.31 million SDTF and US$2.7 million MDTF]).** This subcomponent will finance the day-to-day operations of the PMU including project supervision, management, and oversight. The subcomponent will support: (a) PMU staff costs; (b) PMU project supervision and oversight; (c) environmental and social risk management activities; (d) PMU office equipment, stationary, and other day-to-day operating costs; € State MoH project supervisory visits; (f) costs of specialists needed to support the project; and (g) operational costs of the project's Steering Committee.

45. **Component 4: Contingent Emergency Response Component (CERC) (US$0).** The objective of this component is to facilitate access to rapid financing by allowing for reallocation of uncommitted project funds in the event of an eligible emergency as defined in OP 8.00, such as a disease outbreak or health emergency with the potential to cause a major adverse economic and/or social impact. Any WHR resources that become reallocated to the CERC will only be used to benefit refugees and host communities. Disbursements under this component will be subject to the declaration of emergency, a formal request from the Government, and the preparation of a CERC manual, an 'Emergency Action Plan', and necessary environmental and social instrument(s) by the contracted agencies/PMU, agreed upon by the World Bank. The Project Implementation Manual (PIM) will provide guidance on the required documents and process for triggering the CERC.

Table 1: Project Cost and Source of Financing

Project component	Source of Financing				TOTAL
	IDA	MDTF	SDTF	Gov	
Component 1: Provision of Basic Health Services Nationwide	100.71	196.92	23.14	10	330.77
Component 2: Health Systems Strengthening	5.5	8.5	1	0	15
Component 3: Monitoring and Evaluation and Project Management	10.79	11.58	1.36	0	23.73
Component 4: Contingent Emergency Response Component	0	0	0	0	0
Total	**117**	**217**	**25.5**		**369.5**

C. Project Beneficiaries

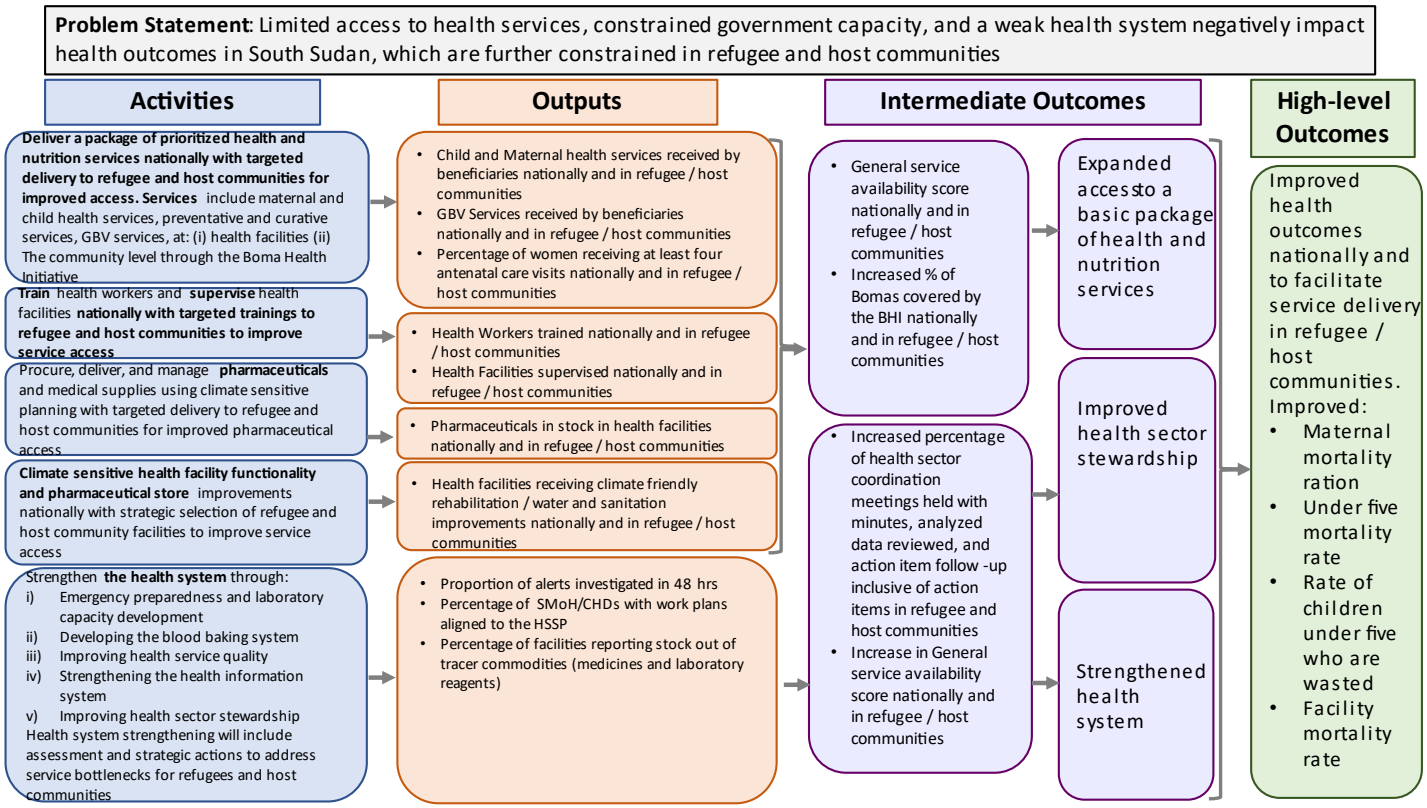
46. The population of South Sudan, particularly women of reproductive age and children under five, will continue to benefit from the sustained delivery of basic health services under the project. The project will cover all ten states and three administrative areas of South Sudan with an estimated population of 12.4 million, 6.5 million of which are female, and an estimated 2.9 million (23 percent of the total population) are of child-bearing age. About 2.4 million children are under five and make up 19 percent of the total population. Project beneficiaries will also include about 330,000 refugees and their host communities. Furthermore, 67 percent of health facilities (1,158) will benefit from the project, while the health system will be strengthened with support for essential system elements, and health sector stewardship capabilities of the MoH at different levels will be strengthened.

D. Results Chain

47. Activities financed under the project will improve access to basic health and nutrition services to the population of South Sudan including refugees and host communities, strengthen health systems, and lay the foundation for building MoH capacities on project management and enhance M&E capacities. These activities will contribute to

outputs such as the number of beneficiaries receiving basic package of health and nutrition services including among refugees and host communities, the expansion of BHI, increased of number of health facilities that have received pharmaceutical supplies ahead of the distribution period, functional laboratories, and enhanced health sector coordination. In turn, these are expected to lead to the following outcomes: improved access to basic package of health services, strengthened health systems, and improved government stewardship capacity. In the long-term, the impact of the project will be improved health outcomes nationwide.

Figure 1. Theory of Change



E. Rationale for Bank Involvement and Role of Partners

48. **The value added of supporting the delivery of a basic package of health services through a World Bank supported operation is high, given the World Bank's ability to provide higher-level technical oversight and facilitate coordination and communication between the partner agencies.** In this regard, the value of providing support through the proposed operation is greater than the sum of its parts. The proposed operation will result in ensuring continuity and expansion in the provision of basic health services in a coordinated manner to cover different population groups who often shift their location in an environment where conflict and uncertainty remain underlying factors. It can bring together diverse actors from both the development and humanitarian service delivery segments and use their comparative advantages to ensure that those with the greatest need benefit equitably from the project's interventions. The project also invests significantly in building capacities of health service providers and managers at the operational level to contribute to a stronger and resilient health system in the country.

49. **The pressing resource needs in the sector combined with the harmonized funding cycles of the largest health sector development donors and strengthened leadership in the MoH present a unique opportunity** for the next

stage in integrating health financing and harmonizing health service delivery nationwide in South Sudan, through the IDA co-financing arrangements (standalone trust funds) to cover health service provision across the country, which complements government resources. Pooling health sector resources through the IDA co-financed by donor funds will: (a) improve efficient use of limited available resources by consolidating management and monitoring mechanisms in the country; (b) reduce fragmentation and simplify the Government's coordination with health sector partners; (c) help transition towards better governance of the sector through strong accountability mechanisms; (d) ensure a streamlined package of services is delivered in a consistent manner throughout the country through unified planning, budgeting, and implementation processes; a€(e) allow for lessons learned through current and previous health service delivery modalities, such as the need for robust management and supervisory systems, strong monitoring, and consistent supply chain systems.

50. **A fund pooling mechanism is also an opportunity to strengthen the Government's role as a steward of the health sector through a gradual shift toward Government contracting of health service providers**. Health sector stewardship, overseeing and regulating health services, is an essential role of the MoH. All other roles in the health sector including service delivery, execution of monitoring functions, and pharmaceutical management could be contracted out to third parties such as (international) NGOs, under the leadership and oversight of the MoH. Currently, several implementing actors deliver health services, manage pharmaceuticals, and conduct monitoring, with no substantive oversight or regulation from the MoH. Lessons from other fragile and conflict-affected situations have shown that reaching a government-led management of health service delivery and service contracting requires a gradual transition to strengthen the MoH's stewardship functions while expanding health service coverage and quality.

F. Lessons Learned and Reflected in the Project Design

51. **The project is informed by over a decade of World Bank experience working in South Sudan**, both in the health sector, supporting two of the most conflict-prone states in the country, as well as service delivery in other sectors in other states. The World Bank has been part of donor coordinated efforts to provide basic services in South Sudan since the time of the Comprehensive Peace Agreement. The South Sudan Country Engagement Note (CEN -FY21—23) provides several key lessons from across the portfolio which have been considered in designing–the project. First, there is recognition that, to ensure any significant impact on service delivery, there is a need for flexibility both at the strategic and operational level to increase speed in delivery of services, accountability and citizen engagement, and strategic partnerships given the enormity of the needs, the scope, and limited resources.

52. **Fragile and complex environments require flexibility in project design and alignment to the political economy.** This ensures that the project activities and implementation plan can adapt to the volatile and constantly changing environment of the country—whether economic or political. Building consensus and ensuring cohesion between the Government's priorities and the project's components becomes critical in this context. Currently, South Sudan is bound by the Revitalized Agreement on the Resolution of the Conflict in South Sudan (R-ARCSS) and is implementing a road map agreement that will ensure elections are conducted in 2024. Such factors may have a direct impact on the implementation of the project and therefore tailored yet adaptable interventions are preferable.

53. **Limited institutional capacity calls for simpler project design that have specific yet achievable results.** Given the MoH's limited capacity, the core activities have been designed to focus on immediate priorities of the MoH which can form the foundation for longer-term objectives. Furthermore, it is important to design realistic and achievable PDOs in such environments. The World Bank will work closely with the MoH and provide the necessary advice and capacity building at each stage of the project.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

54. **The World Bank will set up a standalone MDTF and an SDTF.** Donor grant financing will be pooled to co-finance the IDA grant using the IPF instrument. The World Bank will manage the program (IDA and trust funds) through its operational policies, procedures, and environmental and social risk management.

55. **The timing and use of funds from donors will be governed by Administration Agreements between the World Bank and the donors.** The project will be submitted for approval with the IDA grant, and the amounts indicated by the donor partners. The amounts received from donors after the signing of each respective Administration Agreement will feed directly into the MDTF or SDTF pool of funds and will not require the processing of any additional financing.

56. The project is a platform for donors to join, with a total cost of US$369.50 million, of which US$242.50 million is expected to be co-financed by donor contributions between January 2024 and September 2024 (US$217 million from the South Sudan Health Sector Transformation Multi-donor trust fund [MDTF] and US$25.5 million from a Single-donor trust fund [SDTF]). The expected donors (Canada, EU, FCDO, GAVI, Global Fund, Sweden, and USAID) have been an integral part of the discussion and preparation of the project. In case of any deficit, after consultations with the Government, a project restructuring will be undertaken to downscale the scope of activities and their respective targets. Similarly, any new additional donor interested in joining the co-financing mechanism through pooling resources in the MDTF will sign an Administration Agreement and will be allowed to join after receiving the World Bank's and the MOH's no objections. This is facilitated by the incremental nature of activities under the design of the project. Several other donors have expressed their intent to join the program once it has been approved (Annex 5).

57. **The MoH will contract UNICEF and WHO as implementation partners. 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 according to the required standards. WHO will implement health system strengthening activities to facilitate health service access and capacity improvements at national and state level.

58. **TPM agency/ies** will be contracted by the PMU, with World Bank oversight. TPM agencies will conduct household and health facility surveys along with surveys to solicit community and patient feedback. TPM agencies will submit quarterly monitoring reports to the PMU/World Bank.

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

60. **A PMU will be established at the MoH** 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, FM, procurement and contract management, M&E and environmental and social risk management. The PMU will be contracted by the MoH and report 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 World Bank templates. The PMU will have

a progressive role in project management based on the capacity acquired. In addition, the PMU will contract, with World Bank guidance, technical assistance for capacity-building activities based on a needs' assessment. The current COVID-19 Emergency Response and Health System Preparedness Project (CERHSPP-P176480) is financing customized institutional capacity development at the MoH; a PMU of 15 qualified members is in place at the MoH and started engaging in oversight of core aspects of project activities. A new PMU will be established through an open and competitive recruitment process to be carried out by the MoH with close support from the World Bank. The current PMU team will provide good candidates for the new PMU. A PIM will be prepared, describing the main activities to be carried out by the PMU and implementation modalities.

61. **Two steering committees will be established.** A High-level Steering Committee (HSC) will provide strategic direction, overall coordination and policy guidance on the sectoral challenges and future steps on service delivery, health financing, HRH, information system and medicines and supplies. The HSC will meet on a bi-annual basis. An Operational Steering Committee (OSC) will 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. The PMU will serve as the Secretariat to the SCs and will organize meetings of the SCs based on directions received from the chairs. See Annex 1 for membership and other details.

62. **Consultation for activities in refugee hosting areas**. The project will coordinate and seek to partner with UNHCR, to (a) benefit from UNHCR's expertise as the lead UN agency working on refugee issues; (b) capitalize on UNHCR's existing citizen engagement platforms to ensure the target groups are heard; and (c) identify ways to complement ongoing health activities that UNHCR and its partners are implementing in these areas. In view of their lead role on refugee protection, the project will also closely coordinate with CRA officials in refugee-hosting areas to ensure refugees are equitably included in WHR-financed activities, as well as seek to foster collaboration between local government health officials and CRA on this effort. Further, the OSC will liaise and frequently meet with the South Sudan Humanitarian Cluster, a forum that involves all humanitarian players in the country.

B. Results Monitoring and Evaluation Arrangements

63. **Monitoring and tracking of project outputs will rely on different sources of information and monitoring mechanisms**. Through its team and network of partners, implementing agencies will track the planned and actual activities. An additional level of tracking will be through a TPM arrangement. Additionally, to significantly enhance the transparency and accountability of TPM activities, the project will integrate support from the Geo-enabling Initiative for Monitoring and Supervision (GEMS) to enhance the monitoring and supervision capacity of the project. Working with GEMS will enable the World Bank to 'monitor-the-monitors' and get access to direct field data in near real-time, rather than solely receiving aggregated periodic reports. Through the use of GEMS, the project will seek to further build the local capacity to use technologies to collect and analyze data on the ground to improve accountability for TPM and enhance transparency and accuracy of M&E activities.

64. **The Results Framework for the project will build on the lessons from the COVID-19 Emergency Response and Health System Preparedness Project (CERHSPP-P176480)** and will aim at measuring actual service delivery outcomes. UNICEF and WHO will provide detailed technical reports biannually with narrative updates on the overall project implementation and results as well as reporting on the project's Results Framework indicators. In addition, quarterly matrices will be provided which will contain updated progress of Results Framework indicators as well as social and environmental risk management.

65. The project will identify refugees and host communities' beneficiaries by building on a targeting mechanism that has been designed under the ongoing COVID-19 Emergency Response and Health System Preparedness Project (CERHSPP-P176480) which uses a combination of geographic targeting and community-based targeting, with

some filters mainly related to the presence of children below 12 years and pregnant women. The project will rely on the refugee household data collected by UNHCR. The targeting methodology will be tested to ensure its applicability to refugees and adapted as needed. Moreover, these activities will be complemented by a strong communications campaign designed in partnership with humanitarian agencies to ensure that the project is seen as fair to both refugees and host communities.

C. Sustainability

66. **The project contributes to sustainability in two ways.** First, in line with the CEN, the project focuses on building the institutional capacity, enhancing stewardship and governance of the MoH. This will be undertaken through customized training approach to MoH personnel to ensure an acceptable level of project management and fiduciary oversight at the MoH before transitioning fully to a government-led implementation modality. Investment under the project is expected to strengthen the health system in the country, ensuring institutional sustainability to manage service delivery. By the end of the project, MOH will be able to: (a) monitor and evaluate health programs; (b) lead the health sector planning and policy dialogue; (c) develop some public procurement and public financial management capacity; and (d) manage needed environmental and social activities. Second, the project will support the community-based approach through its community health services provided by BHWs. Evidence indicates that community health workers continue to provide some services such as health promotion and awareness even when funding stops. Furthermore, all project activities are aligned with the Government's priorities detailed in HSSP 2023—2027 and therefore their commitment will help drive the initiatives as well as sustain gains supported by the project.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic Analysis

Economic analysis

67. The economic benefits of investing in health and nutrition services are high. The number of children below 11 years represents more than 40 percent of the population in South Sudan. The identified package of nutrition services under the project will follow a life cycle approach and will focus on children, women of reproductive age, and pregnant and lactating women. Those evidence-based services have been proven to yield high benefit-cost ratios. Investing in specific children and maternal nutrition interventions have been estimated to yield between US$11 and US$35 for each US$1 invested. Not only are investments in nutrition one of the best value-for-money development actions, but they also lay the groundwork for the success of investments in other sectors. Therefore, the US$25 million which will be invested in nutrition under the project is expected to yield between US$275 million to US$875 million worth of benefits and returns, especially to the refugee and host communities where most of the support is allocated.

68. South Sudan registers one of the World's highest maternal mortalities (1,150 deaths per 100,000) and under five mortality (100 per 1,000 live births). Assuming that the project will help a conservative reduction in maternal mortality by 10 percent over the project duration, this will save around 27,920 under five lives of which 2,700 children in refugees and host communities and 514 women's lives of which 172 are in refugees and host communities population. Applying a conservative statistical value of life for low-income countries (US$41,756), this will yield an approximate US$1.187 billion in benefits, of which 120 million are direct benefits to the refugees and host communities.

Paris Alignment

69. The project is fully aligned with the adaptation and mitigation goals of the Paris Agreement on Climate Change. The project supports integrated investments to ensure that health service delivery and systems strengthening activities minimize the risk of climate shocks to activities and greenhouse gas emissions from activities. The publicly disclosed climate change technical note presents a comprehensive outline of climate activities in the project.

70. **Adaptation goal and risk reduction measures.** The main risks to project activities are flooding and high heat. Both are anticipated annually based on seasonal weather patterns and a lack of adaptive capacity in the country, with the potential for extremely high health and extreme flooding during the project period. To address the risks of climate to health service delivery under Subcomponents 1.1 and 1.2, Subcomponent 1.4 will include the development of county-level multi-hazard emergency preparedness and response plans with an emphasis on climate emergency preparedness and response for health service delivery and training for staff on these plans. These plans will detail preparatory and response activities to reduce the risk of climate shocks on activities. In addition, health service delivery through the BHI under Subcomponent 1.2 aims to ensure consistent delivery of health services during flooding, with detailed plans to be reinforced in the climate emergency preparedness and response plans. Subcomponent 1.3 will include climate-sensitive planning, with annual dry season prepositioning plans developed and executed to ensure pharmaceuticals are in place and securely stored ahead of the rainy season. Subcomponent 1.4 will include climate-adaptive pharmaceutical store rehabilitation to ensure adequate, secure pharmaceutical storage capacity for pharmaceutical prepositioning and storage. The subcomponent will also include water and sanitation improvements to health facilities to reduce the risk of vector-borne and waterborne climate-sensitive diseases at health facilities. Minor rehabilitation of pharmaceutical stores and health facilities will focus on climate adaptation measures to reduce heat and flood exposure. A specialized consultant will be hired to incorporate climate adaptation measures into health facility and pharmaceutical store rehabilitation. Subcomponent 2.1 will include national and state level multi-hazard climate emergency preparedness and response plans with an emphasis on climate change emergency preparedness and response, with which county-level plans will be aligned, to minimize the risk of climate shocks to health systems strengthening and PMU activities.

71. **Mitigation goal and risk reduction measures.** Most activities in the project are on the universally aligned list for climate change mitigation. Minor rehabilitation activities under Subcomponent 1.4 will ensure at least 20 percent more energy efficiency than standard practice, aligning with EDGE level 1 building criteria. An energy efficiency consultant will be hired to conduct an energy efficiency audit and ensure these measures are incorporated into health service delivery. Subcomponent 1.4 will also finance solar power for sustainable health facility electrification.

Technical

72. The proposed HSTP will strengthen MoH capacity in management of health services and will contribute to the sustainability of the program. The project has been specifically designed to ensure that the South Sudanese population continue to have access to critical health care services. To guide the design of the operation, several key principles were used in formulating the project activities:

    (a) Achieve a balanced approach on two fronts: (i) providing a package of basic health and nutrition services based on the principle of continuum of care throughout the lifecycle (childhood, adolescence/adulthood, pregnancy, childbirth, postnatal period), and among the models of service delivery (including clinical care settings, outreach, and household and communities); and (ii) supporting the primary care facilities nationwide with the basic inputs for maintaining their operational capacity.

(b) Support the delivery of an integrated package of services building on the experience of the ongoing IDA funded health operations. There are predefined guidelines and protocols for integrated service delivery and facility-based health planning suited to South Sudan that are consistent with the current capacities in the country. These standards ensure that (i) delivery through facilities is focused on basic health and nutrition services and ensure optimum use of the limited resources, (ii) routine outreach and community-based services are planned to complement delivery through fixed services, and (iii) mobile teams respond to the needs of disadvantaged groups in areas lacking functional fixed facility or refugees and host community areas.

B. Fiduciary

(i) Financial Management

73. An FM assessment was carried out covering planning and budgeting, accounting, internal control including internal audit, financial reporting, funds flow, and external audit arrangements.

74. The objective of the FM assessment was to determine whether the MoH maintains adequate FM arrangements to ensure that: (a) project funds channeled through the MoH will be used for the purposes intended in an efficient and economical manner; (b) the project's financial reports will be prepared in an accurate, reliable, and timely manner; and (c) the project's assets will be safeguarded from loss, abuse, or damage.

75. The assessment indicates that basic FM systems and capacity exist in the MoH, but the overall status is considered weak. There are significant capacity gaps within the MoH, which could materially affect the implementation of the HSTP if not mitigated. These include weak and inadequate budgetary preparation and monitoring systems, weak capacity, lack of budget monitoring tools, inadequate staffing capacity, and weak manual accounting system. Weaknesses in the internal control systems include deficiencies in payment authorizations, lack of documented policies and procedure manuals, inadequate segregation of duties with some overlapping roles, and lack of a functional internal audit unit. The external audit also identified weaknesses on the project previously implemented by the ministry, some of which remain unresolved including lack of bank reconciliation statements, no internal audit, and computerized accounting system acquired for the project not used and not available as of the assessment date. As a mitigation measure, the FM arrangements for the project will be discharged through a PMU to be set up within the ministry. The FM activities at the PMU will be overseen by a FM specialist, supported by a project accountant hired for the project and complemented by finance staff deployed by the MoH to strengthen capacity within the ministry. There will also be hands on support and close monitoring by the World Bank. Based on the findings, the overall residual FM risk rating will be substantial.

(ii) Procurement

76. **Procurement capacity assessments of the MoH**. The MoH will implement the project through the PMU to be established at the national level. A procurement capacity risk assessment was conducted as part of project preparation, and general findings from the country situation. The MoH, like many MDAs, does not have a functional procurement unit. Procurement processes are carried out as administrative functions and though the procurement department exist and is headed by the deputy director, there are no dedicated procurement staff. The PPDA Act 2018 provides for establishment of Procurement Unit and Procurement Committee at each procuring entity, and all procurement functions are to be carried and managed by the Procurement Unit. It was established that though the MoH has had experience implementing World Bank-financed projects, the staff being recommended to the PMU have no direct experience with the World Bank's Procurement Regulations.

77. **Project Procurement Strategy for Development (PPSD) and Procurement Plan**. A PPSD was developed to improve implementation of the project and help achieve results. The Government has prepared the Procurement Plan for the initial 18 months, setting forth the selection methods to be followed by the implementing entities during

project implementation in the procurement of goods, works, and non-consulting and consulting services financed by the World Bank. The Procurement Plan will be updated at least annually or as required to reflect the actual project implementation needs and improvements in institutional capacity. Over 80 percent of the project activities will be implemented through an Output Agreement (UNICEF and WHO). UNICEF and WHO shall be contracted to implement through Output Agreement Component 1 (UNICEF) and Component 2 (WHO). All procurement of medical commodities will be handled by UNICEF and WHO based on their systems. The PMU will provide coordination and management roles of the project and supported by TPM agency/ies to be hired by the project.

78. Through an MoH request, the World Bank will approve a Hands-On Extended Implementation Support (HEIS) consultant for a 6-12 months' period to support the establishment of the PMU through advancing the recruitment of key consultants and initiating the contracting of UNICEF and WHO. The hiring of UNICEF and WHO will be done through Systematic Tracking of Exchanges in Procurement (STEP) and the World Bank's no objection will be required prior to the finalization and signing of the agreement. To enable transfer of knowledge, the MoH will second a procurement officer to work with the procurement consultant hired at the PMU.

79. The Procurement risk for the project is rated as 'High'. There is an incomplete public procurement framework, lack of a functional Procurement Unit and oversight functions at the MoH, and general weak public financial management governance. The World Bank's experience and assessment of key issues and risks concerning project procurement processes in South Sudan has also shown several challenges which include: (a) lack of commitment from the Government officials / civil servants in implementation of the project due to irregular and low remunerations (b) delayed procurement and contract implementation due to inadequate number of technical staff to handle increased volume of procurement and contract administration; (c) weaknesses in procurement planning resulting in inappropriate packaging of contracts, high prices and delayed implementation of the project; and (d) weak procurement oversight and contract management resulting in delayed implementation and potential loss of value. The mitigations measures include the following: establishment of the PMU staffed with experienced procurement and other expert consultants, World Bank providing HEIS to support the establishment of PMU and contracting of UNICEF and WHO; and advance procurement of major activities to fast-track implementation of project, including preparation of Procurement Manual and hiring of a procurement specialist as an effectiveness condition, among other conditions.

C. Legal Operational Policies

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

80. The Bank's Policy on Projects in Disputed Areas (OP/BP 7.60) applies to the South Sudan HSTP because of territorial dispute between South Sudan and Sudan, Uganda, and Kenya. Some parts covered by the project fall within the general areas under dispute. In line with OP 7.60, the Bank has ensured compliance with the requirements of the policy and notified the project to the authorities of Sudan, Uganda and Kenya. Given that the World Bank considers that the execution of the project is not prejudicial to the interests of these countries and that the World Bank does not intend to pass any judgment with regard to the legal status, nor any other status in reference to the territories concerned and does not intend to prejudge or influence the final decision of the

International Court of Justice regarding the claims of South Sudan, Sudan, Uganda and Kenya, no objection to the project has been raised.

D. Environmental and Social

81. The project's overall environmental and social (ES) risk classification is rated high. Nine of the ten ESS (except ESS 9) of the World Bank Environmental and Social Framework are relevant to the project. Description of the environmental, social, health, and safety risks and impacts related to the project and the proportionate mitigation measures is summarized as follows.

82. **Environmental risks**. The nationwide provision of basic health services of Component 1 poses several environmental, health, and safety (EHS) risks. The procurement and distribution of essential drugs and medical supplies could result in waste generation if not managed properly, leading to environmental contamination. The increased outreach and use of mobile health services may also lead to higher fuel consumption and vehicle emissions, contributing to air pollution. Also, to improve access to remote communities, existing/new facilities or infrastructure might be rehabilitated/constructed, which could cause deforestation of natural and/or critical habitats. The rise in health services delivery may also lead to a higher amount of medical waste. Component 2 will focus on strengthening South Sudan's health system to facilitate health service access and capacity improvements, including development/updating of policies and legal frameworks which may have direct/indirect EHS risks to people and the environment. It will also support laboratory strengthening, disease control, and procurement and use of ICT equipment which could require waste management. Also, the use of certain chemicals and biological agents for disease control and prevention during emergency preparations could pose environmental hazards if not managed and disposed of properly, whereas, under Component 3, developing and maintaining a common monitoring mechanism and databases may require significant energy and data storage resources, contributing to higher carbon footprints and e-waste generation. Finally, the need for rapid infrastructure construction and the distribution of relief supplies during emergency response efforts of CERC may entail resource-intensive activities that have environmental consequences. There are also potential occupational health and safety and community health and safety risks associated with all components of the project.

83. **Social risks**: The project social risks are classified as High. The project could face multiple potential social risks as it will be implemented nationwide where prevalence of poverty, drought, security challenges, and many more complex social issues under the FCV context of South Sudan are severe. Investments and support to service providers, including in the health sector, increases the risks of service providers becoming targets of attacks, pillaging, and acts of violence by armed groups. Cases of health facilities and hospitals being raided have been documented in South Sudan and experienced during implementation of the parent and previous health projects. These include risks resulting from (a) inter/intra-communal tensions, including between refugees and host communities, over implementation issues, (b) assets and staff becoming targets of violent groups, and (c) GBV and SEA/SH risks that are prevalent and heightened in conflict-affected areas. The SEA/SH risk of the project is considered High. Pervasive incidences of GBV in South Sudan are a significant contextual challenge, exacerbated by a context of pervasive insecurity in the country. More specifically, Component 1 includes activities which may potentially exacerbate existing inequalities or cause social exclusions in health service access, especially for vulnerable and conflict-affected communities. The project activities including the technical assistance activities involve limited potential social risks associated with labor, labor conditions, safety and security of project workers, exclusion of beneficiaries during targeting, and delivery of capacity development trainings, compromising the service delivery quality, and challenges of ensuring the quality and reliability of the data generated, particularly in areas with limited human resources and infrastructure.

84. Risk Management E&S instruments: To effectively assess, manage and monitor the potential the environmental, social, health and safety risks, the project developed the following ESF instruments: Environmental and Social Commitment Plan (ESCP) and Stakeholder Engagement Plan (SEP), and disclosed them on November 24,2023 on Ministry of Finance and Planning website; Environmental and Social Management Framework (including Labor Management Procedures, and GBV/SEA/SH Risk Assessment and Action Plan, General Medical Waste Management Plan, and Social Assessment with Social Development Plan); Resettlement Framework; and Security Risk Assessment and Management Plan as conditions of effectiveness as the project is being processed under the World Bank Policy for IPF, paragraph 12.

85. **Gender.** Women and girls in South Sudan face considerable socio-economic and cultural challenges that contribute to gender gaps in health outcomes and health services. South Sudan has the highest maternal mortality in the world. The fertility rate is also high. The project document identifies early marriages and high fertility, poor access to essential healthcare, and high risk of experiencing SGBV as key issues that affect women and girls' sexual and reproductive health. These outcomes are the reflective of a lack of women's empowerment and their poor access to essential healthcare. Cultural beliefs and fertility preferences contribute to the cycle of early marriages and high and early fertility on the one hand, and on the other demand side challenges such as limited awareness of the benefits for reproductive and maternal healthcare, hidden cost of services, opportunity cost of time, and security concerns deter women from seeking health services. On the supply side, a weak health system with limited infrastructure and disrupted access to health and nutrition services due to emergency situations such as floods make it difficult to ensure that pregnant women and adolescent girls receive appropriate care. Improving women and girls' use of reproductive maternal health will contribute to reducing maternal mortality. This requires improving the access to and the availability of sexual, reproductive, and maternal health services, especially at the community level which includes family planning information, and education, communication (IEC)/social and behavior change communication (SBCC) to reduce misconceptions about sexual and reproductive healthcare and promote delayed births and birth spacing, which are critical for bringing down maternal mortality, especially among younger, adolescent girls.

86. **SGBV** is also of concern in South Sudan. However, the response to SGBV in the country remains inadequate. There is limited capacity within the health system provide appropriate care to survivors of SGBV. Moreover, the stigma associated with rape and sexual violence continues to be a barrier for women and girls in acknowledging the experience and seeking timely and appropriate healthcare for SGBV. There is a need for strengthening the availability of trained medical personnel who can handle Clinical Management of Rape (CMR) and provide basic psycho-social support in a safe environment.

87. **Proposed actions under the project.** Component 1 of the project supports delivery of a set of prioritized services that cover sexual, reproductive, and maternal health and nutrition services that include family planning counselling and delivery of family planning services, ANC, skilled attendance at birth, basic and comprehensive EmONC, and PNC. This comprehensive package of services is essential to ensure that pregnant women, girls, and their newborns have the best chance of surviving birth, especially when there are complications. It is also important for providing the means to exercise more agency in determining the size of families and timing of births – again important for reducing maternal mortality. In addition to strengthening service delivery at primary secondary and tertiary facilities, the component will support the hiring and training of Boma Health Workers (BHWs), including female BHWs, to reach vulnerable and hard-to-reach groups at the community level and last mile delivery of medical supplies and pharmaceuticals. This is especially important for reaching women, mothers, and their children in rural and remote areas. The component will also support provision of SGBV care including identification, counselling, management and proper referral for survivors of SGBV, including rape victims. The intervention package includes BCC focusing SGBV awareness and prevention. These three interventions (i) strengthening delivery of reproductive and maternal health services, (ii) training and deployment of Boma Health Workers, especially female service providers, and (iii)

provision of SGBV services, support the two broad issues identified in the PAD that disproportionately affect women: (a) high fertility and maternal mortality, and (b) limited support for SGBV survivors. The following indicators will be used to monitor progress on both these issues: (i) maternal mortality ratio; (ii) percentage of women receiving four ANC visits; (iii) percentage of deliveries attended by skilled health personnel; (iv) contraceptive prevalence rate (any method); and (v) number of Gender-Based Violence Services provided.

88. **Citizen Engagement.** The project will prioritize meaningful engagement of all direct and indirect stakeholders in the health sector. This will be done through widescale consultative process with Government officials and will engage all relevant donors and development partners and various sector experts/specialists. In addition, the M&E system of the project will facilitate strong citizen engagement and beneficiary feedback throughout project implementation. The project will ensure proactive feedback processes including a feedback mechanism for all health services provided and trainings conducted by the project. Planned procurement activities will include hiring of two TPM entities to verify that resources are reaching the intended beneficiaries and potential harm is minimized, consultancy for health service quality assessment, and citizen engagement and beneficiary feedback surveys. The project will implement and expand an existing GRM developed and implemented under the COVID-19 Emergency Response and Health Systems Preparedness Project (CERHSSP-P176480) which aligns with the requirements of ESS 10 and other relevant E&S standards. The proposed GRM is expected to provide an inclusive, accessible and safe GRM process and procedures that receives and resolves grievances, closes the feedback loop with communities and builds trust, sensitively handles corruption and SEA allegations, and provides the project with actionable data through which to adjust and improve its programming.

V. GRIEVANCE REDRESS SERVICES

89. ***Grievance Redress.*** Communities and individuals who believe that they are adversely affected by a project supported by the World Bank may submit complaints to existing project-level grievance mechanisms or the Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the Bank's independent Accountability Mechanism (AM). The AM houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of Bank non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted to the AM at any time after concerns have been brought directly to the attention of Bank Management and after Management has been given an opportunity to respond. For information on how to submit complaints to the Bank's Grievance Redress Service (GRS), visit http://www.worldbank.org/GRS. For information on how to submit complaints to the Bank's Accountability Mechanism, visit https://accountability.worldbank.org.

VI. KEY RISKS

90. **The overall risk to achieving the project objective is High.** There are significant risks to implementing a project in South Sudan, as evidenced from the previous and ongoing World Bank supported projects. The project will support health services delivery in one of the most challenging FCV contexts in the world. This results in greater risks than those found in non-FCV environments. More specifically, the acuteness of the violence and instability in the country sets South Sudan apart from other FCV environments with even greater levels of risk.

91. **Political and governance risks is High**. The highly fragile context and political economy dynamics pose risks. The country's security situation remains volatile and intercommunal conflicts persist, which fuels further political

uncertainty. There is also a significant risk that frequent changes in political leadership and appointees may undermine government ownership and cause project delays. To mitigate this risk, the World Bank will continue to engage at multiple levels within the MoH and MoFP and with key health sector stakeholders to ensure broad buy-in and ownership. The project will also support regular coordination meetings and ensure flexibility so that adjustments can be made during implementation. Political risks related to refugee issues are minimal, as the Government and South Sudanese have adopted–in policy and practice–a progressive policy towards refugees.

92. **Macroeconomic risks are High.** South Sudan has one of the least diversified economies in the world, a result of being extremely oil dependent. This has made the sector mainly depending on the donor funding with irregular payment of salaries to civil servants including health workers. Even though inflation has seen a dramatic reduction since the implementation of the Government's reform program, the current commodity price shock and the depreciation of the South Sudanese pound are expected to drive a rise in inflation in the short term.[32] Despite the depreciation of the South Sudan Pound, the premium between the parallel and official exchange rate remained low at below 3 percent owing to the tight monetary policy stance, continued foreign exchange auctioning in a weekly basis, and tightening of regulatory framework by the Central Bank. However, given the low gross reserve levels, the likelihood of foreign exchange shortage is eminent, which, in turn, may result in parallel market distortions. The Government's commitment to contribute to the financing of health service delivery remains uncertain and may not be fully adhered to. The proposed project will mitigate this risk by enhancing stewardship of the MoH and MoFP and will develop a clear roadmap for the gradual handover of identified facilities to the Government to sustain. Those facilities will be carefully selected at the beginning to avoid significant gaps in service delivery in case of government's non-adherence to their financial commitments.

93. **Sector strategies and policies risks are Substantial.** It is critical to recognize that after over five decades of continuous assistance and presence in South Sudan, international actors and the aid they provide are now an integral part of the local political economy. The continued change in the MoH leadership over the last few years continued to disrupt the development of sectoral strategies. The provision of basic health services, however, is a priority for the ministry. Maintaining a strong focus on procurement of necessary supplies and equipment and training of health and non-health workers at targeted areas are key mitigation measures.

94. **Technical design of the project risk is High**. The targeting of refugees and host communities increases the complexity of delivering health services. Experiences from humanitarian organizations provide valuable lessons about how to ensure neutrality and impartiality in the delivery of these services. Various mechanisms are proposed, both within agreements with the implementation agencies and across project components. In addition, robust mechanisms for results monitoring and verification will provide an additional oversight in ensuring that the package of services has reached the intended targeted populations of refugees and host communities.

95. **Institutional capacity for implementation and sustainability risks are High**. The risk of the MOH and PMU managing service delivery at a national level is high and is currently being mitigated through an intensified capacity building program on effective project management for several candidates. In addition, UNICEF will be subcontracted by the PMU to provide service delivery activities of the project while WHO will provide the system strengthening elements. Both agencies will seek to expand its operational and technical presence on the ground and nationwide to ensure a smooth transition from World Bank/HPF and effective management of the new pooled fund program. It is expected that by the end of the project MOH will have an enhanced capacity that will enable it to lead on some areas of activity implementation in the future.

[32] IMF Country Report No. 22/266, 2022 Article IV Consultation and Second Review under the Staff-Monitored Program, July 2022.

96. **Fiduciary risk is Substantial**. The FM assessment identified capacity gaps within the MoH and deficiencies in the internal control systems. The external audit for the project previously implemented by the MoH identified weaknesses, some of which remain unresolved. There will also be hands on support and close monitoring by the World Bank. to mitigate incomplete public procurement framework, lack of a functional procurement units and oversight functions at the MoH and general weak PFM governance. As a mitigation measure, the fiduciary arrangements for the project will be handled by a PMU to be set up within the ministry. The FM activities at the PMU will be overseen by a consultant, supported by a project accountant hired for the project and complemented by finance staff deployed by the MoH to strengthen capacity within the ministry., The World Bank will also provide HEIS to support the establishment of the PMU and contracting of UNICEF and WHO, using advance procurement of major activities to fast-track implementation of project, including preparation of a Procurement Manual and hiring of procurement specialist as an effectiveness condition among other conditions.

97. **Environmental and social risks are High**. Despite the promising social impacts, the project social and SEA/SH risks are classified as high. The project could face multiple potential social risks as it will be implemented nationwide where prevalence of poverty, drought, security challenges, and many more complex social issues under the FCV context of South Sudan are severe. The conflict has had a significant impact on children, with profound human rights abuses conducted on them. In this context, investments, and support to service providers in the health sector increases the risks of providers becoming targets of attacks, pillaging and violence by armed groups. Recent attacks on health workers, within and outside the Provision of Basic Health Services Project, have highlighted that risk. Evidence reveals that the context of pervasive insecurity in the country has heightened the risks associated with GBV or SEA/SH. The project's environmental risk rating is Substantial due to EHS issues associated with (a) provision, transport, storage, use and disposal of medicines and vaccines; (b) medical waste management; (c) worker and community health and safety; and d) rehabilitation/construction of public health facilities. With the involvement of the MoH as a direct implementing entity, its limited experiences of managing the environmental and social risks would be concerning to effectively address the complex social issues, pervasive GBV incidents, substantial environmental risks and potential grievances from project affected persons and other stakeholders. In sum, to effectively assess, manage and monitor the potential environmental and social risks and impacts, the project will develop proportional ESF instruments as stated in Section D.

98. **Stakeholders' risk is High**. Experiences from humanitarian organizations provide valuable lessons about how to ensure neutrality and impartiality in the delivery of health services. Despite these lessons and the fact that partner agencies are non-state actors, the proposed project will be implemented by the MOH/PMU, which carries additional complexity in addressing issues to cover entire target populations and ensuring independence in service delivery. To minimize the risks related to delivering goods to health facilities, communication and outreach activities will be conducted to inform the public of the project's support and increase visibility. In addition, the project will strictly follow an objective methodology for procurement and distribution of required supplies to the target facilities. Coordination with UNHCR will also be leveraged to facilitate direct engagement with refugees and host communities to ensure they are aware of, consulted on, and can benefit equitably from, project activities. Finally, the subcontracting of UNICEF and WHO as implementation partners will strengthen such systems.

99. **Other risks (security and data protection) have been identified**. Security risk. Several facilities were previously attacked and looted, leading to deaths of patients and health workers. These risks remain a reality for the World Bank and partner agencies providing support to health services across South Sudan, particularly in the states of Upper Nile, Jonglei, and Unity. Multiple effort has been made, however, to mitigate potential risks through the development of a customized security management plan along with its implementation arrangements. Data protection. There is a substantial residual risk related to data collection, processing, and privacy during implementation of the project activities, which may arise from (a) access to personally identifiable and sensitive

information by unauthorized personnel, (b) gaps in regulation on data privacy and protections, and (c) breaches to cybersecurity. There are regulations protecting personal information, including health-related data. Electronic and paper-based data collection and reporting forms that contain personal information are stored in a manner that prevents unauthorized access to sensitive and confidential information. The project will provide support for software and hardware investments that further mitigate the risk of breaches to cybersecurity.

VII. RESULTS FRAMEWORK AND MONITORING

PDO Indicators by PDO Outcomes

Baseline	Period 1	Period 2	Closing Period
Expand access to a basic package of health and nutrition services			
Percentage of Bomas covered by the Boma Health Initiative (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
16	20	25	32
➢Percentage of Bomas covered by the Boma Health Initiative in refugee areas. (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
16	20	25	32
➢Percentage of Bomas covered by the Boma Health Initiative in host communities' areas. (Percentage)			
Sep/2023	Jul/2026	Jul/2025	May/2027
16	20	25	32
Improve health sector stewardship			
Percentage of MoH budget executed (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
30	50	75	99
Strengthen the health system			
General service availability score (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
30.4	35	40	46
➢General service availability score for refugees (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
30.4	35	40	46
➢General service availability score for HC (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
30.4	35	40	46

Intermediate Indicators by Components

Baseline	Period 1	Period 2	Closing Period
Component 1: Provision of Basic Health Services Nationwide			
Percentage of Gender-Based Violence Services provided (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	10	20	45
Percentage of women receiving four ANC visits (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
20	30	40	52
➢Percentage of refugee women receiving four ANC visits (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
20	30	40	52
➢Percentage of HC women receiving four ANC visits (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
20	30	40	52
Coverage of birth registration notification (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0.4	4.0	8.0	10
Coverage of maternal death review (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	25	35	55
Number of health facilities with climate friendly minor rehabilitation and water and sanitation improvements completed (Number)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	50	100	200
Percentage of deliveries attended by skilled health personnel (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
19	25	35	43
➢Percentage of refugee deliveries attended by skilled health personnel (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
19	25	35	43
➢Percentage of HC deliveries attended by skilled health personnel (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027

19	25	35	43
Percentage of children who have received 1st and 3rd dose of pentavalent vaccine (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
75	80	85	90
➢Percentage of refugee children who have received 1st and 3rd dose of pentavalent vaccine (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
75	80	85	90
➢Percentage of HC children who have received 1st and 3rd dose of pentavalent vaccine (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
75	80	85	90
Percentage of facilities reporting stock out of tracer medicines (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
27	26	24	22
➢Percentage of refugee health facilities reporting stock out of tracer medicines (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
27	26	24	22
➢Percentage of HC health facilities reporting stock out of tracer medicines (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
27	26	24	22
Percentage of children aged <59 months receiving Vitamin A supplements twice a year (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
66	70	80	89
➢Percentage of refugee children aged <59 months receiving Vitamin A supplements twice a year (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
66	70	80	89
➢Percentage of HC children aged <59 months receiving Vitamin A supplements twice a year (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
66	70	80	89
Children under 5 years who are wasted (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
16.1	14	12	11
Proportion of infants who have received first dose measles (MCV1) vaccine (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
72	75	80	85

Under five years' mortality rate (per 1000 live births) (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
98.69	80	70	60
➢HC under five years' mortality rate (per 1000 live births) (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
98.69	80	70	60
➢Refugee under five years' mortality rate (per 1000 live births) (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
98.69	85	70	60
Intermittent prevention of malaria during pregnancy (IPTp≥3) (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
11	50	60	75
Maternal mortality ratio (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
1223	1000	900	843
➢Maternal mortality ratio for refugees (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
1223	1000	900	843
➢Maternal mortality ratio for HC (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
1223	900	800	843
Contraceptive prevalence rate (any method) (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
6	8	9	10.5
The proportion of patients with suspected malaria who received a parasitologic test (RDT/Microscopy) (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	80	90	95
Proportion of health facilities that have a core set of relevant essential medicines and commodities available and affordable (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
73	75	78	81
BHI training material revised to include refugee sensitive health interventions. (Yes/No)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
No	No	Yes	Yes
Number of health and nutrition services provided to refugees and host communities (Number)			

Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	1,300,000	3,700,000	5,940,000
➢Number of health, nutrition and population services provided to refugees (Number)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	300	700	940,000
➢Number of health, nutrition, and population services provided to HC (Number)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	1,000,000	3,000,000	5,000,000
Component 2: Health Systems Strengthening			
Percentage of SMoH/CHDs with work plans aligned to the HSSP (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	30	60	70
Proportion of health alerts investigated in 48 hrs (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
81	84	86	88
Percentage of disease outbreaks in refugee areas that are adequately addressed as per WHO guidelines (Percentage) (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	100	100	100
Component 3: Monitoring and Evaluation and Project Management			
Percentage of health facilities receiving quarterly supervision visits (disaggregated by visits by CHDs, SMoH, and IPs) (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0.00	30	60	85
➢Percentage of refugee health facilities receiving quarterly supervision visits (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	20	40	75
➢Percentage of HC health facilities receiving quarterly supervision visits (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	20	50	75
Percentage of complaints to Grievance Redress Mechanisms satisfactorily addressed in a timely manner (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	35	50	70
Completeness of reporting by facilities (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
41	60	70	80

Percentage of states that conducted quarterly coordination meetings with a review of data and documented with minutes including action items and follow-up (Percentage)			
Sep/2023	Jul/2025	Jul/2026	Jul/2027
0	30	50	70
Component 4: Contingent Emergency Response Component			

Monitoring & Evaluation Plan: PDO Indicators by PDO Outcomes

Expand access to basic package of health and nutrition services	
BHI Coverage (Percentage)	
Description	The proportion of functional BHI as per the standard (based on the population)
Frequency	Quarterly
Data source	Quarterly Health Facility Assessment
Methodology for Data Collection	Quarterly Health Facility Assessment report
Responsibility for Data Collection	Third Party Monitor / PMU Responsible for Monitoring; Measures subcomponent 1.1 Under UNICEF
BHI Coverage for refugees (Percentage) BHI	
Description	The proportion of functional BHI as per the standard (based on the population)
Frequency	Quarterly
Data source	Quarterly Health Facility Assessment
Methodology for Data Collection	Quarterly Health Facility Assessment report
Responsibility for Data Collection	Third Party Monitor / PMU Responsible for Monitoring; Measures sub-component 1.1 Under UNICEF
BHI Coverage for HC (Percentage) Number of health facilities providing at least 75 percent of the basic package of health services to host communities (Number)	
Description	The proportion of functional BHI as per the standard (based on the population)
Frequency	Quarterly
Data source	Quarterly Health Facility Assessment
Methodology for Data Collection	Quarterly Health Facility Assessment report
Responsibility for Data Collection	Third Party Monitor / PMU Responsible for Monitoring; Measures subcomponent 1.1 Under UNICEF
Percentage of MoH budget implemented (Budget execution rate) (Percentage)	
Description	The proportion of Health budget expenditure to allocation
Frequency	Quarterly
Data source	MoH budgetary data
Methodology for Data Collection	PMU and WB
Responsibility for Data Collection	PMU and WB
Percentage of general service availability score (Percentage)	
Description	Service availability is described by an index using the three areas of tracer indicators (infrastructure, workforce, and utilization). This is made possible by expressing the indicators as a percentage score un-weighted average of the three areas
Frequency	Quarterly
Data source	Quarterly Health Facility Assessment
Methodology for Data Collection	TPM report
Responsibility for Data Collection	TPM / PMU
Percentage of general service availability score in host communities' areas (Percentage)	
Description	Service availability is described by an index using the three areas of tracer indicators (infrastructure, workforce, and utilization). This is made possible by expressing the indicators as a percentage score un-weighted average of the three areas

Frequency	Quarterly
Data source	Quarterly Health Facility Assessment
Methodology for Data Collection	TPM report
Responsibility for Data Collection	TPM / PMU
Percentage of general service availability score for refugees.	
Description	Service availability is described by an index using the three areas of tracer indicators (infrastructure, workforce, and utilization). This is made possible by expressing the indicators as a percentage score un-weighted average of the three areas
Frequency	Quarterly
Data source	Quarterly Health Facility Assessment
Methodology for Data Collection	TPM report
Responsibility for Data Collection	TPM / PMU

Monitoring & Evaluation Plan: Intermediate Results Indicators by Components

Component 1: Provision of Basic Health Services Nationwide	
Percentage of Gender-Based Violence Services provided (Percentage)	
Description	Percentage of SGBV survivors who treated for assault + SGBV cases provided with emergency contraceptives + SGBV cases referred out + SGBV survivors given PEP + Clinical management of rape + OPD Rape and GBV services
Frequency	Quarterly
Data source	DHIS
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponents 1.1 and 1.2 Under UNICEF
BHI training material revised to include refugee sensitive health interventions (Yes/No)	
Description	BHI training materials for boma health workers revised to include refugee sensitive health interventions
Frequency	Quarterly
Data source	TPM Report
Methodology for Data Collection	TPM
Responsibility for Data Collection	TPM / PMU; Measures subcomponents 1.1 and 1.2 Under UNICEF
Percentage of women receiving four ANC visits (Percentage)	
Description	Percentage of women at childbearing age with a live birth in a given time period who received antenatal care, four times or more times from any provider.
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Percentage of refugee women receiving four ANC visits (Percentage)	
Description	Percentage of refugee women at childbearing age with a live birth in a given time period who received antenatal care, four times or more times from any provider.

Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Percentage of HC women receiving four ANC visits (Percentage)	
Description	Percentage of HC women at childbearing age with a live birth in a given time period who received antenatal care, four times or more times from any provider.
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Number of health facilities with climate friendly minor rehabilitation and water and sanitation improvements completed (Number)	
Description	Number of health facilities with a.) climate friendly rehabilitation measures as defined by a set list of measures that go beyond standard practice to reduce flooding, heavy rain, and heat risk to health facilities; and/or b.) water and sanitation improvements as defined as improvements in the availability of safe water (drilling of boreholes, piping of water, safe rainwater catchment) and sanitation (pit latrines to ESF specifications; flushable toilets)
Frequency	Quarterly
Data source	UNICEF/TPM report
Methodology for Data Collection	UNICEF/TPM
Responsibility for Data Collection	UNICEF/TPM
Percentage of deliveries attended by skilled health personnel (Number)	
Description	Percentage of live births attended by skilled health personnel during a specified time period.
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Percentage of refugee deliveries attended by skilled health personnel (Number)	
Description	Percentage of refugee live births attended by skilled health personnel during a specified time period.
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Percentage of HC deliveries attended by skilled health personnel (Number)	
Description	Percentage of HC live births attended by skilled health personnel during a specified time period.
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF

Percentage of children under one year of age who have received 1st & 3rd dose of pentavalent vaccine (Percentage)	
Description	Proportion of surviving infants who have received 1st & 3rd dose of the combined diphtheria, tetanus toxoid, pertussis, Hepatitis B and Homophiles influenza type b vaccine
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Percentage of refugee children under one year of age who have received 1st & 3rd dose of pentavalent vaccine (Percentage)	
Description	Proportion of surviving infants who have received 1st & 3rd dose of the combined diphtheria, tetanus toxoid, pertussis, Hepatitis B and Homophiles influenza type b vaccine
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Percentage of HC children under one year of age who have received 1st & 3rd dose of pentavalent vaccine (Percentage)	
Description	Proportion of surviving infants who have received 1st dose of the combined diphtheria, tetanus toxoid, pertussis, Hepatitis B and Homophiles influenza type b vaccine
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Percentage of facilities reporting stock out of tracer medicines (Percentage)	
Description	This indicator measures whether facilities experienced a stockout of one or more tracer medicines and laboratory reagents at any point during the reporting period being assessed. The result is expressed as a percentage of the total number of facilities.
Frequency	Quarterly
Data source	Pharmaceutical agency/ Quarterly Health Facility Assessment
Methodology for Data Collection	Pharmaceutical agency, to be verified quarterly by TPM
Responsibility for Data Collection	TPM; PMU; pharmaceutical agency
Percentage of refugee facilities reporting stock out of tracer medicines (Percentage)	
Description	This indicator measures whether refugee facilities experienced a stockout of one or more tracer medicines and laboratory reagents at any point during the reporting period being assessed. The result is expressed as a percentage of the total number of facilities.
Frequency	Quarterly
Data source	Pharmaceutical agency/ Quarterly Health Facility Assessment
Methodology for Data Collection	Pharmaceutical agency, to be verified quarterly by TPM
Responsibility for Data Collection	TPM; PMU; pharmaceutical agency
Percentage of HC facilities reporting stock out of tracer medicines (Percentage)	
Description	This indicator measures whether HC facilities experienced a stockout of one or more tracer medicines and laboratory reagents at any point during the reporting period being assessed. The result is expressed as a percentage of the total number of facilities.

Frequency	Quarterly
Data source	Pharmaceutical agency/ Quarterly Health Facility Assessment
Methodology for Data Collection	Pharmaceutical agency, to be verified quarterly by TPM
Responsibility for Data Collection	TPM; PMU; pharmaceutical agency
Number of health, nutrition, and population (HNP) services provided to refugees (Number)	
Description	Number of health and nutrition services provided to refugees from health facilities and outreach services, this includes reproductive and maternal health service, immunization and child health, nutrition, OPD consultation, NCD, NTD, TB, HIV testing and treatment services, disaggregated by age and sex)
Frequency	biannual
Data source	Survey
Methodology for Data Collection	Survey report
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Number of health, nutrition, and population (HNP) services provided to HC (Number)	
Description	Number of health and nutrition services provided to HC from health facilities and outreach services, this includes reproductive and maternal health service, immunization and child health, nutrition, OPD consultation, NCD, NTD, TB, HIV testing and treatment services, disaggregated by age and sex)
Frequency	biannual
Data source	Survey
Methodology for Data Collection	Survey report
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Percentage of children aged <59 months receiving Vitamin A supplements twice a year	
Description	Percentage of children aged 6–59 months who received two age-appropriate doses of vitamin A in the past 12 months.
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Percentage of refugee children aged <59 months receiving Vitamin A supplements twice a year	
Description	Percentage of children aged 6–59 months who received two age-appropriate doses of vitamin A in the past 12 months.
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Percentage of HC children aged <59 months receiving Vitamin A supplements twice a year	
Description	Percentage of children aged 6–59 months who received two age-appropriate doses of vitamin A in the past 12 months.
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2

Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Percentage of Children under 5 years who are wasted	
Description	Percentage of wasted (moderate and severe) children aged 0–59 months (moderate = weight-for-height below -2 standard deviations of the WHO Child Growth Standards median; severe = weight-for-height below -3 standard deviations of the WHO Child Growth Standards median).
Frequency	Annually
Data source	Survey
Methodology for Data Collection	Survey
Responsibility for Data Collection	Third Party Monitor / PMU
Percentage of refugee children under 5 years who are wasted	
Description	Percentage of wasted (moderate and severe) refugee children aged 0–59 months (moderate = weight-for-height below -2 standard deviations of the WHO Child Growth Standards median; severe = weight-for-height below -3 standard deviations of the WHO Child Growth Standards median).
Frequency	Annually
Data source	Survey
Methodology for Data Collection	Survey
Responsibility for Data Collection	Third Party Monitor / PMU
Percentage of HC children under 5 years who are wasted	
Description	Percentage of wasted (moderate and severe) HC children aged 0–59 months (moderate = weight-for-height below -2 standard deviations of the WHO Child Growth Standards median; severe = weight-for-height below -3 standard deviations of the WHO Child Growth Standards median).
Frequency	Annually
Data source	Survey
Methodology for Data Collection	Survey
Responsibility for Data Collection	Third Party Monitor / PMU
Percentage of Measles (MCV1) immunization coverage	
Description	Proportion of surviving infants who have received first dose measles (MCV1) vaccine before their first birthday
Frequency	Annually
Data source	Survey
Methodology for Data Collection	Survey
Responsibility for Data Collection	Third Party Monitor / PMU
Under five years' mortality rate (per 1000 live births)	
Description	The probability of a child born in a specific year or period dying before reaching the age of 5 years, if subject to age-specific mortality rates of that period, expressed per 1000 live births
Frequency	Annually
Data source	Survey
Methodology for Data Collection	Survey
Responsibility for Data Collection	Third Party Monitor / PMU
Under five years' mortality rate (per 1000 live births) for HC	
Description	The probability of a child born in a specific year or period dying before reaching the age of 5 years, if subject to

	age-specific mortality rates of that period, expressed per 1000 live births
Frequency	Annually
Data source	Survey
Methodology for Data Collection	Survey
Responsibility for Data Collection	Third Party Monitor / PMU
Under five years' mortality rate (per 1000 live births) for refugees	
Description	The probability of a child born in a specific year or period dying before reaching the age of 5 years, if subject to age-specific mortality rates of that period, expressed per 1000 live births
Frequency	Annually
Data source	Survey
Methodology for Data Collection	Survey
Responsibility for Data Collection	Third Party Monitor / PMU
Intermittent prevention of malaria during pregnancy (IPTp≥3)	
Description	Percentage of women who received three or more doses of intermittent preventive treatment during antenatal care visits during their last pregnancy
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH and UNICEF; Measures subcomponent 1.1 Under UNICEF
Maternal mortality ratio	
Description	Number of maternal deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100 000 live births, for a specified time period.
Frequency	Annually
Data source	Survey
Methodology for Data Collection	Survey
Responsibility for Data Collection	Third Party Monitor / PMU
Maternal mortality ratio for refugees	
Description	Number of maternal deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100 000 live births, for a specified time period.
Frequency	Annually
Data source	Survey
Methodology for Data Collection	Survey
Responsibility for Data Collection	Third Party Monitor / PMU
Maternal mortality ratio for HC	
Description	Number of maternal deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100 000 live births, for a specified time period.

Frequency	Annually
Data source	Survey
Methodology for Data Collection	Survey
Responsibility for Data Collection	Third Party Monitor / PMU
Contraceptive prevalence rate (any method)	
Description	Percentage of women aged 15–49 years, married or in union, who are currently using, or whose sexual partner is using, at least one method of contraception, regardless of the method used.
Frequency	Annually
Data source	Survey
Methodology for Data Collection	Survey
Responsibility for Data Collection	Third Party Monitor / PMU
The proportion of patients with suspected malaria who received a parasitologic test (RDT/Microscopy)	
Description	Percentage of suspected malaria cases that received parasitological diagnosis either by microscopy or RDT
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH / UNICEF; Measures subcomponent 1.1 Under UNICEF
Proportion of health facilities that have a core set of relevant basic medicines and commodities available and affordable	
Description	Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis. Availability: will be calculated based on currently existing data on average proportion of medicines available in health facilities per country.
Frequency	Quarterly
Data source	Quarterly Health Facility Assessment
Methodology for Data Collection	TPM report
Responsibility for Data Collection	TPM / PMU
Component 2: Health Systems Strengthening	
Percentage of disease outbreaks in refugee areas that are adequately addressed as per WHO guidelines (Percentage)	
Description	Disease outbreaks in refugee areas that have been adequately addressed as per WHO guidelines.
Frequency	Quarterly
Data source	WHO/MoH report
Methodology for Data Collection	WHO to provide data
Responsibility for Data Collection	UNICEF/WHO/ PMU- Measures subcomponent 2.1 under WHO
Percentage of SMoH/CHDs with work plans aligned to the HSSP	
Description	Percentage of SMoH and CHDs that develop annual operational work plans aligned to HSSP
Frequency	Quarterly
Data source	WHO report
Methodology for Data Collection	WHO to provide data / TPM to verify
Responsibility for Data Collection	PMU / TPM; Measures subcomponent 2.1 under WHO
Proportion of health alerts investigated in 48 hrs	

Description	Proportion of an alert about a disease, condition, or event of public health importance which may be true or invented
Frequency	Quarterly
Data source	WHO
Methodology for Data Collection	Quarterly and biannual TPM
Responsibility for Data Collection	PMU / TPM; Measures subcomponent 2.1 under WHO
Birth registration notification coverage	
Description	Proportion of live births notified by the health facility among the total expected live births in specific period
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH / UNICEF
Maternal death review coverage (%)	
Description	Percentage of maternal deaths occurring in the health facility that were audited and reviewed.
Frequency	Quarterly
Data source	WHO
Methodology for Data Collection	Quarterly and biannual TPM
Responsibility for Data Collection	PMU / TPM; Measures subcomponent 2.1 under WHO
Component 3: Monitoring and Evaluation and Project Management	
Percentage of health facilities receiving quarterly supervision visits (disaggregated by visits by CHDs, and States MoH) (Percentage)	
Description	Percentage of health facilities receiving at least one quarterly supervision visit within the quarter from either the CHD, or the State MoH
Frequency	Quarterly
Data source	MoH; TPM
Methodology for Data Collection	MoH to provide data; TPM to verify
Responsibility for Data Collection	MoH / TPM
Percentage of health facilities receiving quarterly supervision visits (Percentage)	
Description	Percentage of health facilities receiving at least one quarterly supervision visit within the quarter
Frequency	Quarterly
Data source	MoH; TPM
Methodology for Data Collection	MoH to provide data; TPM to verify
Responsibility for Data Collection	MoH / TPM
Percentage of refugee health facilities receiving quarterly supervision visits (Percentage)	
Description	Percentage of refugee health facilities receiving at least one quarterly supervision visit within the quarter
Frequency	Quarterly
Data source	MoH; TPM
Methodology for Data Collection	MoH to provide data; TPM to verify
Responsibility for Data Collection	MoH / TPM
Percentage of HC health facilities receiving quarterly supervision visits (Percentage)	

Description	Percentage of HC health facilities receiving at least one quarterly supervision visit within the quarter
Frequency	Quarterly
Data source	MoH; TPM
Methodology for Data Collection	MoH to provide data; TPM to verify
Responsibility for Data Collection	MoH / TPM
Percentage of health facilities receiving quarterly supervision visits from the CHD (Percentage)	
Description	Percentage of health facilities receiving at least one quarterly supervision visit within the quarter from the CHD
Frequency	Quarterly
Data source	MoH; TPM
Methodology for Data Collection	MoH to provide data; TPM to verify
Responsibility for Data Collection	MoH / TPM
Percentage of health facilities receiving quarterly supervision visits from State MoH (Percentage)	
Description	Percentage of health facilities receiving at least one quarterly supervision visit within the quarter from the State MoH
Frequency	Quarterly
Data source	MoH; TPM
Methodology for Data Collection	MoH to provide data; TPM to verify
Responsibility for Data Collection	MoH / TPM
Percentage of complaints to Grievance Redress Mechanisms satisfactorily addressed in a timely manner	
Description	Percentage of complaints submitted to the GRM addressed according to the protocol and within agreed time period.
Frequency	Quarterly
Data source	UNICEF
Methodology for Data Collection	UNICEF to provide data / TPM to verify
Responsibility for Data Collection	UNICEF; PMU
Percentage of completeness of reporting by facilities	
Description	Percentage of facilities that submit complete reports within the required deadline.
Frequency	Quarterly
Data source	DHIS2
Methodology for Data Collection	DHIS2
Responsibility for Data Collection	MoH/ PMU
Percentage of states that conducted quarterly coordination meetings with a review of data and documented with minutes including action items and follow-up	
Description	Percentage of State's quarterly health service delivery coordination meetings for the health sector held with a review of data included in the meeting and documented with minutes which include action items and follow-up on action items. Meetings are to be held quarterly in each state. Four meetings are expected each year per state. CHDs and implementing partners will be participated in the review
Frequency	Quarterly
Data source	MoH/ WHO
Methodology for Data Collection	WHO to provide data / TPM to verify

Responsibility for Data Collection	WHO; PMU

ANNEX 1: Implementation Arrangements and Support Plan

Introduction

1. South Sudan's health system is systemically underdeveloped, characterized by poor access to health services, significant shortage of skilled health workers, and difficult operating environment leading to extremely alarming health outcomes. Under-five mortality is 96.2 per 1,000 live births, infant mortality is 62.4 per 1,000 births, and maternal mortality is estimated at 1,150 per 100,000 births.[33] Poor health outcomes are underlined by weak health service delivery including only 40 percent of births assisted by a skilled provider and 11.5 percent of children between 12 and 23 months of age receiving routine vaccinations.[34]

2. Fragmentation is a defining features of South Sudan's health system. Since 2013, health service delivery in South Sudan has been financed by the HPF, a consortium of donors including the United Kingdom, the United States, Canada, Sweden, and the European Union (EU) and Gavi, the Vaccine Alliance and administered by the UK Foreign, Commonwealth and Development Office (FCDO), and the World Bank. While donors have strengthened coordination between the two areas, the two areas have separate management structures creating inefficiencies and coordination challenges. Further, the Government's engagement in health service delivery and financing of the health sector is minimal and to date, many gaps remain regarding the steward of the sector, including effective coordination and facilitation among several resources or IPs which led to further sector fragmentation.

3. The pressing resource needs in the sector, combined with the harmonized funding cycles of the largest health sector development donors, and strengthened leadership in the MoH, are a unique opportunity for the next stage in integrating health financing and harmonizing health service delivery nationwide in South Sudan, through an IDA project co-financing arrangements (standalone MDTF and SDTF) to cover health service provision across the country, in complement to Government resources. Such a pooled fund mechanism is also an opportunity to strengthen the Government's role as a steward of the health sector through the gradual shift toward Government contracting of health service providers and will facilitate operationalizing the concept of one program, one budget, one package of services, and one reporting mechanism.

4. The proposed trust funds will be managed by the World Bank and would draw on the World Bank's systems and experience managing multi and single donor trust funds globally and in South Sudan. The trust funds will reflect the following design features (Figure 1.1), with the opportunity to further develop the trust fund and contracting arrangements based on further learnings from current health service delivery modalities of the World Bank and HPF:

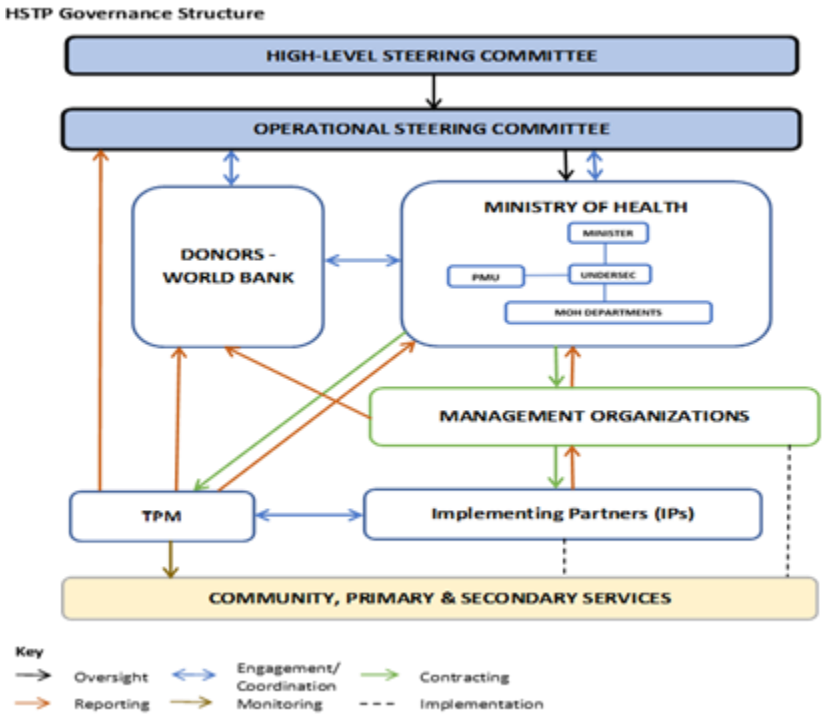
    - World Bank management of the standalone trust funds using an IPF instrument, through which health sector donors will pool their resources through Administration Agreements with the IDA funding under one MDTF and another SDTF managed by the World Bank. In addition, World Bank will sign a Financing Agreement with the MoFP for the IDA+ trust fund resources to clearly identify government responsibilities and contribution.
    - Establishment of a PMU at the MoH to manage health service contracting and the day-to-day engagement with the Government, management organization, and donors.
    - The Government, represented by the PMU, contracts of a management organization which will sub-contract NGOs to deliver the identified package of health services.

[33] WDI, 2019

[34] LGAS, 2020; Routine vaccinations: three doses of Diphtheria, Pertussis, and Tetanus (DPT3)

- NGOs sub-contracted by the management organization will deliver the identified package of health services nationwide as per the required standards.
- TPM agency/ies will conduct household and health facility surveys along with surveys to solicit community and patient feedback. The TPM agency/ies will submit quarterly monitoring reports directly to the PMU, the World Bank, and UNICEF.
- An HSC to provide technical strategic direction and guidance on the sectoral challenges and future steps including service delivery, health financing, HRH, data, and medicines and medical supplies. The HSC will meet on a bi-annual basis and may invite any party to join the meetings.
- An OSC to provide technical guidance on the management and oversight of project implementation, challenges and achieved results of the program. The OSC will meet on a quarterly basis and may invite any party to join the meetings.

Figure 1.1. Structure and Governance

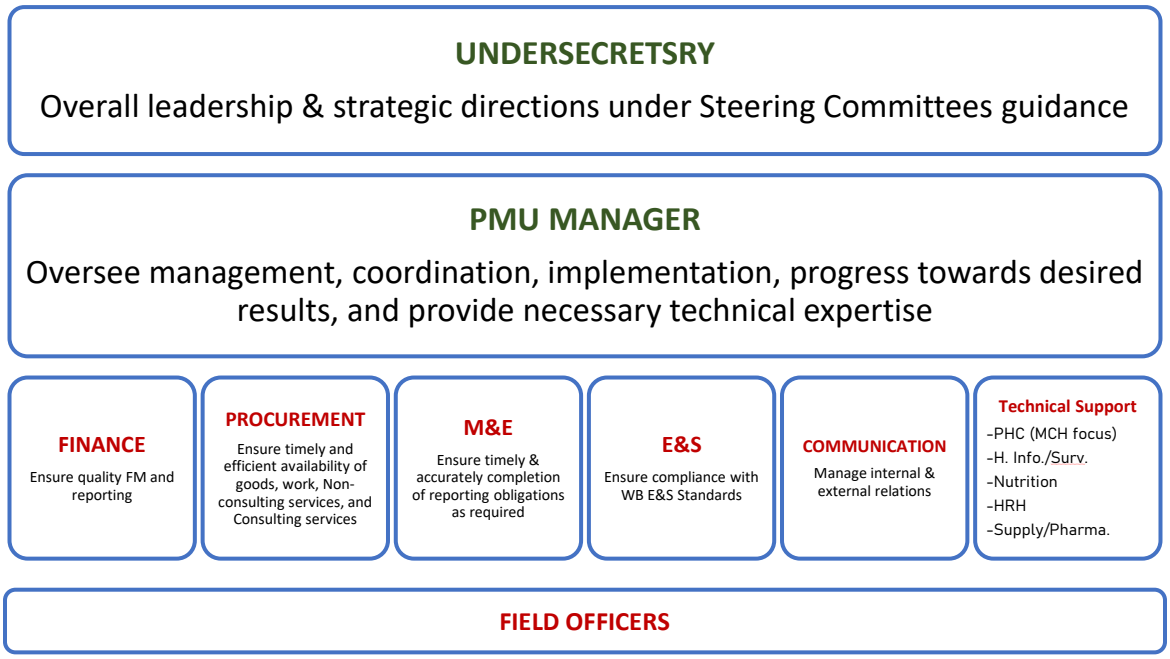


5. Below are the proposed ToRs for the Project Management Unit (PMU), HSC, and the OSC.

Project Management Unit (PMU)

6. The PMU will be responsible for managing health service contracting and the day-to-day engagement and coordination with the Government, management organizations, donors, and the World Bank. The following are the key functions for the unit:

Figure 1.2. PMU Structure



High-Level Steering Committee

High-Level Steering Committee Mandate and Functions

7. The HSC will pursue the following ToRs.

(a) The HSC is mandated to provide strategic direction and guidance on the sectoral challenges and future steps on service delivery and other health system pillars.
(b) The HSC will oversee and monitor the implementation of the project-approved plans and different processes including health facilities hand-over plan, plan to expand coverage of health facilities, BHI expansion plan, MoH capacity-building plan, government and partners' commitments, and any reprogramming amendments.
(c) Review and approve applications to join project funding and/or activities by other potential interested parties.
(d) The committee will review project data to monitor progress towards achieving desired results, identify needed actions, and follow-up on actions during meetings.
(e) The committee will ensure the existence and enforcement of effective coordination and communication between different constituencies and other stakeholders relevant to its mandate.
(f) The committee will mobilize and sustain political commitment to take the necessary actions towards achieving the development goals and the effective processes.

Membership of the Committee

Constituencies

- Government constituencies: this refers to federal ministries and governmental entities relevant to the health sector cooperation (nomination to ensure good representation including for state level); and

- All constituencies and entities' representation should be from the highest senior level, when possible.

Delegations maybe acceptable based on a prior notice to the rest of the committees for specific sessions.

Structure of the HSC

Table 1.1: High-level Steering Committee Membership

No.	The member	Position	Constituency
1.	Minister of Health	Chair	Government
2.	Minister of Finance and Planning	2nd Co-Chair	Government
3.	Undersecretary, MoH	Rapporteur	Government
4.	Undersecretary, MoFP	Member	Government

Governance of the Committee

8. All committee decisions will strive to seek consensus on all matters. Committee meetings should be attended by at least 50 percent of members or their alternates to be valid. The following aspects of governance will be noted by all members:
   - All members should ensure that they provide other members with the appropriate updates on issues related to the committee mandate and functions within their constituencies.
   - The committee may invite any other party to its sessions for discussions.
   - All recommendations proposed by the committee will have to go through the World Bank's prior no objection.

Operational Steering Committee

9. To ensure functionality of the HSC, an OSC will be formulated to complement the mandates of the HSC through providing guidance on the management and oversight of health service delivery and achieved results of the program.

Operational Steering Committee Mandate and Functions

10. The OSC will pursue the following ToR:

    (a) Provide routine oversight and operational direction in line with overall direction from the HSC.
    (b) Steer the proposition of any reprogramming amendments when necessary and report timely to the HSC.
    (c) Follow up the progress in achieving the targets identified in the Results Framework and M&E plans. Identify challenges affecting timely and quality implementation and liaise with the HSC to follow up on problem-solving.
    (d) Formulate and present findings, reports, and recommendations to the HSC on regular basis.

(e) Analyze and discuss quarterly follow up reports submitted by the MOs and produce recommendations for the HSC and respond to queries and clarifications.
(f) The committee may invite any other party to its sessions for discussions.
(g) All recommendations proposed by the committee will have to go through the World Bank's prior no objection.

Structure of the OSC

Table 1.2: Operational Steering Committee Membership

No.	The member	Position
1.	Undersecretary, MoH	Chair
2.	Representative MoFP	Member
3.	4 Director Generals, MoH	Member
4.	2 States MOH representatives	Member
5.	PMU Manager	Rapporteur

* Representation should be from the **technical level**.

Steering Committees' Meetings

- The HSC should conduct at least two general meetings per year; however, additional special meetings may be called by the chair. The OSC shall meet on quarterly basis after project effectiveness. However, during project preparation and transition, the HSC shall meet on a quarter basis while the OSC shall meet on a monthly basis.
- The calendar of regular meetings shall be prepared by the secretariat and circulated to all members in advance.
- If any member is unable to attend a meeting, he/she will inform the Secretariat in advance to the meeting, and state that his/her alternate will attend or not. In such circumstances, the alternate member will be the voting representative.
- Any member can submit items for inclusion in the agenda through the Secretariat.
- The meetings should be moderated by the chair or in the Chair's absence by the Co-chair.
- A quorum is the presence of at least half of the members or their alternates. If there is no quorum, the Chair has the right to cancel the meeting.
- At the start of each meeting, the agenda may be modified and must be approved at the meeting by simple majority.

Steering Committees' Secretariat

11. The PMU will identify one staff member to act as the committees' coordinator and will be supported by an administration assistant. Pending the formation of the official PMU, the MOH and the World Bank will nominate some members to fulfill that role on a temporary basis.

Secretariat ToRs

- Attend all meetings and any offspring committees in a non-voting capacity and serve as Secretary for these meetings.
- Prepare meeting agenda after discussion and approval of the Chair.
- Prepare draft minutes and finalize and disseminate approved minutes to all members.

- Communicate decisions of the committees among and between all members and into any relevant entities and personnel.
- Follow up on committees' decisions and recommendations.
- Maintain a log of the committees' decisions that reflects the confirmed minutes.
- Support and contribute to the committees' communications, representation, and M&E.

Steering Committees Logistics

12. Unless agreed otherwise, the MoH or the World Bank will host the meetings in their offices in Juba. The secretariat shall ensure offering options for virtual joining for those unbale to attend physically.

Table 1.3: Roles and responsibilities for each entity and health service contracting arrangements.

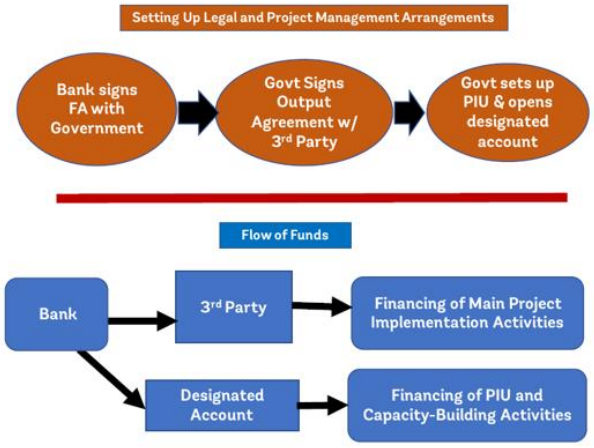
Entity	Composition	Role
Government	MoH	• Provide stewardship and oversight for the health sector and the HSTP
	MoH- PMU	• Contract management organization • M&E functions for the project
	Ministry of Finance	• Contribute financing for health service delivery
Donors	Tentatively current HPF donors, Global Fund, and World Bank	• Contribute financing for health service delivery and other project components through the IDA financing and through a stand alone MDTF • Discuss the progress reports and advise
Fund Manager	World Bank	• Pool health service delivery funds from donors • Develop and oversee the project through which resources will be pooled • Coordinate donor and Government inputs into project documents and monitoring reports • Provide fiduciary, technical, and management oversight for health service delivery financed by IDA and linked MDTF
High Level Steering Committee	Donors, MoH, MoFP, WB, SMoH, UNICEF	• Provide high level direction for the project • Meet every six months • Review project data, identify needed actions, and follow-up on actions during meetings
Operational steering committee	MoH, PMU, World Bank, Donors, UNICEF	• Provide routine oversight and operational direction in line with overall direction from the HSC • Meet on a quarterly basis • Identify and discuss needed actions • Review project data, identify needed actions, and follow-up on actions during meetings
UNICEF	UNICEF contracted by the PMU	• Sub-contract NGOs • Supervise and support NGOs • Sub-contract procurement and logistics agency • Supervise and support logistics agency • Develop capacity of CHDs
Contracted Service Providers	NGOs sub-contracted by UNICEF	• Deliver health services • Engage with communities to support health service delivery

Pharmaceutical Procurement and Logistics agency	Competitively selected agency	• Procure pharmaceuticals • Conduct last mile delivery to health facilities
World Health Organization	WHO	• Conduct state and federal level MoH capacity building activities • Conduct health systems strengthening activities
Third Party Monitor(s)	TPM agency/ies contracted by the PMU	• Conduct quarterly verification visits • Conduct household and health facility surveys to monitor health service delivery and health outcomes • Conduct community satisfaction surveys • Monitor health facility functionality • Prepare analysis, presentations, and bulletins presenting monitoring results and findings • Capacity building for state and district level staff (on-the-job training on M&E activities).

Flow of Funds, Fiduciary Safeguards, and Monitoring Arrangements

13. **The proposed program will build on the World Bank experience with similar structures in South Sudan in other sectors.** The funds for the project interventions and procurement of supplies will flow directly from the World Bank to UNICEF and WHO, while the fund required for PMU salaries and operating expenses will flow from the World Bank to the project designated account managed by the Government.

Figure 1.3. Flow of Funds



14. **Reporting and monitoring**: The PMU, UNICEF, and WHO will submit to the World Bank quarterly financial and technical progress reports as per the required World Bank templates which will cover areas such as technical and operational progress, FM, procurement, social and environmental risk management, visibility and communication, and evaluation on IP performance and corrective actions.

15. **UNICEF and WHO will mitigate the FM risks by implementing various measures including ensuring adequate outreach and implementation through contracted NGO IPs.** Due diligence, monitoring and supervision of the IPs will be conducted in accordance with the Harmonized Approach to Cash Transfers (HACT) framework which involves programmatic field visits, spot checks and special audits. In addition, the managing organizations country program

undergoes scheduled internal audits by the organization's own Office for Internal Audit and Investigation. UNICEF is also subject to multi-country programs external audit when the focus of that audit is also of relevance to UNICEF's South Sudan country office program. Both the final internal and external audits are made public and accessible to any interested party. On the other hand, findings from the HACT linked programmatic visits, spot checks, and special audits are for internal use of UNICEF for program improvement and strengthening, confidential, not for the public, and not shared.

16. **PIM.** The PIM will be the key document based on which the project will be implemented. The PIM will be prepared and adopted by the PMU for the operation to set out detailed guidelines, methods and procedures for the implementation of the project. The PIM provides: (a) detailed description of the project activities, the sequence of implementation, and the workplan defining the target dates; (b) institutional structure along with the decision-making protocols and role and responsibilities of designated staff; (c) budget and budgetary controls; (d) flow of funds, disbursement procedures and banking arrangements; (e) financial, procurement and accounting procedures; (f) personal data collection and processing in accordance with applicable national law and good international practice; (g) M&E arrangements including TPM of project implementation; (h) measures related to the use of security or military personnel in the implementation of project activities (as described in the projects legal agreements); (i) environmental and social; and (j) running the data visualization tool with support from the World Bank.

ANNEX 2: Third Party Monitoring and Data Visualization

1. TPM is critical for an objective understanding of project progress and to collect data to improve service delivery. Along with monitoring and survey activities, the TPM will develop Government capacity for the design of data collection tools, data use, and oversight of health service monitoring. To support high-quality data collected in a conflict-sensitive manner, ToR for health service delivery TPM will be developed to ensure robust supervision as well as data review to assess and address data quality. Comprehensive ToRs have proven critical to high-quality TPM arrangements in FCV settings. All TPM will pay close attention to ensuring all language groups in the country are incorporated in monitoring through translated tools and representative selection of enumerators. Set data entry, reporting, and presentation formats will be established and used by the TPM. The TPM will be expected to produce quarterly reports and presentations for national and state level use as well as quarterly reports for IPs detailing results at the facility level. The TPM will present findings to the State and Federal Level as well as IPs, CHDs, development partners, UNICEF, and The World Bank. Under this arrangement, TPM will be contracted by the PMU with input and oversight from the World Bank. TPM arrangements will include the following:
   (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 2. Quarterly TPM visits will incorporate the following:
      (i) **Quarterly health facility functionality assessments.** At baseline and endline, the assessments will incorporate a sample of operational health facilities not supported by the project to generate comprehensive information on health service delivery nationwide and the added value of the project. Measures on disability access will be included in the assessments.
      (ii) Quarterly data quality verification to provide measures of partner data quality and reporting accuracy.
      (iii) Bi-annual health service quality assessment to capture the quality of key health services, focusing on health service process and structural quality. On an annual basis the health service quality assessment will include direct observation of health service process quality measures at hospitals and health centers.
      (iv) Bi-annual patient feedback using exit surveys.
      (v) Bi-annual visits to a sample of BHTs to measure service outputs and quality.
   (b) Periodic TPM data collection:
      (i) Biennial household coverage surveys as baseline/endline surveys in the project's three-year timeframe.[35]
      (ii) Citizen engagement survey collected at the household level, with the coverage survey every other year.

2. **Data Analysis and Visualization Platform.** The platform will emphasize development of an integrated, institutionalized, and sustainable system. The platform will include analysis of health service delivery in refugee and host community areas. The platform will include the following:
   (a) Interactive data visualization platform presenting Results Framework and core indicators. The platform will use data from DHIS2 and the TPM and will include BHI data. It will be updated at least on a quarterly basis.
   (b) Presentation of data in data visualization platform in the form of static and interactive maps, charts and graphs, tailored to project monitoring needs and partner priorities.
   (c) Incorporation of HSF data within the data visualization platform through a link or page within the platform.
   (d) Overlay of disease and health service delivery data with meteorologic data to better understand seasonal patterns in service delivery and infectious disease data.

[35] 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.

ANNEX 3: Project Financing Sources by Component[36]

		Initial IDA				Additional Resources			
Project Components	**Project Subcomponents**	**PBA**	**WHR**	**IDA Financing**	**Govt**	**SDTF**	**MDTF**	**Trust Funds**	**Total**
Component 1: Provision of Basic Health Services Nationwide	Subcomponent 1.1: Delivery of high impact basic health and nutrition services Nationwide through Health Facilities	0	62.67	62.67	10	21.14	179.92	201.06	273.73
	Subcomponent 1.2: Boma Health Initiative	0	3.41	3.41		0.95	8.05	9	12.41
	Subcomponent 1.3: Last Mile Pharmaceutical Delivery	0	3.41	3.41		1.05	8.95	10	13.41
	Subcomponent 1.4: Climate Resilient Health Service Delivery	10.22	21	31.22		0	0	0	31.22
	Component 1 Total	**10.22**	**90.49**	**100.71**	**10**	**23.14**	**196.92**	**220.06**	**330.77**
Component 2: Health Systems Strengthening	Subcomponent 2.1: Health emergency preparedness and response, laboratory strengthening, and disease control	0.66	1.38	2.04		0.36	3.1	3.46	5.5
	Subcomponent 2.2: Blood Banking and Transfusion	0.29	0.64	0.93		0.17	1.4	1.57	2.5
	Subcomponent 2.3: Health Service Quality Improvement	0.3	0.53	0.83		0.17	1.5	1.67	2.5
	Subcomponent 2.4: Health Management Information Systems	0.3	0.63	0.93		0.17	1.4	1.57	2.5
	Subcomponent 2.5: Health Service Stewardship and Financing	0.23	0.54	0.77		0.13	1.1	1.23	2
	Component 2 Total	**1.78**	**3.72**	**5.5**	**0**	**1**	**8.5**	**9.5**	**15**
Component 3: Monitoring and Evaluation and Project Management	Subcomponent 3.1: Third Party Monitoring	0	6.15	6.15		0.8	6.8	7.6	13.75
	Subcomponent 3.2: Data Analysis and Visualization Platform	0	0.3	0.3		0.05	0.38	0.43	0.73
	Subcomponent 3.3: Contract and Program Management Capacity Development	0	1.54	1.54		0.2	1.7	1.9	3.44
	Subcomponent 3.4: Project Management	0	2.8	2.8		0.31	2.7	3.01	5.81
	Component 3 Total	**0**	**10.79**	**10.79**	**0**	**1.36**	**11.58**	**12.94**	**23.73**
Component 4: Contingent Emergency Response Component		0	0	0		0	0	0	0
Total Costs		**12**	**105**	**117**	**10**	**25.5**	**217**	**242.5**	**369.5**

[36] The amounts exclude direct and indirect costs for UNICEF, WHO and WB for MDTF and SDTF.

ANNEX 4: Refugees and Host Communities

1. **The HSTP will provide services to the population of South Sudan through IDA and expected donor financed MDTF and SDTF funding.** Within the scope of the project there is a special focus to continue to address the pressing health and nutrition needs of refugees and host communities. It includes the following measures:

   - **Maintain the provision of health and nutrition services to refugees and host communities** that are currently covered under the COVID-19 Emergency Response and Health System Preparedness Project (CERHSPP-P176480) (with funds available to cover until July 2024) in Upper Nile, Jonglei and Unity States. In addition, the project includes: (a) scaling up disease surveillance and early detection activities; (b) strengthening the rapid response teams; (c) increasing the operational support costs to facilities to improve access to enhanced water and sanitation services, electricity, and fuel; and (d) providing minor repair works in various facilities. The HSTP aims to address rapidly increasing and evolving needs of refugees and host-communities.

   - **Expand the provision of the high-impact package of basic health and nutrition services nationwide.** The project expands the provision of services across the country in addition to Maban and Jamjang (which benefited from previous resources accessed through WHR). This includes Western Equatoria State (Ezo and Yambio Counties), Central Equatoria (Juba and Yei Counties) and Jonglei State (Pochalla County) which are among the largest refugee-hosting counties in South Sudan. The support provided takes the form of a gradual replacement of support by humanitarian agencies (including UNHCR and ICRC) which are pulling back their support from at least 50 health facilities to cater to other humanitarian priorities (especially Sudan).

   - **Ensure better strengthened elements of the health care systems that will directly affect maternal and child mortality rates through WHO implemented activities.** The project will support the functionality of state and district level blood banks and reference laboratories. This will allow enhanced access to those services and directly decreasing preventable causes of death. In addition, the project will support the expansion of surveillance systems for early disease detection that would enable timely response to disease outbreaks which is highly relevant to refuges and host communities' population.

2. **Achievements by the COVID-19 Emergency Response and Health System Preparedness Project (CERHSPP-P176480):** Through the support of WHR, CERHSPP was able to provide the following:

   - Health and nutrition services to refugees and communities in 4 hospitals, 20 PHCCs, 28 PHCUs and 10 nutrition facility sites in Upper Nile, Jonglei and Unity states.
   - Between January and July 2023, 73,937 children were treated for severe wasting.
   - About 98 percent of eligible population from host communities and 35 percent from refugees have received COVID-19 vaccine.
   - About 60 percent of targeted refugees' deliveries were attended by skilled health personnel.

3. **Lessons learned:** The HSTP will build on the achievements of, and lessons learned from the CERHSPP support to refugees and host communities as follows:

Table 5.1. Lessons Learned

Lessons Learned	HSTP response
There is an urgent need to expand coverage to all areas affected by the refugee movement in the country given the pre-existing fragile context.	• Nation-wide focus of project • Close coordination with Humanitarian partners

Focus on demand side activities to generate adequate demand for services is necessary given the contextual challenges and the low literacy rate among the population.	• Enhanced focus on health literacy and updating communication messaging and materials in local languages.
Moving from facility based to community/outreach mode of service delivery is important to consider given the difficult context (flooding, movement, and transportation cost).	• Expansion in BHI program
The support offered by the humanitarian actors is not sustainable. As of September 2023, different humanitarian actors are in discussion with the to vacate 50 health care facilities catering for the refugees and their host communities owing to other competing global priorities, for example, conflict areas in Sudan. Those facilities will require urgent substitute support to prevent any interruption in services.	• Transition plan established for the handover process. This will be monitored by MoH, World Bank and donor partners.
Close coordination between IPs, donors and humanitarian agencies is of critical importance to ensure one plan and one strategy for service provision efforts. The refugee community has witnessed disproportionally higher levels of disease outbreaks over the past year. This has required intensified efforts, and increased demand for costly surveillance, diagnostic and curative services by the IPs. Several measles, hemorrhagic fever, and schistosomiasis outbreaks were frequently recorded.	• All project partners (MoH, World Bank, donors, UNICEF and WHO) will coordinate through the two established coordinating bodies, namely: high and technical steering committees. • Technical steering committee will meet and coordinate with the Humanitarian Cluster in South Sudan on a regular basis. • Coordination links in county and state level with other humanitarian partners.
Refugees and their host communities are usually subject to inadequate access to food and water, sanitation, and other basic services, increasing their risk of communicable diseases, particularly measles and foodborne and waterborne illnesses. They are also at a higher risk of accidental injuries, hypothermia, burns, unwanted pregnancy and delivery-related complications, and various noncommunicable diseases. This stresses the need for more responsive health care services that are capable of early detection and management of those cases.	• Enhanced surveillance and early response • Introduction of ambulance evacuation services to nearest hospitals. • Improved access to laboratory and blood bank services.
Health illiteracy is a widespread issue among refugees, and only about 40 percent have sufficient knowledge to effectively navigate health care systems. The barriers are important for individuals with disabilities, affecting 30% of this subgroup. In addition, nearly 50% of women and girls in the refugee population struggle to access sexual and gender-based violence protection services.	• Expansion of BHI program • Enhanced health and nutrition education materials. • Introduction of Sexual and Reproductive Health Services in the Package (SRH). • Introduction of GBV services.

Growing Humanitarian Needs in Refugee and Host Communities

4. Since gaining eligibility to the WHR under IDA19, the Government of South Sudan has made important progress in fostering longer-term benefits for refugee and host communities. First, the Government has allocated some 4,000 ha of land to refugees for agricultural cultivation, a step taken in support of its Global Refugee Forum pledge of expanding equitable economic opportunities in refugee-hosting areas. Second, the Government has contributed a significant number of textbooks to schools serving refugees, a step taken in support of implementing its policy commitment to full integration of refugees into the national education system. Third, in late 2021, as part of the Solutions Initiative for South Sudan and Sudan led by the Intergovernmental Authority on Development (IGAD), the Government finalized its Durable Solutions Strategy and Plan of Action for Refugees, Internally Displaced Persons, Returnees and Host Communities. Fourth, in September 2022, the Government finalized discussions with the Government of Sudan on the so-called 'Four Freedoms' agreement, which would guarantee people from both countries 'freedom of residence, freedom of movement, freedom to undertake economic activity and freedom to acquire and dispose property'. While these freedoms are not limited to refugees and host communities, their proximity to the border with Sudan means they would disproportionately benefit refugees and host communities in South Sudan by allowing them to capitalize on trade networks and broaden economic opportunities on both sides of the border. Finally, the country has continued to uphold in practice its strong policy commitment to refugee protection, granting refuge not only to the hundreds of thousands of Sudanese and other refugees who have been in South Sudan since its independence in 2011 but to new inflows of refugees from recent and ongoing conflicts in Sudan and the Horn of Africa. To ensure South Sudan's refugee policy remains robust and continues to improve both de jure and de facto, the World Bank worked with UNHCR and the Government to prepare a baseline assessment for South Sudan under the Refugee Policy Review Framework that promotes and monitors the design and implementation of pro-refugee policy over time. Together, these actions constitute good progress in advancing the strategy South Sudan submitted as part of the IDA20 WHR eligibility process and in promoting durable solutions for refugees and host communities more broadly.

5. The HSTP will be implemented against the backdrop of a dramatically evolving force displacement landscape in South Sudan. The continuation of the conflict in Sudan further exacerbates the needs of refugee and host populations. Wunthow (Juda) border crossing in Upper Nile (near Maban) is the main point of entry for refugees and returnees arriving from Sudan. When the conflict broke out in April 2023, a large majority of arrivals from Sudan (over 91 per cent) were South Sudanese returnees. However, since August, there has been a notable increase in refugee arrivals. As of November 2023, the number of refugees has increased to 17 per cent and analysts expect a continuous uptick in numbers in the coming months[37]. Taking a closer look at numbers recorded at Renk border crossing sheds light on the severity of humanitarian needs in the area. UNHCR notes that the proportion of refugee arrivals in Renk has starkly increased from an average of 9.5 percent in September, to an average of 52 percent in the first week of November,2023.[38] Further compounding the stress on humanitarian resources, seasonal floods pose additional challenges to transport and movement of refugees (leading to overcrowding at transit centers).

6. Humanitarian needs have risen significantly with the uptick in the arrival of refugees, particularly as the focus shifts to addressing evolving needs in Sudan. Over 80 per cent of refugees in Maban and Jamjang are women and children. UNHCR notes that on average 103 children per month were admitted to health facilities in Upper Nile for moderate or severe malnutrition between July-August (admissions before the conflict were an average of 40).[39] Further WASH

[37] UNHCR-IOM Updates on arrivals from Sudan
[38] UNHCR Flash Update, Emergency Response Renk, Upper Nile State, November 10, 2023.
[39] UNHCR-IOM Updates on arrivals from Sudan

partners are struggling to keep up with growing needs in in these areas and failing to meet the need could lead to health and sanitation risks.

7. **The current refugee population estimates are as follows:**

Table 5.1 Refugee and Asylum-Seeker Population in South Sudan

State	Total Pop.	Ref. Pop.	ASY Pop.	Ref. Pop.%
Upper Nile	184,962	184,738	224	55%
Unity	111,777	111,685	92	34%
Central Equatoria	21,515	18,534	2,981	5%
Western Equatoria	13,967	13,955	12	4%
Northern Bahr El-Ghazal	2,452	2,452	0	1%
Jonglei State	1,936	1,936	0	1%

Source: UNHCR, September 2023

8. The projected refugee population estimates for 2024 and 2025 are as follows – based on UNHCR data analysis:

Table 5.2 Projected Refugee Population Estimates

	2023		2024		2025	
	Total	Assisted	Total	Assisted	Total	Assisted
Refugees	366,028	366,028	446,625	446,625	456,496	456,496
Asylum-Seekers	4,908	4,908	6,799	6,799	7,397	7,397
Internally Displaced Persons	2,267,236	500,000	2,027,331	540,000	2,392,236	650,000
Returned Refugees	555,000	555,000	870,000	870,000	1,250,000	1,250,000
TOTAL	3,193,172	1,425,936	3,350,755	1,863,424	4,106,129	2,363,893

Consultation with UNHCR

9. The World Bank is working closely with UNHCR and the MoH to ensure South Sudan's refugee protection framework remains adequate, including through periodic assessments. UNHCR has provided the World Bank with an overall positive assessment of South Sudan's protection framework while highlighting a set of protection-related challenges. In addition to the legal framework in place, the Government has maintained its policy of granting refugees access to its territory and installing practical arrangements for their initial reception and registration.

Transition to UNICEF

10. **UNICEF, through World Bank support, has developed an operational model where support was complementary to UNHCR activities through day-to-day coordination.** This coordination included areas such as human resources, warehousing, pharmaceutical supply, nutrition programs and vaccination. This has allowed UNICEF to gather a firsthand operational knowledge of the specific needs and pre-requisites of those specific communities within the context of South Sudan. It is worth noting that other donor agencies, for example, FCDO are also providing their support to communities hosting refugees through UNICEF.

11. **UNICEF has started its preparatory work to facilitate its coverage of the anticipated expansion of activities to the refugees and host community areas**, this includes: (a) the development of a strategic framework (in partnership with

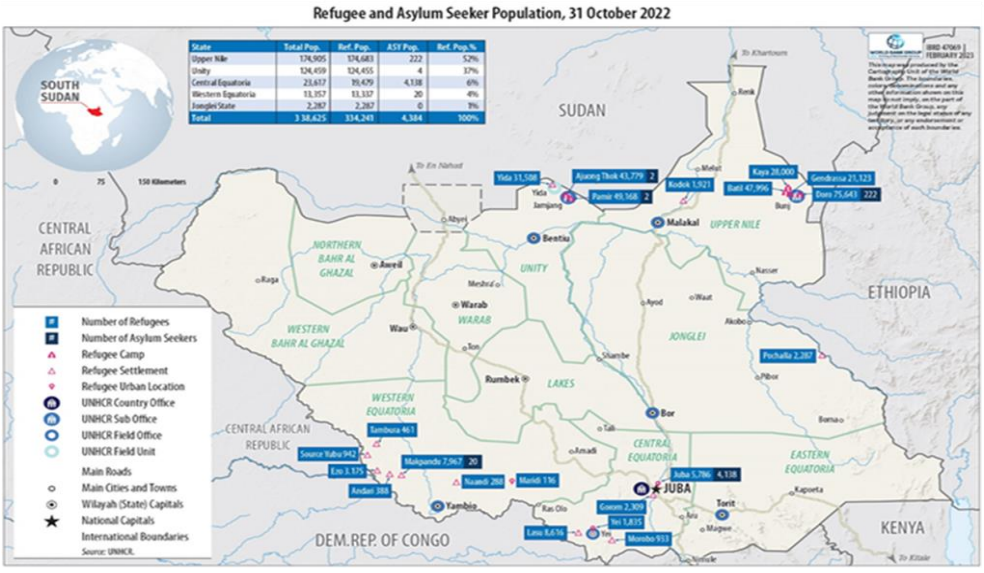
UNHCR and MOH) to address the needs of those specific areas; (b) development of a detailed and timed transition plan towards the gradual onboarding of the additional 50 facilities that will be handed over by the humanitarian agencies, the transition will is planned to start on January 2024 and to be completed by June 2024; (c) advanced procurement of medical supplies and pharmaceuticals is underway based on a commitment letter issued by the World Bank on May 2023 under the anticipated HSTP to avoid any gaps in service continuity; (d) early selection of IPs (to be completed by December 2023) to facilitate early and gradual onboarding of the selected partners towards a smooth transition from the humanitarian agencies; and (e) expansion of local footprint through additional hiring of dedicated staff to support local county health departments and implementing partners.

Economic Analysis of Supporting Refugees and Host Communities

12. **The Economic benefits of investing in health and nutrition services to refugees and host communities are high.** The number of children below 11 years represents more than 40 percent of the refugee population in South Sudan. The identified package of nutrition services under the project will follow a life cycle approach and will focus on children, women of reproductive age, and pregnant and lactating women. Those evidence-based services have been proven to yield high benefit cost ratios. Investing in specific children and maternal nutrition interventions have been estimated to yield between US$11 and US$35 for each US$1 invested. Not only are investments in nutrition one of the best value-for-money development actions, but they also lay the groundwork for the success of investments in other sectors. Therefore, the US$25 million which will be invested in nutrition under the project are expected to yield between US$275 million to US$875 million worth of benefits and returns to the refugee and host communities.

13. South Sudan registers one of the world's highest maternal mortalities (1,150 deaths per 100,000) and under five mortality (100 per 1,000 live births). Assuming that the project will help a conservative reduction in maternal mortality by 10 percent over the project duration among the refugee and host community population, this will save around 2,700 children under five and 172 women. Applying a conservative statistical value of life for low-income countries (US$41,756), this will yield an approximate US$120 million in benefits.[40]

Figure 5.1. Locations of Refugees in South Sudan[41]



[40] Saluja S, et al. BMJ Global Health 2020.

[41] The map has been cleared by the map unit on December 5,2023

ANNEX 5: Estimated Financial Contribution to the Program by Different Partners[42]

Indicative amounts for the program

Source	Amount pledged (original currency) in millions	Estimated Equivalent Amount (US$, millions)	Type of Trust Fund	Estimated time for signing Administrative Agreement
EU	EUR 24.4	26.8	MDTF	December 2023 (before Board)
Canada	CAD 75	55.5	MDTF	Spring 2024
FCDO	GBP 50	62.5	MDTF	May 2024
USAID	US$30	30	SDTF	March 2024
GAVI	US$20	20	MDTF	• US$10 million by June 2024 • US$10 million by June 2026
Global Fund	US$53	53	MDTF	March 2024
Sweden	SEK 260.7	25	MDTF	TBD
Total Donors		**272.5***		
World Bank		117 (105 WHR + 12 PBA)		January 2024 (by project effectiveness)
		Possible future resources from IDA		
Government co-financing		10		US$10 allocation from General Budget
Total Program		**399.5 plus future resources from IDA**		Financial gap for the immediate needs of the HSTP before the Board approval (to be filled during January – August 2024) is US$242.5 million.

* Includes cost recovery and World Bank-executed portions

[42] The table illustrates the estimated total amounts that are to be contributed from different sources over the lifetime of the project.