OFFICIAL USE ONLY
IDA/R2016-0165/1

June 16, 2016

Closing Date: Monday, June 27, 2016 at 6 p.m.

FROM: Vice President and Corporate Secretary

South Sudan - Health Rapid Results Project

Second Additional Financing

Project Paper

Attached is the Project Paper regarding a proposed second additional grant to South Sudan for a Health Rapid Results Project (IDA/R2016-0165), which is being processed on an absence-of-objection basis.

Distribution:
Executive Directors and Alternates
President
Bank Group Senior Management
Vice Presidents, Bank, IFC and MIGA
Directors and Department Heads, Bank, IFC and MIGA

Document of
The World Bank

FOR OFFICIAL USE ONLY

Report No: PAD1823

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED SECOND ADDITIONAL IDA GRANT

IN THE AMOUNT OF SDR 28.6 MILLION
(US$40 MILLION EQUIVALENT)

TO THE

REPUBLIC OF SOUTH SUDAN

FOR

HEALTH RAPID RESULTS PROJECT

June 14, 2016

Health, Nutrition, and Population Global Practice
Africa Region

CURRENCY EQUIVALENTS
(Exchange Rate Effective May 31, 2016)

Currency Unit	=	South Sudanese Pound (SSP)
SSP 30.045	=	US$1
US$1	=	SDR 0.71281934

FISCAL YEAR
July 1 – June 30

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
ANC	Antenatal Care
CHD	County Health Department
CSDO	Coordination and Service Delivery Organization
DA	Designated Account
DFID	U.K. Department for International Development
DHIS	District Health Information System
DPT3	Diphtheria-Tetanus-Pertussis 3
EAA	External Audit Agent
EMF	Emergency Medicines Fund
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
ESSAF	Environmental and Social Screening and Assessment Framework
FCV	Fragility, Conflict and Violence
FM	Financial Management
FMS	Financial Management Specialist
GRS	Grievance Redress System
HMIS	Health Management Information System
HIV	Human Immunodeficiency Virus
HPF	Health Pooled Fund
HRIS	Human Resources Information System
HRRP	Health Rapid Results Project
IDP	Internally Displaced Person
IDSR	Integrated Disease Surveillance and Response
IFR	Interim Financial Report
IP	Implementation Partner
IPSAS	International Public Sector Accounting Standards
ISDS	Integrated Safeguards Data Sheet
LLIN	Long-lasting Insecticidal Net
LQAS	Lot Quality Assurance Survey
M&E	Monitoring and Evaluation

MWMP	Medical Waste Management Plan
MoFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MTR	Mid-term Review
NAC	National Audit Chamber
NGO	Non-governmental Organization
OPRC	Operational Procurement Review Committee
PP	Procurement Plan
PPA	Project Preparation Advance
PPF	Project Preparation Facility
PHCC	Primary Health Care Center
PHCU	Primary Health Care Unit
PBC	Performance-based Contracting
PBF	Performance-based Financing
PDO	Project Development Objective
PIM	Project Implementation Manual
PMU	Project Management Unit
QSC	Quantitative Supervisory Checklist
QVV	Quarterly Verification Visit
SCD	Systematic Country Diagnostic
SMOH	State Ministry of Health
SPLM-IO	Sudan People's Liberation Movement-in Opposition
SPLA-IO	Sudan People's Liberation Army-in Opposition
SSEPS	South Sudan Electronic Payroll System
SSS	Single-Source Selection
TGoNU	Transitional Government of National Unity
TOR	Terms of Reference
UN	United Nations
USAID	U.S. Agency for International Development

Regional Vice President:	Makhtar Diop
Country Director:	Carolyn Turk
Senior Global Practice Director:	Timothy G. Evans
Country Manager:	Sahr John Kpundeh
Practice Manager:	Magnus Lindelow
Task Team Leader:	Noel Chisaka

SOUTH SUDAN
SOUTH SUDAN HEALTH RAPID RESULTS PROJECT AF

CONTENTS

ADDITIONAL FINANCING DATA SHEET

South Sudan

South Sudan Health Rapid Results Project AF (P156917)

AFRICA

HEALTH, NUTRITION, AND POPULATION

Basic Information – Parent			
Parent Project ID:	P127187	Original EA Category:	B - Partial Assessment
Current Closing Date:	30-Jun-2016		

Basic Information – Additional Financing (AF)			
Project ID:	P156917	Additional Financing Type (from AUS):	Scale Up
Regional Vice President:	Makhtar Diop	Proposed EA Category:	B - Partial Assessment
Country Director:	Carolyn Turk	Expected Effectiveness Date:	31-Aug-2016
Senior Global Practice Director:	Timothy Grant Evans	Expected Closing Date:	30-Sep-2017
Practice Manager/Manager:	Magnus Lindelow	Report No:	PAD1823
Team Leader(s):	Noel Chisaka		

Recipient/Borrower				
Organization Name	Contact	Title	Telephone	Email
MIINISTRY OF FINANCE	Moses Mabior	Director, Aid Coordination	+211912733926	aidco.mofep@gmail.com

Project Financing Data - Parent (South Sudan Health Rapid Results Project - P127187) (in US$, millions)

Key Dates

Project	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date
P127187	IDA-54010	Effective	13-Mar-2014	09-May-2014	09-Sep-2014	31-Oct-2015	30-Jun-2016
P127187	IDA-H9210	Effective	13-Mar-2014	09-May-2014	09-Sep-2014	31-Oct-2015	30-Jun-2016
P127187	TF-12272	Effective	20-Apr-2012	20-Apr-2012	02-Aug-2012	31-Oct-2014	30-Jun-2016

Disbursements

Project	Ln/Cr/TF	Status	Currency	Original	Revised	Cancelled	Disbursed	Undisbursed	% Disbursed
P127187	IDA-54010	Effective	US$	10.00	10.00	0.00	7.40	1.83	74.02
P127187	IDA-H9210	Effective	US$	25.00	25.00	0.00	23.62	0.09	94.47
P127187	TF-12272	Effective	US$	28.00	28.00	0.00	27.96	0.04	99.85

Project Financing Data - Additional Financing (South Sudan Health Rapid Results Project AF - P156917) (in US$, millions)

[ ] Loan [ ] Grant [X] IDA Grant
[ ] Credit [ ] Guarantee [ ] Other

Total Project Cost: 40.00 Total Bank Financing: 40.00

Financing Gap: 0.00

Financing Source – Additional Financing (AF)	**Amount**
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	40.00
Total	40.00

Policy Waivers

Does the project depart from the CAS in content or in other significant respects?	No

Explanation
–

Does the project require any policy waiver(s)?	No

Explanation
–

Team Composition

Bank Staff

Name	**Role**	**Title**	**Specialization**	**Unit**
Noel Chisaka	Team Leader (ADM Responsible)	Senior Health Specialist	Senior Health Specialist	GHN01
Pascal Tegwa	Procurement Specialist (ADM Responsible)	Senior Procurement Specialist	Senior Procurement Specialist	GGO01
Adam Shayne	Lead Counsel	Lead Counsel	Lead Counsel	LEGAM
Abiy Demissie Belay	Financial Management Specialist	Sr Financial Management Specialist	Senior Financial Management Specialist	GGO25

Anne Margreth Bakilana	Team Member	Sr Economist (Health)	Sr Economist (Health)	GHN01
Anton Karel George Baare	Safeguards Specialist	Senior Social Development Specialist	Social Safeguards	GSU07
Bernard O. Olayo	Team Member	Health Specialist	Health Specialist	GHNDR
Carmen Carpio	Team Member	Senior Operations Officer	Senior Operations Officer	GHN04
David Kuany Manyok	Team Member	Team Assistant	Team Assistant	AFMJB
Desta Solomon	Safeguards Specialist	Consultant	Social Safeguards	GSU07
Evelyn Anna Kennedy	Team Member	Senior Operations Officer	Senior Operations Officer	GHN01
John Bryant Collier	Safeguards Specialist	Senior Environmental Specialist	Environmental Safeguards and Medical Waste Management	GEN01
Joyce Wani Gamba	Team Member	Team Assistant	Team Assistant	AFMJB
Lilian Wambui Kahindo	Safeguards Specialist	Social Development Specialist	Social Safeguards	GSU07
Miyuki T. Parris	Team Member	Operations Analyst	Operations Analyst	GHNGE
Nicolas Antoine Robert Collin Dit De Montesson	Team Member	Consultant	Governance and Service Delivery, Citizen Engagement	GGO25
Nyabicha Omurwa Onang'o	Team Member	Consultant	Financial Management	GGODR

Extended Team

Name	Title	Location
–	–	–

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
South Sudan	Upper Nile State	Upper Nile State	X	X	
South Sudan	Jonglei State	Jonglei State	X	X	

Institutional Data

Parent (South Sudan Health Rapid Results Project - P127187)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change

[ ] Fragile, Conflict & Violence

[ ] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	82		
Public Administration, Law, and Justice	Public administration-Health	18		
Total		100		

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Child health	25
Human development	Health system performance	25
Human development	Population and reproductive health	25
Human development	Other communicable diseases	25
Total		100

Additional Financing (South Sudan Health Rapid Results Project AF - P156917)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Fragile, Conflict & Violence

Cross Cutting Topics

[ ] Climate Change

[X] Fragile, Conflict & Violence

[ ] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation	Mitigation Co-

			Co-benefits %	benefits %
Health and other social services	Health	80		
Public Administration, Law, and Justice	Public administration-Health	20		

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Child health	30
Human development	Health system performance	30
Human development	Population and reproductive health	20
Human development	Nutrition and food security	10
Human development	Malaria	10
Total		100

Consultants (Will be disclosed in the Monthly Operational Summary)

I. Introduction

1. **This Project Paper seeks the approval of the Executive Directors to provide an IDA Grant in the amount of US$40 million for a second Additional Financing (AF) (P156917) to the South Sudan Health Rapid Results Project (HRRP) (P127187).**

2. **This second proposed AF will support the provision of critical health services and pharmaceutical commodities in the states of Jonglei and Upper Nile, which are among the most conflict-affected states in South Sudan.** The proposed second AF will be the only source of financing for the delivery of critical health services in Jonglei and Upper Nile after June 2016.[1] The proposed AF will build on a successful contracting arrangement between the Ministry of Health (MOH) and the Coordination and Service Delivery Organization (CSDO). In addition, the AF will support the procurement and distribution of pharmaceutical commodities in the states of Upper Nile and Jonglei and hence help reduce the risk of stock-outs as other partnership arrangements for provision of pharmaceutical commodities in the two states come to an end in the country.[2]

3. **The parent project (P127187) was designed to address critical health care needs and constraints in two of the most challenging states in South Sudan.** These are historically the most conflict-affected states (see Box 1), with the least investment in infrastructure. Because of the challenging terrain and seasonal heavy rains, they are also the most difficult to access physically. South Sudan's turbulent history spans several decades. The country's independence in 2011 offered high hopes of reconciliation, nation-building, and peace dividends. However, it did not put an end to tensions with Sudan, nor did it end internal divisions or ethnic and political clashes or secure macroeconomic stability. Both the parent project and the first AF were developed and implemented during highly volatile periods of conflict and complex political context. In spite of the difficult context, the results have been notable (see Boxes 2 and 3).

4. **The proposed second AF is being processed under procedures specified under OP 10.00 paragraph 12** (Projects in Situations of Urgent Need of Assistance or Capacity Constraints) to respond quickly to critical needs in two of the most conflict-affected states in South Sudan. The use of this policy is justified because the proposed project meets both eligibility criteria as South Sudan is deemed to (a) have urgent needs of assistance and (b) experience capacity constraints.

[1] The current contract between the MOH and the CSDO ended on March 31, 2016, but is extended to June 30, 2016. A Project Preparation Advance (PPA) was approved for the period from April 1 to June 30, 2016, to ensure that there is no gap in the provision of critical services between the contract expiration and the proposed second AF.

[2] From 2013 to 2015, the Emergency Medicines Fund (EMF) was the main funding, procurement, and distribution mechanism of pharmaceuticals in South Sudan. The EMF ended in June 2015 while its supplies covered health facilities' needs until December 2015. To avoid a countrywide stock-out of essential medicines, a stopgap measure was constituted with financing from the U.K. Department for International Development (DFID) (US$12 million) and U.S. Agency for International Development (USAID) (US$4 million). This arrangement, EMF 2, was planned to cover emergency pharmaceutical supplies needed for the period from January 2016 to June 2016. However, this emergency measure only prioritizes 55 most critical medicines instead of the 102 products previously supplied by the EMF. With the planned exit of EMF 2 by June 2016, the proposed second AF will become the main and only financier of pharmaceuticals in Jonglei and Upper Nile for primary care and county hospital services.

5. **Since December 2013, South Sudan has been affected by political instability and renewed conflict.** The past two and a half years have seen several unfulfilled peace agreements between the Government and the opposition (Sudan People's Liberation Movement-in-Opposition [SPLM-IO]). The latest peace agreement was signed in August 2015, and a Transitional Government of National Unity (TGoNU) was formed on April 29, 2016. Even though the opposition returned to Juba and the political environment appears calm, the implementation of the peace process and consolidation of the TGoNU remains a challenge given the difficult fiscal and macroeconomic context. In line with the peace process, the UN Security Council passed Resolution 2252 extending and expanding the mandate of the UN peacekeeping mission. There will now be some 15,000 UN uniformed military and police personnel for the mission, with protection of citizens as its top priority. A key instrument of mediation support, created in the Agreement, is the Joint Monitoring and Evaluation Commission (JMEC), led by the former President of Botswana, Festus Mogae, charged with shepherding the peace process during the transition.

II. Background and Rationale for Additional Financing

6. **South Sudan is characterized by inadequate access to basic services, limited economic opportunities, poor infrastructure, and food insecurity.** Life expectancy at birth for both sexes is only 42 years. Over 90 percent of the population lives in rural areas.[3] At independence, only about 27 percent of the population was literate. South Sudan has only 192 km of paved roads (concentrated in the south), which continues to be a significant barrier not only to deliver health services but also to foster economic and social development. This lack of infrastructure implies that large areas of the country are unreachable during the six-month long, heavy rainy season.

Box 1. Fragility Context and Conflict in Jonglei and Upper Nile

South Sudan has been mired in conflicts since 1955. The south's demands for greater autonomy spanned two civil wars with the north (today's Sudan). The first Sudanese Civil War ended in 1972. Relative peace with Sudan lasted until 1983 when the second Sudanese Civil War began. The signing of the Comprehensive Peace Agreement in 2005 ushered in another period of relative peaceful coexistence with Sudan (though some fighting remained around the border areas), with greater autonomy and self-determination on a wide range of issues for Southern Sudan. From 2005 to 2011, Southern Sudan underwent a transition period, leading to formal independence in 2011.

Even as greater autonomy from the north was being fought for and later achieved, political and ethnic divisions continued to exist within South Sudan, especially in the states of Unity, Lakes, Upper Nile, and Jonglei. Internal conflicts rooted in local political tensions, cattle raiding, and conflict over water and grazing resources often turned into violent clashes. In Jonglei, since 2010, rebellions by the Murle ethnic group against the South Sudanese Government emerged (or re-emerged in some cases) and intra-state ethnic clashes have occurred recurrently. In Upper Nile, the combination of tensions on the one hand with the Government, and between the Nuer and Shilluk ethnic groups, and on the other hand, with Sudan along the border have also maintained the area in a continuous state of fragility and conflict, even before 2013. Moreover, a breakdown in law and order has always been present in the two states in times of economic downturn and low food production.

The states of Upper Nile and Jonglei are also the most remote and hard to reach being affected by long rains and poor infrastructure that require careful advance planning to ensure availability of medical supplies during rains. The populations are also nomadic, following the feed for their livestock, which presents specific challenges for health service delivery. It was in this historically fragile context and ongoing conflict that the parent project was designed.

[3] 2008 Census, Southern Sudan Centre for Census, Statistics and Evaluation.

7. **Since gaining independence in 2011, South Sudan has faced several deep macroeconomic crises triggered by continuing tensions with Sudan, internal conflict, and oil- related shocks.** South Sudan's economy remains heavily dependent on oil revenues. Around 80 percent of its gross domestic product is driven by petroleum-based activities. Until July 2014, oil exports represented more than 85 percent of government revenues. Due to the fall in global oil prices and lower production resulting from the conflict in the two oil-producing states (Unity and Upper Nile), the government's monthly revenue contracted by 75 percent—from over SSP 800 million in July 2014 to SSP 200 million in August 2015.[4] With global forecasts estimating average oil prices at US$37 per barrel in 2016,[5] the Government has sought renegotiation of the Transitional Financial Agreement with Sudan (currently fixed at US$26.5 per barrel that transits through Sudan's pipelines).

8. **The macroeconomic and fiscal situation remains greatly challenged.** In December 2015, to address the long prevailing parallel currency exchange rate system, the Government moved from a fixed exchange rate to a managed floating exchange rate regime. This decision brought the parallel market exchange rate closer to the official one. However, the new regime has not prevented the continuing depreciation of the South Sudanese pound against the U.S. dollar (the SSP lost over 85 percent between February 2014 and February 2016).[6] As most consumer goods are imported, the combination of depreciation, lower foreign exchange reserves, and a growing money supply has been fueling inflation. In December 2015, the annual inflation reached 109.9 percent.[7] Increasing food prices are particularly affecting poor households and contribute to widespread malnutrition.[8] Despite the Government's efforts to cut public spending and realign the exchange rate with the market rate, depreciatory and inflationary trends remain. In the short term, it seems highly unlikely that viable options will create sufficient fiscal space for primary health care programs and procurement of basic pharmaceuticals.

Sector Context

9. **Decades of conflict, massive displacement of the population, widespread insecurity, and consistent underinvestment have resulted in a poorly performing public health care system.** At the time of the Comprehensive Peace Agreement (2005), South Sudan had one of the highest maternal mortality ratios in the world, estimated at 2,054 per 100,000 live births,[9] while the contraceptive prevalence rate was only 5 percent. The infant mortality rate and under-five mortality rate were very high at 102 per 1,000 live births and 135 per 1,000 live births, respectively.[10] Moreover, 13 of the 17 prioritized neglected tropical diseases in the world are endemic in South Sudan. Malnutrition remains high with 31 percent stunting under five years of

[4] Ministry of Finance and Economic Planning, Government of the Republic of South Sudan, 2015.
[5] World Bank Commodity Markets Outlook, Commodities Price Forecast, January 2016.
[6] World Bank, Market Prices Surveys - High Frequency Survey, March 2016.
[7] Republic of South Sudan, National Bureau of Statistics, Government of the Republic of South Sudan, January 2016.
[8] World Bank, Market Prices Surveys - High Frequency Survey, March 2016.
[9] 2006 Sudan Household Health Survey.
[10] 2010 Sudan Household Health Survey.

age and general acute malnutrition at 23 percent, despite very fertile land in the south and adequate rainfall.[11]

10. **Service delivery remains highly dependent on humanitarian and donor-funded programs.** About 75 percent of public health services are funded through external assistance. Three main donor-funded programs support health service delivery in the 10 states: the USAID has been supporting the states of Central and Western Equatoria and the Health Pooled Fund (HPF)[12] has covered Eastern Equatoria, Lakes, Warrap, Unity, Western Bahr-el-Ghazal, and Northern-Bahr-el-Ghazal, while the World Bank supports Jonglei and Upper Nile States. Critical functions of the health system depend on these three programs, including the recruitment of health care workers, payment of salaries, procurement and distribution of pharmaceuticals, and monitoring and evaluation (M&E).

11. **Under the World Bank project, an effective partnership between the MOH and a contracted CSDO has enabled the Government to sustain key health services in the project-supported states in spite of the continued volatility.** The CSDO contracts non-governmental organizations (NGOs) and county health departments (CHDs) to deliver services in public facilities. It also undertakes capacity-building activities in facilities and CHDs in overall management, monitoring, and public financial management (FM). This model was designed before the December 2013 crisis to respond to the context of endemic violence, limited access and infrastructure, and population mobility (see Box 1). The arrangement proved to be effective. While health services were almost entirely interrupted in the state of Unity since December 2013, the model enabled the MOH and the contracted CSDO to maintain critical health care services in Jonglei and Upper Nile and set the health system on a path to recovery even though it has been a slow process (see Box 2). Although the contracting of NGOs sets some sustainability issues, the CSDO has progressively built the capacity of CHDs to take greater responsibilities in managing service delivery. The MOH and other donors are currently discussing the extension of that model to the rest of the country.

Box 2. HRRP Successes during Conflict: Delivering Basic Health Services across the Conflict Divide

The conflict that started in December 2013 tested the resilience of the HRRP to continue supporting the provision of basic health care on both sides of the battlefront in two of the most remote and difficult working environments in South Sudan.

When fighting began, the first test was whether the Government in power, through its MOH, would show commitment to continue to provide support to areas under opposition control (SPLM-IO). The second test was whether the CSDO (being a government contractor) would be able to reach areas behind opposition lines. The third test was whether the CSDO would be able to perform its coordinator role effectively, ensuring that stakeholders on different opposition sides would allow transit of personnel, landing of flights, and movement of medical goods, responding to displaced peoples, to outbreaks of diseases, and so on. Finally, the fourth test was whether the monitoring system built with the help of the World Bank was robust enough to track access to health care facilities during times of conflict.

All expectations suggested that health services in these two states would completely collapse as the fighting was characterized by frequent shifts in alliances along ethnic lines. Retaliatory destruction of facilities and looting and

[11] The State of the World's Children 2015, United Nations Children's Fund.

[12] The HPF is supported by the Governments of Australia and Canada, the DFID, the European Commission, and the Swedish International Development Cooperation Agency.

killing did not offer much hope for effective delivery of services in such a complicated context that required deep local knowledge and understanding of quickly evolving context.

The experience of the last two and half years has shown that public health services are being delivered on both sides of the battle lines in Jonglei and Upper Nile States, independent of who is in control of a territory. Data from the CSDO, subcontracted NGOs, and the Health Management Information System (HMIS) managed by the CHDs show that, overall, there is no difference in the provision of health care between areas controlled by the Government and the opposition (SPLA-IO). In March 2015, at the height of fighting, on average, 65 percent of public health facilities supported by the central MOH remained functional on both sides of the battlefront[13] (see Figures 1 and 2).

A positive result of the investments made by the World Bank was that the team was able to closely monitor the changes in closure and availability of services through the network of various stakeholders. Although deep system challenges remain, the gains under the project's support had a positive impact on the population's welfare and on the pattern of inclusive development in South Sudan.

Figure 1. Functionality of Health Facilities in Areas Controlled by the Government and the Opposition (As of June 2015)

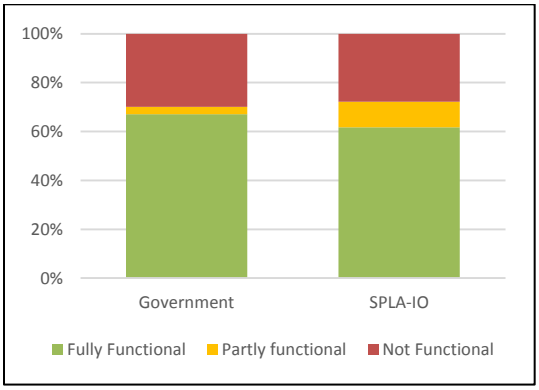
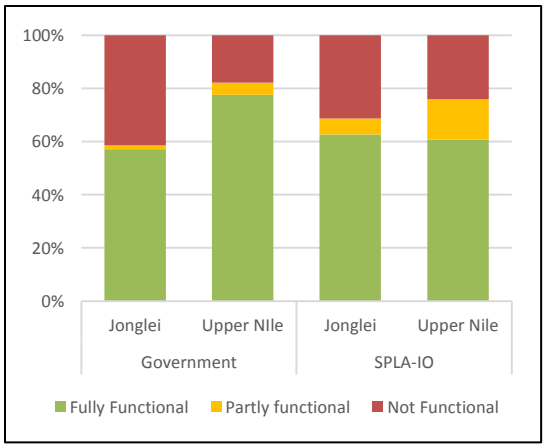


Figure 2. Functionality of Health Facilities by State and by Actor in Control of the Area (As of June 2015)

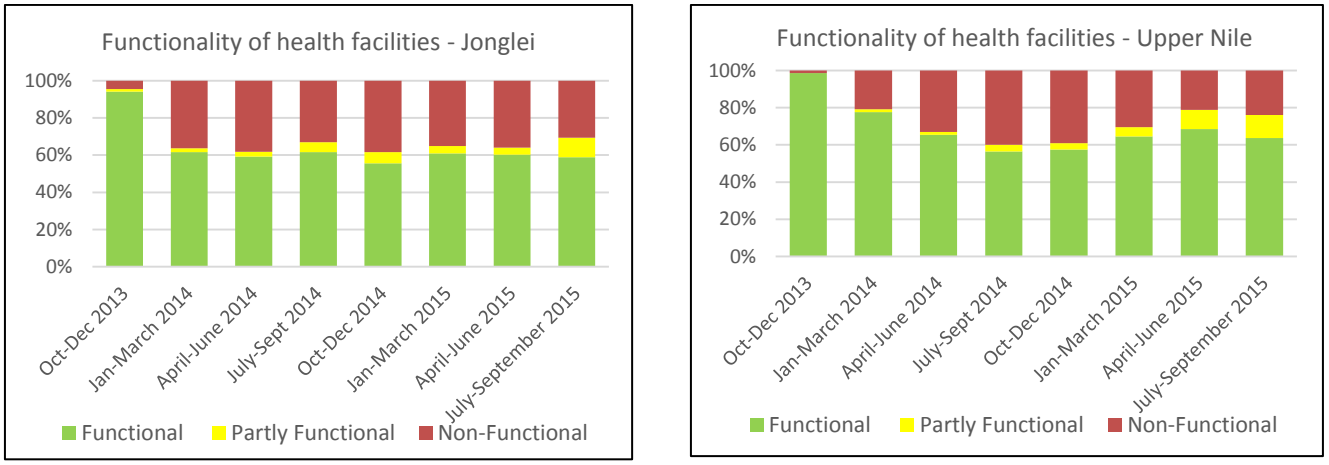


12. **The most recent crisis has affected the health system in the most conflict-affected states of Unity, Jonglei, and Upper Nile more strongly than in the rest of the country.** Destruction of facilities, displacement of qualified health workers, and shortages of essential drugs and commodities have dramatically reduced the capacity of the health care system to deliver services to the population. High levels of insecurity and large numbers of internally displaced persons (IDPs) have put a significant stress on an already weak health system and

[13] Situation as of March 31, 2015.

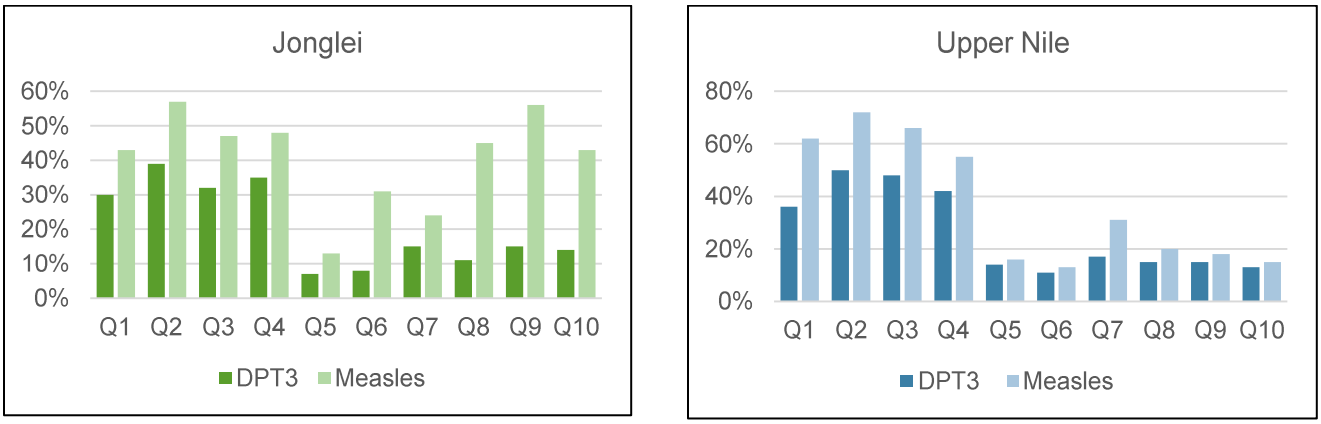
contributed to a rise in the cost of critical inputs. In the states of Jonglei and Upper Nile supported by the World Bank, there was a 40 percent drop in the number of fully functional facilities during the first year of the conflict (see Figure 3). Consequently, health services such as vaccination (diphtheria-tetanus-pertussis 3 [DPT3] and measles) declined progressively (see Figure 4). In the other states covered by the USAID and HPF, service delivery was less affected by the conflict (with the notable exception of Unity). Nevertheless, continuing conflict in Upper Nile (where most of the fighting between the Government and the opposition forces takes place) has increased the difficulty and cost of ensuring the delivery of services. In Jonglei, health services have generally recovered to their pre-conflict levels. However, renewed violence is slowing the recovery. As in other conflict-afflicted, fragile contexts, the CSDO mechanism has proven effective in operating in this difficult environment, demonstrating agility and flexibility in dealing with unforeseen events, and addressing bottlenecks in innovative ways.

Figure 3. Impact of Conflict on the Functionality of Health Facilities in Jonglei and Upper Nile (October 2013–September 2015)



Source: CSDO quarterly review reports.

Figure 4. Impact of Conflict on Measles and DPT3 coverage in Jonglei and Upper Nile (January 2013–September 2015)



Source: CSDO quarterly review report.
Note: % reflects the number of children vaccinated over the estimated population in each state. Q1 = January–March 2013 and Q10 = April–June 2015.

13. **With support from the World Bank in Jonglei and Upper Nile, the Government has maintained its commitment to ensure that all sides of the political divide continue to benefit equitably from the resources provided.** The flexibilities embedded in the project design allowed the World Bank to ensure that resources are used to provide services to the population, independently of the political affiliation or armed group in control of a given area. The Results Framework shows improvements in key indicators that are borne out by the HMIS, which shows that for 2013, states supported by the World Bank performed well and showed faster improvement in various system indicators.

14. **The proposed second AF is in line with OP 10.00 paragraph 29 on AF. It will finance the implementation of additional activities that scale up the project's impact and address current unmet needs.** The proposed second AF is fully consistent with the parent project development objective (PDO). There are no outstanding or unresolved safeguard or fiduciary issues under the project. The additional investments will not require any changes to the environmental Category B of the project, nor will they trigger any new safeguard policies.

15. **The proposed second AF will address critical gaps in health services and essential medicines in the conflicted-affected states of Jonglei and Upper Nile and continue strengthening the capacity of the MOH in its stewardship and management functions.** The interventions to be supported represent a continuation of activities initiated under the parent project (P127187) and continued with the first AF (P146413). A new component will be introduced with the second AF to support the procurement and distribution of pharmaceutical commodities and essential medicines.

16. **The availability of essential medicines in the country is a major concern for the MOH and health partners.** The lack of medicines in health facilities not only affects the capacity to manage illness but also reduces care-seeking behaviors, independent of whether the pathology requires drug-based treatment. Thus, increased stock-out of medicines adversely affects the utilization of health services. The second AF will be a response to the expected discontinuation of the supply of basic medicines with the main funding mechanism for pharmaceuticals in the country.[14]

17. **The World Bank will play a key role in both states, bringing critical services to populations in dire need of support.** The World Bank is the only development partner supporting the states of Upper Nile and Jonglei, while other partners support the remaining states. The restructuring of the donor mechanisms for pharmaceutical procurement has created a financing gap for Jonglei and Upper Nile, which the Government is unable to cover. Given the macroeconomic context, this situation is unlikely to change in the near future. Moreover, the increasing costs of delivering goods and services associated with insecurity and adverse geographical terrain have further exacerbated the funding gaps.

[14] The EMF was funded by the USAID, the DFID, and the Norwegian Ministry of Foreign Affairs. It is ending in June 2015, and the temporary arrangement for pharmaceuticals supply (EMF 2) is concluding in June 2016. The upcoming donor-coordinated financing mechanism for pharmaceuticals beyond June 2016 will not cover Jonglei and Upper Nile, and thus the Bank will become the main, and only, funder of pharmaceuticals in Jonglei and Upper Nile.

18. **Building upon the strengths of the parent project, the proposed AF is therefore expected to support provision of key health services and provide critical pharmaceutical commodities to the population through September 2017.** The fragility and macroeconomic contexts will remain binding constraints for the project's objectives; however, experience has shown that the activities still have a significant impact on the population's health. A US$4 million PPA, signed on May 17, 2016, is already instrumental in ensuring continuity in service provision.

Relationship with Country Engagement Note

19. **The proposed investments are aligned with the Systematic Country Diagnostic (SCD) of October 2015 for South Sudan, and the new Country Engagement Note (CEN) which is currently under preparation following the formation of the TGoNU.** The SCD underscores the importance of ensuring access to basic services and the role that contracting arrangements can have in supporting service delivery in contexts of fragility. The proposed second AF is in line with the Government's 2012–2016 Health Sector Development Plan objectives to "increase the utilization and quality of health services, with emphasis on maternal and child health" and to "strengthen institutional functioning including governance and health system effectiveness, efficiency, and equity". The new CEN proposes a strategy with two pillars: (i) provision of basic social services to the most marginalized and vulnerable populations; and (ii) social protection of the most vulnerable households, supporting livelihoods and basic economic recovery.

Collaboration with Other Donors

20. **Building on the strong track record of partnerships under the parent HRRP and the first AF, project activities will be implemented in close collaboration and coordination with other development partners.** The proposed second AF will continue to coordinate with health partners to support service delivery in a geographically complementary manner. The project will maintain its focus on the states of Jonglei and Upper Nile while the other key donors such as the USAID, the DFID, Canada, Australia, the European Commission, and Sweden through the HPF will focus on the remaining states. Under Component 2, the World Bank-supported project is closely coordinated with partners to build and use country monitoring systems such as the HMIS, the Human Resources Information System (HRIS), the District Health Information System (DHIS), and national surveys. This proposed second AF will support the rollout of the HRIS by the MOH with the support of the HPF in Jonglei and Upper Nile (see detailed project description). Other donors are supporting training for health care workers through the United Nations Population Fund to reduce the capacity shortage at the facility level and contribute to increasing the pool of skilled health workers to be recruited under all donor-funded programs.[15] Moreover, this proposed second AF will maintain its close coordination mechanisms with UN agencies, and development partners to support several vertical programs; in particular, the use of HRRP delivery mechanisms under Component 1 to distribute mosquito nets funded by the

[15] Donors fund the United Nations Population Fund to build the capacity of nurses, midwives, and lab technicians with the objective of reducing the critical shortage of skilled health workers and eventually reducing the maternal mortality rate.

Global Fund. Finally, through regular meetings, health partners aim to coordinate programs and the policy dialogue with the MOH.

Alternatives

21. **Alternative approaches to the second AF, including a new stand-alone operation, and different implementation arrangements were considered.** The proposed approach for the second AF was found to represent the optimal approach for several reasons. First, the second AF builds on a project with a solid track record in a highly fragile context. Second, the implementation modalities for the ongoing project have worked well in spite of the challenging country context and hence can be leveraged for the activities under the second AF. The current implementation arrangements have proven robust and have yielded good results, as discussed in greater detail in the following paragraphs and in Box 2. Third, given the urgency of the request, the processing of this second AF was viewed as the most expeditious way for the World Bank to respond proactively and efficiently to the urgent needs in the two states. Given the high levels of conflict, violence, and instability in South Sudan, the proposed AF modality appears to be the single most efficacious way to provide urgently needed financing for critical health services and essential drugs to a population in dire need.

Parent Project

22. **The proposed second AF builds on a project with a solid implementation and disbursement record in one of the most difficult and challenging countries on the continent.** The original grant for the HRRP was approved on April 20, 2012, (US$28 million) and became effective on August 2, 2012, with the original closing date of October 31, 2014. This original grant was fully financed by the South Sudan Transition Trust Fund and has disbursed 99.85 percent of total Grant funds. The first AF was approved on March 13, 2014, and became effective on September 9, 2014, (US$25 million in IDA Grant and US$10 million in IDA Credit). The current closing date is June 30, 2016. The objectives of the parent project are to (a) improve delivery of high-impact primary health care services in Upper Nile and Jonglei States; and (b) strengthen coordination and M&E capacities of the MOH. The parent project consists of the following two components: Component 1 - Delivery of High Impact Primary Health Care Services in Jonglei and Upper Nile States and Component 2 - Capacity Development of the MOH at the National Level, which had two subcomponents as follows: (a) Strengthening Grant and Contract Management and (b) Bolstering the Monitoring and Evaluation Function.

23. **The project is almost fully disbursed (US$1.9 million to be disbursed) and 100 percent committed to be disbursed before the June 30, 2016, closing date.** Due to the urgent need for additional resources to ensure the delivery of basic services in Jonglei and Upper Nile after March 2016, a PPA for US$4 million will contribute to maintaining a basic level of service delivery from April 1, 2016 until effectiveness of the AF. The AF will be crucial in providing the resources to continue service delivery beyond June 30, 2016, with the proposed 15-month extension of the project to September 30, 2017.

24. **Currently, the project is rated Satisfactory for both implementation and progress toward achievement of the PDO.** As the PDO and selected intermediate results indicators show, despite the ongoing conflict, the impact of the HRRP on service delivery in two of the

most conflict-affected states has been noteworthy. Of the five PDO-level indicators, four have surpassed end-of-project targets and one shows progress, and of the five intermediate results indicators, two have surpassed end-of-project targets and one shows progress.

Box 3. Lessons Learned and Innovative Approaches

In spite of the fragility context before, during, and after the December 2013 crisis, the flexibilities embedded in the project design have allowed the project to meet its objectives. Current implementation arrangements have proven resilient in spite of the difficult context (see Figure 3) and service delivery has recovered progressively. The project has provided valuable lessons, including valuable experience of data collection in fragile contexts; verification of information on service delivery; and importance of flexibilities in design.

- The strong focus on local service delivery has allowed the CSDO to maintain neutrality in the face of ethnic and political conflicts. It has enabled the project to maintain a minimum level of service delivery on both sides of the battle front. A total of 60 percent of the health facilities continued to provide services to the population of Jonglei and Upper Nile. In comparison, the other conflict-affected state—Unity—almost entirely stopped delivering services (see Box 2).
- **The focus on local service delivery has allowed the Government to progressively build the capacity of the CHDs and strengthen country systems.**
- **The HRRP is the only project that has strengthened the capacity of the Government to contract CHDs** (in lieu of NGOs) and transfers selective service delivery and direct oversight responsibilities to CHDs. Five CHDs have been contracted under the current project. Given the success of this model in the most difficult states, other partners are currently discussing replicating the approach under their supported programs.
- **Based on the continuous support provided through the M&E component at the county level, the MOH has been able to build its country monitoring system and has published annual HMIS reports since 2012.** In coordination with an independent M&E firm, the MOH successfully conducted additional thematic surveys including a Health Facility Survey and Lot Quality Assurance Sampling Surveys (LQASs 2011 and 2015). These surveys have generated key information about the health status of the population, which enabled all the partners to identify service delivery bottlenecks and potential areas for improvement.
- **The piloted performance-based financing (PBF) model has proven successful** in improving NGOs' and CHDs' performance to deliver services at the local level (increased opening hours of facilities, higher outputs). It has been expanded to all NGOs and CHDs.
- **Due to the flexibility built into the project, the MOH through its contracts with CHDs and NGOs has been able to implement mobile clinics to effectively respond to the needs of the displaced populations.**
- **The implementation arrangements** whereby service delivery is under the coordination of a CSDO and highly experienced subcontracted NGOs **offer the most protection against fiduciary risks**, given the low but growing capacity of the Government in both procurement and FM.

Lessons Learned

25. The mid-term review (MTR) of the HRRP was conducted in June 2015 and crystallized the lessons learned by both the Government and the World Bank. These lessons have been incorporated in the proposed second AF.

26. **Projects in fragile contexts must factor in the rapidly changing environments.** The project design must include core elements of flexibility and adaptability. When the crisis erupted in December 2013, the need for health care services increased manifold in the two states supported by the project due to the growing number of IDPs fleeing violence and treatment of trauma cases. The ability to quickly respond was a key success factor when the control of counties changed frequently between the Government and the opposition. The presence of a single CSDO that organized health service delivery was critical to ensure a coherent response and avoid the fragmentation of humanitarian response with no central coordination mechanism.

27. **It is possible to design implementation arrangements in fragile contexts that both enable service delivery and gradual capacity-building activities.** As the CSDO built the capacity of CHDs in managing and monitoring facilities, public FM, and human resource management,[16] it was able to identify CHDs with the sufficient capacity to manage service delivery in their area. So far, five CHDs have been contracted in places where NGOs previously managed service delivery. Although the CSDO still provides support to the CHDs, these arrangements contribute to fostering the sustainability and ownership of the project by local health authorities. The CHDs' performance has been comparable to that of the NGO, but the delivery cost is significantly lower. While the capacity required for such contracting mechanisms is currently lacking in most of the counties, the success of this pilot has prompted an interest from other donors and the MoH to expand the model to the remaining states.

28. **Coordination of services in areas under the control of opposing sides requires a neutral and trusted entity.** Given the CSDO's neutrality, experience has shown that the model works in ensuring tight coordination and transport of medical personnel and goods across the conflict lines. The CSDO was able to maintain a link with key stakeholders that would have been broken otherwise. It kept communication channels with State Ministries of Health (SMOHs), CHDs, humanitarian organizations, and the MOH independently of the political alignment. Moreover, it has also addressed the needs of refugees and displaced populations of all ethnicity.

29. **The World Bank was well placed to support innovations in alternative delivery models in countries affected by fragility, conflict and violence (FCV).** The World Bank-supported project is the only one that has support for performance-based elements in the sector and probably in the whole South Sudan portfolio. Invaluable lessons were learned in the performance-based contracting (PBC) pilot and in verification mechanisms in FCVs. Other innovations in pharmaceuticals procurement such as procurement through the CSDO were also tested and found to be effective.

III. Proposed Changes

Summary of Proposed Changes
The proposed second AF will continue the activities initiated under the parent project and continued under the first AF (Components 1 and 2) and will expand the project scope by adding a new third component. **Additional funds.** A total of US$40 million additional IDA Grant funds will be provided. **New component.** A third component will be added that will primarily focus on the procurement and distribution of pharmaceuticals in Jonglei and Upper Nile. Progress is measured through an indicator on the availability of essential medicines at the health facility level. **New activities.** Citizen engagement activities under Component 2 that aim at improving health

[16] Capacity building activities were conducted directly by the CSDO and through the NGOs contracted for delivering services in the counties.

service delivery and accountability at the local level will be included.

New indicators. Three new indicators are being introduced. Under Component 2, two indicators will capture project progress in supporting citizen engagement and another indicator will collect data on the involvement of vulnerable and marginalized people in community-based decision-making and management structures, in line with the indigenous peoples safeguard policy OP/BP 4.10.

Project end date. The project closing date will be extended from June 30, 2016, to September 30, 2017.

Results framework targets. The end-of-project targets of all Results Framework indicators will be revised to reflect the proposed extension of the closing date to September 30, 2017. Following the World Bank guidance on M&E and core sector indicators, six indicators will be adjusted to reflect the cumulative effect of the HRRP since 2012.

Legal Covenants. Three new legal covenants have been added to ensure that an ESMF and a Social Assessment are prepared and adopted by set deadlines.

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

Development Objective/Results	
Project's Development Objectives	
Original PDO	
The objectives of the Project are: (a) to improve the delivery of High Impact Primary Health Care Services in Upper Nile and Jonglei states; and (b) to strengthen the coordination, monitoring and evaluation capacities of the Ministry of Health. The PDO under the AF will remain the same.	
Change in Results Framework	
Explanation:	
Four key changes are being made to the project's Results Framework. The first change is related to Component 2 under which two new indicators on citizen engagement have been included. The second change, also under Component 2, is the introduction of a new indicator to monitor the involvement of vulnerable and marginalized people in community-based decision-making and management structures, in line with the indigenous peoples safeguard policy OP/BP 4.10. The third change is the revision of the targets to reflect the proposed extension of the closing date to September 30, 2017. The fourth change concerns the adjustment of six indicators to reflect the cumulative values since the beginning of the parent project. Following the World Bank guidance on core sector indicators and general OPCS guidelines for designing Results framework, the baselines of these indicators have been set to *zero* and their corresponding current values and targets have been adjusted accordingly (DPT3 vaccination, ANC, provision of vitamin A, measles vaccination, deliveries attended by skilled birth attendant, and distribution of mosquito nets).	

Compliance

Covenants - Additional Financing (South Sudan Health Rapid Results Project AF-P156917)

Source of Funds	Finance Agreement Reference	Description of Covenants	Date Due	Recurrent	Frequency	Action
IDAT	Schedule 2, Section I. E. 3. (a)	The Recipient shall adopt and publish an ESMF, in a manner acceptable to the Association, no later than one month after the Effective Date.	November 27, 2016			New
IDAT	Schedule 2, Section I. E. 3. (b)	The Recipient shall adopt and publish a Social Assessment, in a manner	September 30, 2016			New

		acceptable to the Association, no later than September 30, 2016.				
IDAT	Schedule 2, Section II. B. 5	The Recipient shall engage, not later than six months after the Effectives Date, the external auditor referred to in Section 4.09(b) of the General Conditions in accordance with Section III of Schedule 2 of this Agreement and pursuant to terms of references satisfactory to the Association.	April 27, 2017			New

Conditions

Source Of Fund	Name	Type
IDAT	Financing Agreement, Schedule 2, Section IV, B.1 Withdrawal Conditions; Withdrawal Period	Disbursement

Description of Condition

No withdrawal shall be made (a) for payments made before the date of the Financing Agreement (b) unless and until each of the two Contract Management Agreements has been entered into by the parties thereto, and all conditions precedent to the effectiveness of each such contract have been met.

Risk

Risk Category	Rating (H, S, M, L)
1. Political and Governance	High
2. Macroeconomic	High
3. Sector Strategies and Policies	High

4. Technical Design of Project or Program	High
5. Institutional Capacity for Implementation and Sustainability	High
6. Fiduciary	High
7. Environment and Social	High
8. Stakeholders	High
9. Other (Security Risk)	High
OVERALL	High

Finance

Loan Closing Date - Additional Financing (South Sudan Health Rapid Results Project AF - P156917)

Source of Funds	Proposed Additional Financing Loan Closing Date
IDA Grant	30-Sep-2017

Loan Closing Date(s) - Parent (South Sudan Health Rapid Results Project - P127187)

Explanation:

The current parent loan closing date is June 30, 2016. As part of the proposed AF, the parent loan closing date will be extended to September 30, 2017. Given the volatile conflict context, this will provide sufficient time to cover supply needs and the related service delivery from July 1, 2016, to September 30, 2017.

Ln/Cr/TF	Status	Original Closing Date	Current Closing Date	Proposed Closing Date	Previous Closing Date(s)
IDA-54010	Effective	31-Oct-2015	30-Jun-2016	30-Sep-2017	30-Jun-2016
IDA-H9210	Effective	31-Oct-2015	30-Jun-2016	30-Sep-2017	30-Jun-2016
TF-12272	Effective	31-Oct-2014	30-Jun-2016	30-Sep-2017	31-Oct-2015, 30-Jun-2016

Allocations - Additional Financing (South Sudan Health Rapid Results Project AF - P156917)

Source of Fund	Currency	Category of Expenditure	Allocation	Disbursement % (Type Total)
			Proposed	Proposed
IDA	SDR	GDS,WKS,CS,NCS,WKP,TRG,OP for components	15,000,000	100.00

		1 and 2 of the Project		
	SDR	GDS,CS,NCS,WKP,TRG,OP for Component 3 of the project	10,600,000	100.00
	SDR	Project Preparation Advance	3,000,000	100.00
		Total:	28,600,000.00	

Reallocation between Disbursement Categories

Explanation:

The column for the proposed allocation for IDA-54010—Current Category of Expenditure 'GDS, WKS, CS, NCS, WKP, TRG, OP'—of SDR 21,600,000 reflects the current allocation of SDR 6,600,000 plus SDR 15,000,000 for Components 1 and 2 of the second AF. The new category introduced below is for the new Component 3—procurement of pharmaceuticals—which amounts to SDR 10,600,000.

Ln/Cr/TF	Currency	Current Category of Expenditure	Allocation		Disbursement %(Type Total)	
			Current	Proposed	Current	Proposed
TF-12272	US$	GDS/WKS/CS/NCS/OP EXCL PT 1.3b and 2.1	23,094,460.00	23,094,460.00	100.00	100.00
TF-12272	US$	GDS/WKS/CS/NCS/WKP,TRG and OP PT 2.1	3,769,150.00	3,769,150.00	100.00	100.00
TF-12272		GD/STAFF PERF INC,CS/NCS PT 1.3b	1,136,390.00	1,136,390.00	100.00	100.00
TF-12272		Designated Account	0.00	0.00	0.00	0.00
		Total:	28,000,000.00	28,000,000.00	–	–
IDA-54010	SDR	GDS,WKS,CS,NCS,WKP,TRG,OP for components 1 and 2 of the Project	6,600,000.00	21,600,000	100.00	100.00
IDA-54010	SDR	GDS,CS,NCS,WKP,TRG,OP for Component 3 of the project	0.00	10,600,000.00	100.00	100.00
IDA-54010	SDR	PPF Refinancing	0.00	3,000,000.00	100.00	100.00
		Total:	6,600,000.00	35,200,000.00	–	–

IDA-H9210	SDR	GDS,WKS,CS,NCS,WKP,TRG,OP	13,700,000.00	13,700,000.00	100.00	100.00
IDA-H9210		PPF Refinancing	2,600,000.00	2,600,000.00	0.00	0.00
IDA-H9210		Designated Account	0.00	0.00	0.00	0.00
		Total:	16,300,000.00	16,300,000.00	–	–

Components

Change to Components and Cost

Explanation:

Component 1: Delivery of High Impact Health Services in Jonglei and Upper Nile States (US$21 million)

No changes and current activities will be maintained. Building upon the good resilience of the project after the two years of crisis, the project will keep supporting the MOH's PBC with a CSDO to improve the delivery of high-impact primary health care services including maternal and child health services such as vaccination, prenatal care, skilled birth attendance, and so on. Efforts to transition from NGO- to CHD-managed services will be maintained and encouraged where the Government capacity allows it. The CSDO will continue to procure a buffer of essential drugs to face temporary supply shortages linked to insecurity and access restriction.

Component 2: Capacity Development of the MOH at the National Level (US$4 million)

Subcomponent 2.1 (US$1 million): No changes and current activities will be maintained. The AF will support the MOH in planning, managing, and monitoring grants and contracts under this AF. With the positive performance of the PMU under the project, the MOH plans to further enhance donor coordination and hence support and coordinate all donor-supported programs and financing.

Subcomponent 2.2 (US$3 million): Citizen Engagement Activities will be added

Citizen engagement activities will aim at fostering beneficiary feedback. The project will build upon existing community structures and government policies by strengthening the village health committees (or Boma health committees). The committees are composed of community members and have a role in providing feedback to the CHDs and implementing partners on the quality of health services at the local level, as well as coordination of community interventions. The feedback mechanism will be integrated within the project's monitoring tools (the revision of the quantitative supervisory checklist (QSC) and quarterly verification visits (QVVs) are currently discussed with the MOH) and the response to the feedback will be tracked by the CSDO, CHD, and SMOH. An independent entity, in this case the third-party monitoring agent, will verify the feedback loop on citizen engagement and the mitigation measures undertaken by the project team to meet the concerns of the citizens.

Other activities under Subcomponent 2.2 will remain the same and will aim to ensure a steady stream of independent and credible data on health outcomes and sector performance. The existing regular monitoring tools (QSC and QVV) will be revised to incorporate the changes proposed in

this AF.

Component 3 (new): Pharmaceutical Commodities (US$15 million)

This component will finance the procurement, storage, and distribution of pharmaceutical commodities. Starting in June 2016, a proposed new donor-pooling mechanism (HPF 2) will not finance pharmaceutical supplies for health facilities in Jonglei and Upper Nile, the two World Bank-supported states. This will require the AF to contribute significantly to the procurement of the pharmaceuticals needed in these two states. The US$15 million allocation for this component will cover supply for the period of July 1, 2016, to September 30, 2017. The World Bank will remain engaged with the Government and partners to resolve the financing constraints for pharmaceuticals in the medium and long term.

Cost structure for Second Additional Financing (P156917)

Current Component Name	Proposed Component Name	Current Cost (US$, millions)	Proposed Cost – AF 2, including PPA (US$, millions)	Action
Component 1: Delivery of high impact Primary Health Care services in Jonglei and Upper Nile State	Component 1: Delivery of high impact Primary Health Care services in Jonglei and Upper Nile State	23.00	21.00	Revised
Component 2: Capacity development of MOH at the national level	Component 2: Capacity development of MOH at the national level	5.00	4.00	Revised
	Component 3: Pharmaceutical Commodities	0.00	15.00	New
	Total:	28.00	40.00	

Overall Cost Structure (Parent Project +AF1 +AF2)

Current Component Name	Proposed Component Name	Current Cost (US$, millions)	Proposed Cost (US$, millions)	Action
Component 1: Delivery of High Impact Primary Health Care Services in Jonglei and Upper Nile States	Component 1: Delivery of High Impact Primary Health Care Services in Jonglei and Upper Nile States	54.2	75.2	Revised

Component 2: Capacity Development of the MOH at the National Level	Component 2: Capacity Development of the MOH at the National Level	8.80	12.8	Revised
	Component 3: Pharmaceutical Commodities	0.00	15.00	New
	Total:	63.00	103.00	

Other Change(s)

Change in Procurement

Explanation:

For the new Component 3, a direct contracting procurement method will used to recruit a firm for Supply, storage and distribution of medicines and pharmaceuticals commodities. Choice for the procurement method is based on the outcome of Market analysis and taking consideration of quality, time, and logistical constraints. In principle OPRC clearance has been provided on May 26, 2016.

Change in Implementation Schedule

Explanation:

The AF will extend the implementation period to September 30, 2017. This will allow full utilization of the new AF resources across the implementation period.

Other Change(s)

Explanation:

Exceptional Arrangements in Situations of Urgent Need of Assistance or Capacity Constraints:

Despite the peace agreement signed in August 2015, the country remains fragile and tension between opposing sides is ongoing. The team presented a memo to the country director, approved on April 13, 2016, to apply paragraph 12 of OP 10.00 according to the World Bank's OP under "Projects in Situations of Urgent Need of Assistance or Capacity Constraints".

PPAs. In response to the MOH request, the World Bank has approved a PPA of US$4 million to help bridge the implementation gap between April 1, 2016, and effectiveness of the AF (expected by August 31, 2016). The PPA will also respond to the critically low supply of pharmaceutical commodities in Jonglei and Upper Nile States. The PPA of US$4 million is part of the Additional Financing of US$40 million. OP 10.00 paragraph 12 specifies that when designing implementation arrangements in situations of urgent need of assistance or capacity constraints, "the Project Preparation Facility (PPF) may also finance urgent start-up activities, using agreed simplified procurement procedures that are acceptable to the World Bank."

Summary of Proposed Implementation Arrangements

The project team in place comprises the project manager, FMS, procurement assistant, health planner, and M&E specialist. To strengthen the implementation capacity of the SMOHs, the project is supporting a planning officer for Jonglei. It has been challenging to recruit for a similar position in Upper Nile due to insecurity. Given the successful project implementation under the PMU, the MOH sees itself in a stronger stewardship role whereby it will support and coordinate all donor-supported programs and financing.

Component 1: Delivery of High Impact Health Services in Jonglei and Upper Nile States (US$21 million)

- Jonglei State: PHC service delivery through the CSDO, CHDs, and implementation partners (IPs) and supervised by the MOH and M&E consultants
- Upper Nile State: PHC service delivery through the CSDO, CHDs, and IPs and supervised by the MOH and M&E consultants

Component 2: Capacity Development of the MOH at the National Level (US$4 million)

- PMU implementation support, M&E, supervision, and implementation of national surveys
- Through M&E consultants and MOH

Component 3 (new): Pharmaceutical Commodities (US$15 million)

- Procurement of pharmaceutical medicines and delivery to counties and facilities through contract with one agency/firm with capacity to purchase, store, and distribute the quantities that Jonglei and Upper Nile are able to manage

Procurement

The arrangements for procurement management under the parent project will remain unchanged. Procurement for the proposed second AF will be carried out in accordance with the World Bank's Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers, dated January 2011 and revised in 2014 and Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers, dated January 2011 and revised in 2014. The flexibilities in the procedures described in OP 10.00 will be used. The MOH developed a Procurement Plan (PP), dated June 7, 2016, which will cover the duration of implementation of the proposed second AF. The PP for the use of the PPA amount of US$4.0 million has already been prepared by the MOH and reviewed and cleared by the World Bank. The PP will be updated in agreement with the World Bank project team on an annual basis or as needed to reflect the actual project implementation needs. For the period covered by the PPA (April 1, 2016, until effectiveness of the AF expected by August 31, 2016), the current contracts with the CSDO, which expired on March 31, 2016, will be extended in the amount of US$2,113,692 million for Jonglei and US$1,886,308 for Upper Nile contracts, respectively.

For the proposed second AF, the current CSDO contracts will have expired and will leave gaps in service delivery in the two states. Given the emergency situation, a CSDO must be operational by effectiveness of the proposed additional financing, in both states. In this regard, clearance was received from the Operational Procurement Review Committee (OPRC) to extend the current contracts. The estimated contract value for each state is US$10.5 million for service delivery until September 2017.

Similarly, concerning the supply and distribution of medicines for the two states, clearance was provided by the OPRC to the direct contracting of an agent, Crown Agents/International Procurement Agency (CAIPA). The agent will be responsible for the purchase, storage, and distribution of pharmaceutical commodities under the proposed second AF by August 2016 given that the stock of the drugs is estimated to last until August 2016. The agent will be contracted under a supplier contract based on the World Bank's standard contract form of Health Sector Goods. This contract would be developed and finalized with inputs and clearance from the Africa Region Procurement Manager. The estimated value for this procurement is US$15 million.

Due to limited procurement capacity, the support of the procurement officer will continue during the proposed second AF period. Keeping in view the overall country procurement environment due to the security condition in the country, the overall procurement risk is rated as High.

Financial Management Arrangements

The FM arrangements for the second proposed AF are similar to those of the parent project. The FM for the grant will be managed by the PMU in the MOH. The FM capacity in the MOH is being developed with support from the project by hiring an international FMS and attaching one accounts staff from the MOH and hiring of a national accounts staff to work in the accounting section for on-the-job training and capacity development. The TOR for the FMS will have a major component on capacity development and skills transfer to the local FM staff. The last project financial audit for the fiscal year ended June 30, 2015, was carried out by the National Audit Chamber (NAC) and the audit report together with the Management Letter was submitted to the World Bank before December 2015. No major internal control issues were identified during this audit. The project received an unqualified audit opinion (clean report). All the project quarterly unaudited interim financial reports (IFRs) were received, reviewed, and filed by the World Bank on time. The Financial Procedures Manual used for the project will be updated and included in the Project Implementation Manual (PIM) for the project. The regular FM on-site supervisions of the project have been carried out as scheduled and the reports, in addition to quarterly desk review of the IFRs, did not indicate any major accounting or internal control issues. The project will support the NAC to engage an external audit agent (EAA) to ensure that staff of the Audit Chamber are able to carry out the project audit and to provide an independent opinion on the reliability of the financial statements produced for the project, the systems and internal controls used by the project, and the eligibility of expenditures incurred. The annual external audit will be carried out in accordance with international standards on auditing. In view of the current conflict in Upper Nile and Jonglei States where the project will be implemented, staff from FM may not access these areas to ascertain how the lead agency is implementing the project. Taking this into consideration together with the weak FM capacity at the MOH, the FM risk is rated High.

Disbursement Arrangements

Disbursement arrangements under the parent project have been found to be adequate and have ensured smooth disbursements to date. The project FMS shall continue to submit payment requests to the World Bank based on direct payment, advances, and reimbursements. Detailed disbursement arrangements will be documented in the Disbursement Letter. Funds flow and banking arrangements will remain the same under the AF; the FMS will provide the day-to-day oversight of funds through the project's designated bank account denominated in U.S. dollars and located in a commercial bank. The funds flow process will continue to require that the management team in the MOH carries out its due diligence on the activities of the lead agencies in accordance with criteria set under the grant and contained in the Grant Agreement.

IV. Appraisal Summary

Economic and Financial Analysis

Explanation:

This proposed second AF has the same economic rationale as the parent project.

The project will have a direct impact on the health of 3 million people in Jonglei and Upper Nile (28 percent of South Sudan's population). This AF will be the main and almost only source of financing for the health system in these two states. There is no plausible alternative to this AF. Without the support of the World Bank, the Government will not be able to provide the most basic level of care given the dire macroeconomic context and the fall in monthly revenue since December 2013 (over 75 percent decline). Partners (USAID and the HPF) are already overstretched covering the remaining eight states. Humanitarian agents are also already overstretched in the remaining states where conflict is expanding (especially in Unity, Western Equatoria, and Western Bahr-el-Ghazal). The opportunity cost of not implementing the project is very high. Populations will have very limited access to health care and no access at all to pharmaceuticals. There is already extreme vulnerability of the population, and a lack of support to these two states will further deteriorate their health status.

In this context, this proposed second AF focuses on the most cost-effective activities and interventions focusing on provision of high-impact primary care interventions such as immunization, safe delivery, nutrition, insecticide-treated bed nets, vitamin A, malaria treatment, and so on. Primary health care remains the focus of the proposed second AF. The economic return of investment in basic primary care, especially for children and mothers, has been extensively demonstrated. Among other activities, interventions to improve child nutrition have high economic returns (physical and cognitive development and so on) and require very low investment. These interventions are the most cost-effective interventions available and are of singular importance in a country such as South Sudan with a weakened health system due to conflict and war and a high disease burden of malaria, neglected tropical diseases, and malnutrition.

Based on the MTR and the Health Public Expenditure Review (forthcoming), the cost of delivering services through the Government health system is the most cost-effective when capacity is

available at the local level. This proposed second AF will use government facilities to maximize efficiency and use NGOs only when the capacity is not available even though the delivery cost is higher.

Technical Analysis

Explanation:

The proposed second AF is well aligned to the PDO and is well designed to contribute to the achievement of the desired impact.

The AF will support delivery of services in Jonglei and Upper Nile States—two of the three states (including Unity State) that were the most affected by the latest round of civil war in South Sudan. The conflict that broke out in December 2013 destroyed health infrastructure and displaced a significant proportion of the population including the health workforce in the area. The proposed second AF recognizes the increased difficulties and costs for delivery of health services under such active conflict situations.

Inclusion of pharmaceutical procurement and distribution as a component in the AF is critical to meeting the health needs of the two target states. Access to pharmaceutical supplies forms a critical component of the World Health Organization's six building blocks for health systems—medical products, vaccines, and technologies. The current primary source of medicines in the country, EMF 2, will end in June 2016 and the proposed new project will not include the two target states for the supply of medicines. It therefore makes sense for the AF to have a new component dedicated to ensuring access to pharmaceutical products.

There is a collaborative framework in place with other development partners in South Sudan. While the HPF (supported by the DFID, Canada, Norway, and the European Union) will support delivery of care in other states including procurement of drugs, they will not be able to support procurement of pharmaceutical supplies in Jonglei and Upper Nile beyond June 2016 when the EMF 2 will lapse. This proposed second AF therefore comes at an appropriate time to ensure that the delivery of pharmaceutical supplies in the targeted states is not disrupted.

The AF activities focus on filling the gaps in delivery of high-impact primary care services using a PBF approach. The proposed extension of the contract with the CSDO that has been working in the area under the PPA and potentially under the proposed second AF, depending on approval of the procurement method, is a smart way to ensure continuum of care while at the same time addressing the capacity limitations of the Government. Applying a PBF approach in contracting with the CSDO and subsequently with the facilities takes into account a new paradigm in health delivery, which shifts the focus away from inputs to results. This approach promises to bring more efficiency and accountability in health service delivery.

Proposed activities in line with national priorities. Activities being proposed for the second AF will address not just PDOs but also national priorities. South Sudan has one of the highest, if not the highest, maternal mortality ratios in the world. By continuing to support primary health care, the proposed second AF addresses key pillars of the South Sudan National Health Strategic Plan, in particular reproductive health and nutrition. The proposed second AF takes into account the

lessons learned from the early phases of the project and what other development partners have done in South Sudan and tweaks the interventions to address potential gaps, for example, by including the procurement of pharmaceuticals as a component. Furthermore, the proposed support through the AF to the MOH at the national and regional levels will strengthen its implementing capacity in management of health services in line with the South Sudan national priorities and will contribute to the sustainability of the program.

Social Analysis

Explanation:

No change. The latest integrated safeguards data sheet (ISDS) was disclosed on February 7, 2014, as part of the first AF (P146413). The first AF stage ISDS triggered OP/BP 4.10 - Indigenous Peoples and is applicable to the project as analysis by World Bank and other experts confirms that the overwhelming majority of people in the project area are expected to meet the requirements of OP 4.10. To ensure compliance of the project with the principles of the OP 4.10, the implementation process will ensure that the campaign and outreach activities under the first and now proposed second AF will ensure the participation of all sections of the community, and the delivery of the essential health services benefits all communities in the project area. No separate Indigenous Peoples Plan is required for the project.

Due to the conflict affecting the country in 2013 and 2014, it was not possible to finalize a Social assessment under the first Additional Financing. The violence in Jonglei and Upper Nile prevented the team and Recipient from conducting consultations. However, some advanced analysis had already started under the first Additional Financing with the development of reports on social aspects in South Sudan (P148353). The formation of the TGoNU provides a new window of opportunity to conclude the social assessment under the second AF. The close collaboration between the CSDO, the MOH and County Health Departments will facilitate that process. With the approved safeguards deferral, the team and the borrower will finalize the project social assessment before September 30, 2016.

The first AF phase Project Implementation Manual (PIM) will be reviewed to verify that it adequately reflects the principles of OP 4.10. Related human resource issues will be considered, including options to ensure adequate social safeguards and citizen engagement supervisory capacity on the PMU team. Capacity-building activities will be conducted to strengthen feedback mechanisms at the local level. Potential grievances will be collected at the community level through the village/Boma health committees and monitored closely by CHDs at the local level (see further details in the detailed project description).

The Results Framework includes selected citizen engagement indicators.

Environmental Analysis

Explanation:

No change. The proposed second AF is a continuation of the ongoing HRRP and has the same PDO and activities as the parent project and therefore has the EA Category B like the parent project and triggers OP 4.01 - Environmental Assessment. Environmental issues pertaining to safe

water supply, sanitation, and waste disposal are expected to come up as minor renovation of existing functioning health facilities and health care activities will continue to be supported under the AF. The main environmental safeguard policy relates to health care waste management, in view of the risks associated with the handling and disposal of medical waste.

To avoid/offset the anticipated environmental impacts, as the parent project, this AF will use the project-specific ESSAF of the parent project that explains the operational policies triggered, safeguard screening, and mitigation based on the possible types of subprojects, responsibilities for safeguards screening and mitigation, capacity building and monitoring of safeguards framework implementation, and consultation and disclosure. With the approved safeguards deferral, the team and the borrower will also update the ESMF no later than one month after the effectiveness date of AF2.

The Medical Waste Management Plan (MWMP), prepared, finalized, and disclosed in the World Bank's InfoShop on February 10, 2014, will guide AF implementation. This focuses on existing waste generation as well as segregation, storage, collection, transport, and final disposal practices; technologies for waste disposal; public awareness programs; and relevant national legislation. The South Sudan MOH will continue to use this plan as a guideline to avoid or minimize the potential impacts that could be generated due to the implementation of the project, particularly lack of proper hygiene and sanitation facilities and mismanagement of medical wastes.

During the parent project implementation period, no significant environmental impacts were identified, no safeguards non-compliance were recorded, and all the issues were managed by the best practice method stated in the ESSAF and MWMP.

Risk

Explanation:

The overall project risk continues to be High due to the operating environment (widespread insecurity, political and macroeconomic instability), implementing capacity, technical design, and fiduciary risks. The risk ratings have been increased to High for the following four sections: Sector Strategies and Policies, Technical Design of Project or Program, Environment and Social, and Stakeholders, which are described within each section below.

Political and Governance

The political and governance situation remains unstable and could affect the PDO. With the formation of the TGoNU in April 2016 and the continuity of the MOH's leadership, the main political and governance risk is associated with the potential implementation of the presidential decree on the creation of 28 states. This may create tensions between states and the central bodies.

The AF will keep mitigating the political and governance risk by maintaining a strong focus on local-level collaboration with CHDs whose boundaries have been maintained. The neutrality of the CSDO and past collaboration with local authorities have reduced and will reduce the risk associated with the potential political and governance turmoil at the national and state levels. This mitigation strategy has proven effective to maintain project activities during times of instability even before the December 2013 crisis and when the Greater Pibbor administrative area had been

created in Jonglei State as a result of political and military tensions with the Murle-led South Sudan Democratic Movement.

Macroeconomic

The macroeconomic risk is High. Low oil prices and the current fiscal situation could affect the PDO through two main channels. First, the low Government revenue may trigger a reduction in Government funding for the health sector (which could be further affected by the cost of reintegration of the armed forces and civil servants from the opposition into the state institutions). Second, inflation could affect food prices and magnify even further food insecurity and malnutrition. The general health status of the population would worsen.

This AF will keep coordinating with development and humanitarian partners to adjust for potential drop in Government funding (by transferring medical inputs and human resources across counties to address temporary gaps). Since most of the health sector is funded by donors and humanitarian organizations in Jonglei and Upper Nile, this AF, together with health partners, has the capacity to mitigate the risk. Moreover, this AF will keep mitigating the effect of inflation on malnutrition by including malnutrition prevention and treatment activities and working complementarily with the United Nations Children's Fund, World Food Programme, and other humanitarian actors.

Sector Strategies and Policies

The risk associated with sector strategies and policies has been increased from substantial to high given the political instability from a transition government being in place and the associated future uncertainties. However, the MOH's leadership has been maintained in the TGoNU, which fosters the continuity of sector policies that have been built in close collaboration with health partners since 2005.

However, the World Bank is further mitigating this risk by engaging continuously with the MOH and all international partners in minimizing the risk of unexpected changes in health policy and strategy. In particular, the MOH will soon release its new health policy 2016–2025 and the Boma Health Initiative that have been developed in close collaboration with health partners. The AF has been designed to fully align with the MOH strategies and policies, especially with regard to the focus given to local service delivery and accountability at the Boma level (the AF will support Boma health committees).

Technical Design of Project or Program

The risk rating for the technical design of the project has been increased from moderate to high due to the added complexity of including the pharmaceutical procurement component. Although the project was designed for a conflict-affected environment, the addition of a component to the parent project presents a risk. The procurement of pharmaceuticals to such a scale is new to the operation (procurement of buffer stocks was part of the parent project and first AF). Due to conflict and poor transport infrastructure, the risk is mainly associated with the quality and timeliness of procurement, storage, and distribution of pharmaceuticals up to the counties in Jonglei and Upper Nile. Given the presence of counterfeit pharmaceuticals in the country, the quality of commodities

remains at risk.

To mitigate these risks, the team has been working closely with UN agencies, health partners, and the MOH to determine the option that maximizes quality and minimizes the risk of delay in the delivery to counties. Based on their experience, this AF will mitigate the risk by (a) contracting one single agent that manages all the stages from procurement to the delivery in the counties; (b) contracting an agency with proven track record (especially concerning quality controls and timeliness) verified by international health partners; and (c) transporting a significant amount of medicines during the dry season to minimize the risk of inaccessibility during the rainy season (same mitigating strategies used by all health partners). With the support of the World Bank, the PMU will verify the quantification and pricing soundness of the list of commodities to be procured with health partners. Moreover, the FM and procurement teams will provide close support and supervision of the procurement process.

Institutional Capacity for Implementation and Sustainability

The risk is High. The institutional capacity for implementation is particularly low at the county level where few CHDs have enough skilled staff to lead the project implementation.

This AF will keep mitigating that risk by building the capacity of CHDs through the CSDO. In counties where the CHD does not have enough capacity to implement the project, the CSDO will keep contracting IPs (NGOs) to deliver services while building the CHDs' capacity. The parent project and first AF have successfully mitigated that risk by building the capacity of five CHDs that are now directly contracted (instead of NGOs). This mitigation strategy will be maintained for this second AF, and it will contribute to building the sustainability of the project.

Fiduciary

The fiduciary risk is High due to the weakness of the FM system in the country, the limited physical access to the project implementation areas, and the volatile macroeconomic and fiscal context. In spite of the new exchange regime implemented in December 2015, the SSP has depreciated significantly against the U.S. dollar and has not stabilized. This has also contributed to inflationary trends throughout the country. The project might face challenges in budgeting and disbursements in local currency. In addition to these, the FM system is weak. The Government has low capacity to prepare budgets that lay down physical and financial targets with sufficient details to be able to fully monitor their performance and to properly account for and report on funds utilization. In addition, the difficulties to access the project implementation sites will constitute an additional challenge to perform FM supervision and audit functions. Furthermore, the project has added a new component under Component 3 "Pharmaceutical Commodities". The procurement and distribution of pharmaceuticals in the counties will be undertaken by one single agent - only one firm has been identified as having the capacity to carry out this activity worth US$15 million. In addition, the agent will have to supply and distribute pharmaceuticals by August 2016 which means the entire process will be completed in a short period of time. There are a number of fiduciary risks in this process; key ones include the risk of procuring/distributing substandard/expired medicines and over billing and short delivery. For all these reasons, the FM risk is High.

Mitigation measures envisaged to address the FM risk. The project will budget and plan to make disbursements in U.S. dollars as much as possible. The current PMU will be strengthened during the implementation of the PPA, which will support the implementation of the AF. Measures to strengthen the PMU will include the following: (a) a qualified FMS in addition to two national staff, namely, project finance officer (to be hired) and an accountant (to be seconded by the MOH) will be hired; (b) The external audit of the project will cover all aspects/activities/components of the project including reviewing activities performed by service providers with ultimate goal of ensuring that resources are used for purposes intended. The TORs of the project audit will be reviewed to ensure that these issues are well captured. Contracting of EAA to support audit of project activities by the National Audit Chamber and its TOR will also be reviewed by the World Bank ; (c) the World Bank will provide continuous assistance including thorough reviews of quarterly unaudited IFRs to ensure that the project staff are able to prepare adequate budgets, monitor progress, and make adjustments when necessary; (d) the World Bank will work with the Ministry of Finance and Economic Planning (MoFEP) and the Directorate of Internal Audit to post an internal auditor to the MOH who will support the project's internal controls review process of the project starting from the MOH up to and including operations at the field level. Semiannual internal audit reports will be submitted to the MOH and the World Bank; (e) the project is encouraged to make payments to the CSDO using the direct payment method; (f) the TOR for external audit of the CSDO on the activities financed by the project will be agreed upon by the Government and the CSDO; however, the World Bank will review and provide for a 'no objection'. The audit report together with the Management Letter from this audit shall be shared with the World Bank through the task team leader; (g) the World Bank in consultation with the Government will perform a market survey to increase the number of banks holding designated accounts and allow the projects to get better banking conditions; (h) the PMU will ensure service providers are paid on the basis of evidence that they have delivered as per contracts (for instance for component 3 there should be adequate proof of delivery of pharmaceutical commodities supplied to the health facilities before processing payments as per contracts); (i) in regards to specific fiduciary risk from component 3, the TOR/contract of the CSDO will be revised to include responsibility of verifying the bills of the agent, in terms of delivery, before payment by PMU; the Internal Audit to be assigned by MoFEP will give particular attention to this component and will review on a sample basis including spot checking to ensure that there is performance as per contract including delivery, and finally the PMU will recruit an independent agent for ensuring medicines are not sub-standard and expired and are indeed fit for consumption; and (j) the World Bank will continue to conduct close supervision and implementation supports to follow up on these FM issues.

These mitigation measures will be reviewed on an ongoing basis during the project implementation.

Environment and Social

The risk rating for the environment and social contexts has been increased from moderate to high due to potential drought and heavy rains which constitute recurrent risks for all operations in the country. Poor rains will foster food insecurity and malnutrition and will damage the overall population health status in Jonglei and Upper Nile, hindering the project's ability to achieve the PDO. Heavy rains will further damage a fragile infrastructure (facilities and roads) and boost

malaria epidemics.

As explained earlier, this AF will maintain the current mitigating measures on malnutrition in place (health care activities targeting malnutrition and coordination with humanitarian partners) and will use air and river transportation assets when roads cannot be used during the rainy season (to transport medical inputs and personnel). Although the project is not expected to have a significant environmental impact, the AF will also mitigate the risk of contamination by implementing the MWMP (see Environmental Analysis section).

The social risk is High. Despite the peace agreement, widespread violence remains in Upper Nile and Jonglei. However, this violence responds to many different forces depending on the location, mainly national politics (SPLA vs SPLA-IO), local ethnic clashes, local politics, and economic hardship. This violence was already present before and during the parent project and first AF. The risks for the project concern the resulting displaced populations and health care workers.

The AF will maintain the mitigating measures implemented under the parent project and first AF. As proven during the December 2013–2015 crisis and before, the CSDO has maintained neutrality and the same level of engagement with counties independently of the ethnic population distribution and armed forces in control of a given area (see Box 2). Moreover, mobile health teams managed by CHDs and NGOs will attend to IDPs when access is possible.

Stakeholders

The risk rating for stakeholders has been increased from moderate to high due to the complex dynamics among different stakeholder groups. Furthermore, there is a risk of irregular and diminishing Government resources allocated to health which could cause some facilities to face shortages of commodities potentially leading to the personnel reducing the opening hours which could create tension with the population.

The AF will keep mitigating that risk by supporting citizen engagement and accountability activities through the Boma health committees where communities discuss potential grievances and issues with service delivery. CHDs will also be engaged to resolve potential issues in their power and provide responses to the communities and issues raised by particular groups (including women who are represented in the committee). CHDs will raise issues to the SMOHs and MOH when necessary. Moreover, the flexibility given to the CSDO to manage contracts and funds allows responding to certain temporary resource gaps (commodities or human resources).

Other (Security Risk)

Although insecurity is an underlying risk for most of the risks described earlier, it remains a key threat in itself for achieving the PDO. Beyond the direct impact on the population's health, insecurity (independently of its roots: ethnic based, cattle raiding, political, or economic) poses a risk to the project by: (a) constraining movement of all stakeholders, including monitoring agents; (b) discouraging the settlement of health workers in the region; and (c) increasing the cost of the delivery of health commodities.

Since widespread violence was already a characteristic of Jonglei and Upper Nile States before the

December 2013 crisis, the parent project incorporated the fragility and conflict parameters into the project design to respond to these constraints. Most of the mitigation measures are described above and will be maintained during the second AF. In particular, the neutrality and close collaboration with local health authorities have enabled the project to maintain a certain level of activity, independently of the group in control of an area. Contracting CHDs has facilitated the continuity of services (whereas some NGOs temporarily withdrew from certain areas at the height of the conflict in 2014 and 2015 in Unity State and in some parts of Jonglei and Upper Nile). Although the capacity shortage remains a risk at the country level, training programs funded by other donors are currently contributing to bridge this gap. Although the drivers of conflict are outside the scope of this project, the experience acquired and the mitigation measures put in place under the parent project and the first AF since 2012 will minimize the impact of insecurity on the achievement of the PDO.

V. World Bank Grievance Redress

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

Annex 1. Revised Results Framework and Monitoring Indicators

Project Development Objectives							
Parent Project Development Objective - Parent:							
The objectives of the Project are: (a) to improve the delivery of High Impact Primary Health Care Services in Upper Nile and Jonglei states; and (b) to strengthen the coordination, monitoring and evaluation capacities of the Ministry of Health.							
Proposed Project Development Objective - Additional Financing (AF):							
The objectives of the Project are: (a) to improve the delivery of High Impact Primary Health Care Services in Upper Nile and Jonglei states; and (b) to strengthen the coordination, monitoring and evaluation capacities of the Ministry of Health.							
Results							
Core sector indicators are considered: Yes			Results reporting level: Project Level				
Project Development Objective Indicators							
Status	**Indicator Name**	**Core**	**Unit of Measure**		**Baseline**	**Actual(Current)**	**End Target**
Revised	Number of children under the age of 12 months immunized against DPT3	☐	Number	Value	0.00	74,973.00	90,000.00
				Date	15-Jun-2011	30-Sep-2015	30-Sep-2017
				Comment	Monitors the cumulative progress of immunizations of children under 12 months for DPT3 under the project activities in both states. Output is dependent on (a) improved security conditions to support renovation of facilities and (b) training of health workers. This indicator is highly dependent on campaigns and the state of relative calm in the country.	Cumulative value from the start of the project to September 30, 2015 (Q11)	The target factors security and access constraints. Campaigns may not reach all the counties.
Revised	Pregnant women receiving antenatal care (ANC) during a visit to a health provider (number)	☒	Number	Value	0.00	115,505.00	150,000.00
				Date	15-Jun-2011	30-Sep-2015	30-Sep-2017
				Comment	Monitors the cumulative progress for pregnant mothers accessing ANC first visit. Dependent on improved	Cumulative value from the start of the project to September 30,	The target factors security and access constraints

					security conditions to support renovation of facilities and training of health workers.	2015 (Q11)	
Revised	Percentage of functional health facilities submitting standardized HMIS monthly reports within one month of the reporting month	☐	Percentage	Value	62.00	71.50	75.00
				Date	06-Apr-2012	31-Aug-2015	30-Sep-2017
				Comment	Monitors the capacity of facilities in submitting HMIS returns. Dependent on improved security conditions to support renovation of facilities and training of health workers.	–	The target factors security and access constraints. The capacity to provide technical support to facilities could be limited.
Revised	Outpatient visits per capita per year	☐	Percentage	Value	0.10	0.49	0.50
				Date	06-Apr-2012	31-Aug-2015	30-Sep-2017
				Comment	Monitors the number of outpatient visits to the health facilities. Dependent on improved security conditions to support renovation of facilities and training of health workers.	–	–
Revised	Percentage of direct beneficiaries of which female	☐	Percentage	Value	–	53.00	50.00
				Date	–	31-Aug-2015	30-Sep-2017
				Comment	Will depend on population displacement and migration and impact of the conflict on population demographics.	–	–
Intermediate Results Indicators							
Status	**Indicator Name**	**Core**	**Unit of Measure**		**Baseline**	**Actual(Current)**	**End Target**
Revised	Children 6–59 months receiving a dose of vitamin	☐	Number	Value	0.00	486,025.00	515,000.00
				Date	15-Jun-2011	30-Sep-2015	30-Sep-2017

	A			Comment	Monitors cumulative distribution of vitamin A to children under 5 years old. Dependent on improved security conditions to support renovation of facilities and training of health workers for improved access and service delivery.	The large increase is due to the mass campaigns implemented in 2013. These campaigns stopped during the latest crisis, and the security and weather conditions required to reinitiate them are unlikely to be met before September 2017.	The target factors security and access constraints. Campaigns may not reach all the counties.
Revised	Number of children under 59 months old who received measles vaccination	☐	Number	Value	0.00	131,350.00	150,000.00
				Date	15-Jun-2011	30-Sep-2015	30-Sep-2017
				Comment	Monitors cumulative number of children vaccinated against measles. Dependent on improved security conditions to support renovation of facilities and training of health workers.	The high level of violence and insecurity has affected the capacity to conduct campaigns and deliver services in all the facilities.	The target factors security and access constraints. Campaigns may not reach all the counties.
Revised	Births (deliveries) attended by skilled health personnel (number)	☒	Number	Value	0.00	10,921.00	12,000.00
				Date	15-Jun-2011	30-Sep-2015	30-Sep-2017
				Comment	Monitors utilization of health facilities by pregnant women at time of delivery. Dependent on improved security conditions to support renovation of facilities and training of health workers.	The high level of violence and insecurity has affected the capacity to deliver services in 100% of the facilities. Moreover, the	–

						availability of skilled health workers is very limited in the country, especially in conflict-affected areas.	
Revised	Long-lasting insecticide-treated malaria nets purchased and/or distributed (number)	☒	Number	Value	0.00	2,534,785.00	2,600,000.00
				Date	06-Apr-2012	31-Oct-2014	30-Sep-2017
				Comment	Monitors the cumulative number of insecticide-treated mosquito nets distributed in the communities served by the project.	–	–
Revised	Percentage of health facilities having essential drugs at the time of supervisory visit	☐	Percentage	Value	50.00	57.00	80.00
				Date	06-Apr-2012	31-Aug-2015	30-Sep-2017
				Comment	Monitors the availability of pharmaceuticals at health facilities. Dependent on improved security conditions to enable the distribution and storage of medicines.	–	–
Revised	Percentage of health facilities with structured supervision visit (using the QSC) within a month before a verification visit	☐	Percentage	Value	25.00	54.00	55.00
				Date	06-Apr-2012	31-Aug-2015	30-Sep-2017
				Comment	Dependent on improved security conditions to allow access to facilities and supervision.	–	The target factors security and access constraints.
Revised	Percentage of children aged 0-59 months sleeping under a Long-lasting Insecticidal Net (LLIN) the night before survey.	☐	Percentage	Value	34.20	26.80	40.00
				Date	01-Jan-2013	31-Aug-2015	30-Sep-2017
				Comment	Monitors proportion of children under five years old sleeping under LLINs as a	–	–

					measure of protection against malaria. Dependent on improved security conditions to support community mobilization activities.		
Revised	Percentage of health centers with at least two skilled health workers	☐	Percentage	Value	50.00	58.00	60.00
				Date	01-Jan-2013	31-Aug-2015	30-Sep-2017
				Comment	Monitors the percentage of PHCC with at least two trained health workers to provide care. Dependent on improved security conditions that allow to retrain staff, support training of health workers and conduct renovation of facilities.	–	The target factors security constraints.
New	Percentage of health facilities with Boma/village health committee established and that meets at least twice every quarter	☐	Percentage	Value	TBD	TBD	40.00
				Date	31-Jul-2016		30-Sep-2017
				Comment	Baseline to be established by CHDs under PMU oversight during the first month of effectiveness.	–	The target factors security constraints and IDPs.
New	Percentage of established Boma/village health committees that feel that their feedback related to health service delivery has been responded to by CHDs and IPs	☐	Percentage	Value	TBD	TBD	50.00
				Date	31-Jul-2016		30-Sep-2017
				Comment	Baseline to be established by CHDs under PMU oversight during the first month of effectiveness.	–	Among the Boma/village health committees established, this indicator reflects whether the feedback loop has been closed between beneficiaries and service providers and local health

							authorities (CHD).
New	Representatives in community-based decision-making and management structures that are women	☐	Percentage	Value	TBD	TBD	90.00
				Date	31-Jul-2016		30-Sep-2017
				Comment	This core social indicator will reflect the % of functioning village health committees that include women. This will be monitored through the QSC and QVV. Baseline will be established during the first quarter of the project effectiveness.	–	–

Annex 2. Detailed Project Description

Component 1: Delivery of High Impact Primary Health Care Services in Jonglei and Upper Nile States

1. Under Component 1, the proposed second AF will continue to improve the delivery of high-impact primary health care services in Jonglei and Upper Nile. The parent project has provided critical support in maintaining health services before and throughout the current conflict. As the situation remains fragile and new pockets of conflict emerge in Jonglei and Upper Nile, the provision of essential health services to the local and displaced populations is urgent and critical. Current implementation arrangements will not change. The proposed second AF will finance the MOH's PBC with a CSDO to implement activities under Component 1. The CSDO will continue to play an overall coordination function to ensure the delivery of services and to minimize duplication of efforts.

Services Delivered and Facilities Supported by This AF

2. This AF will support 282 primary health care facilities (primary health care centers [PHCCs] and primary health care units [PHCUs]) and eight county hospitals that provide basic surgery services. The difference is in types of services offered and capacity. The number of facilities per county ranges from 3 to 25 depending on the size of the county and population. The county hospitals supported by the project are Melut, Bunj, Nasir, and Renk in Upper Nile State and Boma, Akobo, Fangak, and Duk Lost Boys Clinic in Jonglei State. The detailed number of facilities supported in each state is given in Table 2.1.

Table 2.1. Number of Facilities Supported by the AF

	Counties	PHCU	PHCC	Total Number of Facilities Supported	County Hospitals	Population Covered (excluding IDPs)		
						Male	Female	Total
Jonglei	11	113	37	150	4	954,026	858,301	1,812,327
Upper Nile	13	95	37	132	4	707,888	624,455	1,332,343
Total	24	208	74	282	8	1,661,914	1,482,756	3,144,670

Source: PMU, MOH.

3. The project will cover a population of 3.1 million people (53 percent male and 47 percent female). However, this figure does not include IDPs. It is estimated that Jonglei and Upper Nile have about 495,606 and 247,848 IDPs, respectively. The CSDO and United Nations Office for the Coordination of Humanitarian Affairs figures will be used to approximate the in and out flows of IDPs. While these estimates cannot be verified, discussions with health partners on the ground indicate that the project should expect to see more populations demanding services compared to the past 3 years. This is due to the return of IDPs and refugees from Ethiopia and Sudan to Jonglei and Upper Nile.

4. In some cases, the CSDO and IPs have to follow displaced populations to other counties to maintain services. For example, in Baliet County, health workers and the majority of the population were displaced to Akoka County. The CSDO through its IP had to go to Akoka to provide targeted curative care for pathologies particularly prevalent in IDP populations (malaria, diarrhea, and pneumonia). Mobile clinics are established by the CSDO in coordination with the CHD when the displaced populations cannot be reached by local facilities. The need for such mobile service delivery mechanisms deployed from the CHDs will remain and may increase as slightly improving security conditions enable access to isolated population that had fled into the bush.

5. The services delivered are defined in the Health Sector Development Plan 2012–2016 and are centered on the Basic Package of Health and Nutrition Services. These include the following:

- Child health services (immunization, vitamin A supplementation, promotion of adequate infant and young child feeding, caring behaviors, and LLIN)
- Maternal health (ANC, intermittent preventive treatment, institutional deliveries, postnatal care, family planning)
- Basic curative services (treatment of malaria, acute respiratory infection, diarrhea, tuberculosis and Human Immunodeficiency Virus [HIV] services—tuberculosis and HIV services offered in selected health facilities)
- Nutrition and general primary health care services

6. In spite of services being offered in the health facilities, it has been challenging to increase the utilization of certain services. This is because of a combination of factors. First, widespread violence and access constraints during the rainy season have significantly reduced accessibility to health services. Second, social and cultural norms and traditional practices are often forces antagonistic to the use of such services. To maximize the utilization of services, the MOH and the CSDO concentrate some activities during the dry season, when roads are passable. These dry season campaigns focus especially on immunization and vitamin A supplementation.

7. In addition, the MOH and CSDO coordinate with health partners to support several vertical programs. In particular, the AF will continue to distribute mosquito nets funded by the Global Fund.

8. All of these strategies will be maintained to increase availability of and demand for services. The flexibility in adapting the delivery strategies and tools is a key element for the success of the project given the highly volatile environment and rapid and frequent shift in demand and needs.

Implementation Arrangements

9. Implementation arrangements will not change. Under the current arrangement, the MOH contracts a CSDO. For each county, the CSDO subcontracts CHDs and/or IPs (international and

national NGOs). The SMOH works in close collaboration with the CSDO to implement service delivery and play a supervisory role of the CSDO, IPs, and CHDs.

10. Under the current project, the MOH has implemented PBC.

11. The CSDO, IPs, CHDs, hospitals, PHCCs, and PHCUs covered by the project received performance-based incentives against specific achievements. The MOH assesses the CSDO's performance through the M&E firm (contracted under Component 2). All IPs, CHDs, and health facilities are assessed by the CSDO. For PHCCs, performance is measured through five indicators (DPT3, ANC1, HMIS, waste management, and Integrated Disease Surveillance and Response [IDSR]). PHCUs' performance are measured against four indicators because the level of services provided is lower than PHCCs. Specific evaluations mechanisms and arrangements have been developed in the 'PBC Operational Manual' in 2013 and will remain valid during this AF. The CSDO has conducted training with the CHD, IPs, and facilities in implementing the manual and will continue providing support throughout this AF.

Table 2. 2. PBC Monitoring Structure

Agent Monitored	Monitoring Agent	Parameters
CSDO	The MOH through the M&E firm	DPT3, ANC (first visit), QSC, HMIS, and availability of essential drugs (MOH provides the list). To be introduced under the new AF: HRIS data submission
IPs/NGO	CSDO	DPT3, ANC (1st visit), QSC, HMIS, and curative care. To be introduced under the new AF: HRIS data submission
CHDs	CSDO/NGOS	The QSC, IDSR, HMIS, village health committee formation, delivery of trainings, undertaking their administrative, and coordination functions (meetings with partners and the SMOH). To be introduced under the new AF: HRIS data submission
County Hospitals	CSDO	IDSR (weekly data reporting to World Health Organization), HMIS, waste management, assisted delivery and services such as family planning, Prevention of mother-to-child transmission of HIV, emergency obstetric care
PHCC, PHCU	CHDs	DPT3, ANC (first visit), HMIS, and waste management. The PHCU is exempted from the IDSR requirement due to the type of services provided

12. The PBC provides financial incentives. The amount paid varies among different actors. The CSDO can receive up to 10 percent of the contract value; IPs up to 5 percent of contract value; SSP 3,000 per month for CHDs; SSP 4,000 per month for county hospitals; SSP 1800 per month for PHCCs; and SSP 600 for PHCUs. These amounts will be reassessed by the MOH after the proposed Additional Financing project becomes effective.

13. These payments have made a difference in improving service availability and utilization. With the PBC, facilities have been opened longer (continuously open from 8 a.m. to 5 p.m. in a more systematic manner) with all the services offered, timeliness and completeness of data reporting increased, and coordination of activities by as well as supervisory roles of CHDs improved. The data submitted through the HMIS increased from a baseline of 60 percent to 90 percent. Curative consultations per inhabitant per month was at a low of 0.1 at the beginning of the project and increased to 0.7. Average ANC coverage went from 22 percent to 38 percent. Although the overall performance declined during the December 2013 crisis, the project regained momentum after April 2014. Some of the facilities remained functional in rebel controlled areas thanks to resources provided through the PBC fund since the Government was unable to access these areas and pay health workers (who threatened to desert facilities if they were not paid).

Expanding CHDs

14. For this AF, the project will expand the number of CHDs contracted as IPs (i.e., taking over the functions and responsibilities of NGOs). This is one of the results of three years of HRRP implementation that strengthened the capacity of CHDs to deliver services and assume FM, reporting, and supervision functions. Currently, six CHDs are contracted under Component 1 (Melut, Renk, Malakal, Akoka, and Manyo in Upper Nile and Twic East County in Jonglei). The MOH plans to include additional counties on PBC through a gradual process. Experience has indicated that not all counties have the required capacity to implement PBC. Hence, the MOH will first assess the CHD capacity with regard to human resources with special attention paid to the critical positions of the finance officer, CHD director, and M&E officer. Moreover, to reduce the FM risks, the CHD will have to have access to a bank account for safe and timely transfers of funds (for both the HRRP and the Government fiscal transfers) and prevailing security on the ground.

15. When the capacities of CHDs are strong enough to assume their service delivery and coordination role at the local level, contracting them directly implies significant efficiency gains: (a) the implementation costs are significantly lower than NGOs; (b) medical and nonmedical staff usually remain in the facilities even when fighting reaches their areas (NGO personnel usually withdraw temporarily); and (c) the sustainability of the project activities is strengthened as the ownership of the project activities and outputs belongs to local staff and authorities. Based on these advantages, the MOH and the World Bank are favoring CHD contracting when they have the required capacities.

Procurement Arrangements for Component 1

16. For Component 1, during the period covered by the PPA (April 1 to effectiveness of the AF), the project will extend the CSDO contract until effectiveness of the AF (expected by August 31, 2016). For the AF, based on the earlier recommendation from the OPRC that required

the new engagement of the CSDO to be based on competitive recruitment, the task team has initiated this competitive bidding process. However, it has become evident that this process will not be on time as it will take nine months to completion resulting in the interruption of service delivery to the two target states. Therefore, following initial discussions with the regional procurement team, the task team was advised to present a request to the OPRC to use the SSS method to extend the current CSDO contract by once again applying OP 10.00 paragraph 12 (b) and OP 11.00 for the 'Simplified Procurement and Consultants' Selection Procedures for Fragile and Conflict Situations and Small States'. This will ensure that the World Bank can quickly respond to the urgent need for health care services that are now being provided by the CSDO and prevent the consequences that an interruption of critical services will have on the population. The CSDO presents a clear advantage for the required services, since the firm has a proven track record of good performance in the most conflict-affected states of South Sudan. The CSDO is already supporting 283 health facilities in Jonglei and Upper Nile and thus will be able to use its current operational structure to continue service delivery.

Complementarity between the World Bank Funding and the Government Resources

17. The HRRP and the Government resources are complementary. While Government resources are limited, the fiscal transfers to states, counties, and service delivery units allow to pay part of Government health care workers in the facilities and CHDs, undertake minor renovations of health facilities, coordinate meetings with county partners, and cover some logistical costs. However, the conflict context has reduced the fiscal transfers that actually reach the facilities, particularly in areas controlled by the opposition. The World Bank financing becomes critical for ensuring a minimum level of functionality for facilities in conflict-affected areas (see the impact of World Bank funding in Figure 3).

18. Moreover, the HRRP will enable synergies with other donor-funded programs. In particular, the Global Fund will provide funding and HIV and malaria treatments to the CSDO in Jonglei and Upper Nile to deliver treatments to patients and implement campaigns.

Component 2: Strengthening Implementation Capacity of MOH at the National Level

19. Under Component 2, the proposed AF will continue to support the MOH and SMOHs in their management and stewardship roles. Activities will aim at supporting the MOH in (a) grant and contract management and (b) M&E. In particular, the AF will focus on improving routine data collection through the HMIS, the HRIS, and QSCs, as well as ensuring timely health facility surveys and household surveys. Moreover, this AF will pilot citizen engagement activities with particular focus on improving health governance mechanisms and service delivery at the local level.

20. Subcomponent 2.1 (US$1 million) supports the MOH in planning, managing, and monitoring grants and contracts under this AF. With the positive performance of the PMU under the project, the MOH plans to expand the responsibilities of the PMU within the ministry. In particular, the PMU will be gradually involved in monitoring the main donor programs outside Jonglei and Upper Nile. The HRRP will remain the priority for the PMU. By strengthening the role of the PMU, the ministry aims to further enhance donor coordination and planning.

21. The PMU has the responsibility to lead (a) contract management activities including drafting contracts with IPs and medical input suppliers; (b) budget negotiations; (c) M&E activities; (d) auditing; and (e) supervision of the project.

22. The PMU does the routine management of the project including providing information to guide decision-making. In the MOH, the directorates who are involved in key decisions regarding the project are the Directorate for International Health and Coordination, the Directorate for Policy, Planning, Budgeting, and Research, and the Directorate for Primary Health Care. These actors can coordinate on an ad-hoc basis with other relevant directorates such as Reproductive Health, Pharmaceuticals, Preventive Health Services, and Administration and Finance.

23. During the MTR, partners and the MOH highlighted the encouraging capacity-building results at the national and local levels (i.e., CHDs). However, capacity building activities have been very limited at the state level. This AF will rebalance the support between the different levels of the Government by strengthening the support of SMOHs to perform key functions that contribute to Components 1 and 2 of the project: FM and M&E. Hence, this AF will support the recruitment of one FM officer and one M&E officer in each SMOH in Jonglei and Upper Nile.

24. Subcomponent 2.2 (US$3 million) aims to ensure a steady stream of independent and credible data on health outcomes and sector performance.

M&E

25. The M&E activities will continue to support the implementation of Components 1 and 3.

26. **Quantitative Supervisory Checklist.** The QSC is a tool used by the MOH to assess quality of care at the county level on a quarterly basis as well as identify issues affecting delivery of services such as availability of drugs and staff. The tool is simple and has seven components (Human Resources, HMIS, Pharmaceuticals, Utilization of Health Services, Infrastructure, Equipment, and Service Provision). Each component is scored out of 100 percent. Then an average score for the seven components is calculated for the state, county or facility. On average, a facility should score at least 50 percent. The results of the QSC are entered into the DHIS and submitted quarterly to each SMOH, which then reports the information to the central MOH. Based on the score, the supervisor (CHDs and IPs) discusses with the facility staff any issue affecting the facility and they jointly develop an action plan for the quarter. The QSC tool is used by all stakeholders, i.e., the MOH, SMOH, CHDs, and IPs.

27. The MOH is currently reviewing the components of the QSC based on the past three years of implementation. As part of the rollout of the human resources to Jonglei and Upper Nile, the QSC will include an item on the submission of HRIS data to the national system.

28. **Quarterly Verification Visit.** The QVV is a tool implemented under the parent project to assess the performance of the CSDO quarterly. This tool is the basis to allocate incentives under the PBC system (see Component 1). The M&E firm conducts the QVV using a random selection of 20 PHCCs in each state. The tool has five indicators (DPT3, ANC first visit, HMIS, supervision using the QSC, and availability of essential drugs in the facility). This tool enables the MOH to assess the validity of the data submitted by the CSDO. The M&E firm conducts

field visits and verifies data from the registers (primary source of data). The project plan also includes the HRIS as one of the indicators to be monitored to ensure that the HRIS is functional and provides timely information on human resources for planning.

29. The QSC and QVV will incorporate the monitoring of the main feedback and grievance redress mechanism of the project—the village health committees.

30. The MTR highlighted the difficulty to conduct the QVV during the rainy season and when security conditions were not guaranteed to the M&E firm. In such cases, the MOH, the World Bank , and the M&E firm agreed to use the relatively robust data provided by the HMIS as an alternative to field visits. During this AF, when access to certain areas will be restricted, the verification of the facilities' performance will be carried out based on HMIS data.

Supporting Service Delivery through Country Systems

31. The current project has allowed the ministry to put in place a robust HMIS at the national level. This system provides a continuous flow of data on health outputs. While the conflict has slowed the roll-out process, as of April 2016, more than 90 percent of the facility reports have been submitted through the HMIS. This AF will keep supporting NGOs and CHDs in reporting their activities in Jonglei and Upper Nile through the HMIS. This system is a fundamental piece of the planning and budgetary processes for both donors and the MOH. The MOH and the CSDO will ensure a continuing use of the HMIS by the CHDs and IPs. Annual HMIS reports will be produced by the MOH with the support of the M&E firm.

32. **The HRIS and South Sudan Electronic Payroll System (SSEPS).** With the support of the HPF, the MOH has developed a HRIS. The HRIS aims at registering all health workers in the South Sudan public health system (both on Government and donor-funded programs payrolls), including their qualifications, credentials, location, gender, and grade. The MOH has implemented the system in eight states so far. Currently, Jonglei and Upper Nile are not integrated into the national system (mostly due to the level of conflict). Since the country system is already in place and working, this AF will support the inclusion of the counties supported by the HRRP.

33. In coordination with the Ministry of Labor, the MOH is implementing the SSEPS. This tool has been rolled out and is operational in the eight states supported by the HPF and USAID.

34. The CSDO will conduct training and coordinate with the MOH, SMOH, and CHDs to ensure the implementation of the HRIS and SSEPS in Jonglei and Upper Nile. Raw data and reports will be shared with all health partners and the World Bank. The project will maintain the same capacity-building activities in support of service delivery.

35. Personnel from the CSDO and IPs will be seconded to the MOH, SMOH, and CHD based on the needs to ensure critical functions, including planning processes, budget monitoring, FM, and M&E. Moreover, the CSDO and the MOH will conduct capacity building assessment to identify gaps or areas that need specific attention and recommend appropriate solutions. Finally, to strengthen the capacity of local staff in a sustainable manner, the CSDO, M&E firm, and IPs will incorporate, whenever possible, the staff from the MOH, SMOH, and CHDs into their

activities. In particular, joint supervision activities with the MOH, SMOH, and CHD in the field will include on-the-job mentoring and training.

National Health Surveys to Be Conducted

36. After independence, the MOH set the goal of having at least one health facility assessment per year and one LQAS every two years. Under the current project, the MOH conducted three national surveys: two health facility assessments and one LQAS. These surveys were carried out successfully by the MOH with support of the M&E firm (London School of Tropical Hygiene). Although the December 2013 crisis caused delays in the implementation of the LQAS 2014 (conducted in 2015), the MOH has been able to maintain a continuous flow of reliable data on the health system even from the most conflict-affected states: Unity, Jonglei, and Upper Nile. This AF will build upon these positive results to support one health facility assessment and one LQAS in 2017.

Citizen Engagement to Improve Service Delivery

37. The AF will step up its support to citizen engagement mechanisms in the health sector. The project will build upon existing structures and reinforce them to strengthen accountability and feedback mechanisms related to service delivery. Village health committees (or Boma health committees) will be established where they are currently not. The MOH will establish the baseline through the M&E mechanisms defined earlier (QSC and QVV). Although the exact number of functioning health village committees is unknown, informal interviews with the MOH and partners on the ground seem to indicate that, in Upper Nile and Jonglei, committees have been established in a few counties only. These structures are suffering from low awareness and capacity (mostly financial) of the SMOH and CHDs to operationalize them (it is worth noting that the intensity of the conflict has also reduced the priority given to these committees in the two states). The PIM will be updated to reflect the role of the village health committees as part of the project commitment to further operationalize the implementation of OP 4.10.

38. This activity is fully aligned with the new MOH focus on improving service delivery at the local level. The MOH has adopted the 'BOMA Health Initiative' this year and will implement it next fiscal year. Among other actions, the initiative aims to operationalize and incentivize the effectiveness and role played by committees in engaging health providers and authorities on service delivery matters. Therefore, supporting the committees will improve the project outcomes (under Component 1) and support the MOH policy to empower local communities.

39. Health committees are composed of community members, including women (mandatory). These committees meet on a monthly basis with the CHDs, health care facilities and NGOs (when they act as IPs). Overall, health committees provide feedback to any stakeholder involved in health service delivery and discuss potential grievances. In particular, the committees have three main roles:

- Oversight of services delivered (from both the Government and NGO-run facilities): health workers attendance, health workers' treatment of patients, availability of drugs, and other medical inputs

- Oversight of facilities: condition of the infrastructure, equipment, cleanliness, and so on

- Coordination with health partners to carry out specific activities within the community and voice the feedback from individual beneficiaries to health authorities and facilities: community-based activities to include supporting awareness raising activities, mobilize families for vaccination campaigns, and so on

40. Village health committees can also undertake community action to improve service delivery such as renovations of health facilities, cleaning of the facilities, and management of small amount of resources for providing basic inputs to facilities (such as soap). The CHDs and IPs must record meetings and attendance and provide responses to the issues raised by the community members. Minutes of the meeting will be co-approved by the committees and CHDs and shared with the SMOH to foster appropriate follow-up actions, if required. Through the QVV, a third party (the M&E firm) will evaluate the performance of health committees, with particular attention paid to the resolution of beneficiaries' grievances by the CHD, SMOH, CSDO, and MOH. As part of the QVV, the third party will provide a short summary note on the results of village health committees (annex to the QVV report) to the World Bank.

41. The QSC will be revised to include three new indicators to monitor the functionality of the health committees. Moreover, it will be reflected in the results framework by adding two indicators reflecting the progress with regard to coverage of health committees and whether the feedback loop is closed (health committees that feel that their feedback has been responded to by the CHD or IPs).

Component 3: Pharmaceutical Commodities (US$15 million)

42. The third component will primarily focus on the procurement and distribution of pharmaceuticals and medical inputs in Jonglei and Upper Nile. This component is a response to the expected discontinuation of the supply of basic medicines after the main funding mechanism for pharmaceuticals in the country, the EMF[17], ended in June 2015, and following the end of a temporary arrangement for pharmaceuticals supply that is expected to close in June 2016. Beyond June 2016, the upcoming donor-coordinated financing mechanism for pharmaceuticals will not cover Jonglei and Upper Nile, and thus the World Bank will become the main, and only, funder of pharmaceuticals in Jonglei and Upper Nile.

Drugs Availability at the Facility as the Main Challenge

43. The lack of medicines in health facilities not only affects the capacity to treat patients but also reduces their care-seeking behaviors, independent of whether the pathology requires drugs-based treatment. Lower availability of drugs can, therefore, negatively affect the utilization of health services. The drugs availability has been a structural issue in South Sudan for a long time. Due to the lack of transport infrastructure, the delivery of medicines to health facilities is hampered during the rainy season. Moreover, the widespread violence has added a layer of

[17] The EMF was funded by the USAID, the DFID, and the Norwegian Ministry of Foreign Affairs.

constraints for drugs delivery. For the past four years, the country has experienced several drugs stock-outs in different areas. Therefore, this AF will tackle the core bottleneck in service delivery, which is the challenge of availability of medicines at the facility level. Achieving the project's objective under Component 1 is intrinsically linked to Component 3.

List and Quantification of Items to Be Procured

44. The list of items to be procured is being revised by the Directorate for Pharmaceuticals at the MOH, the World Bank and the CSDO to reflect the specific needs in Jonglei and Upper Nile. Under the EMF, all states were receiving the same pre-established kits using a 'push system'. Although this mechanism had significant advantages given the security context and capacity constraints of CHDs, a significant share of the medicines was wasted. Therefore, the list and quantity of items to be procured, and the sequencing of distribution, will aim to minimize waste by tailoring them to the particular needs of Jonglei and Upper Nile. Moreover, the quantification is based on past consumption data and estimates of future consumption linked to the return of IDPs and refugees from Sudan and Ethiopia.

45. The procurement and distribution of pharmaceuticals up to the counties will be undertaken by one single agent. The CSDO will coordinate with CHDs and IPs to transport the commodities from the counties to the facilities.

Monitoring Mechanisms for Pharmaceuticals

46. Expected outputs from Component 3 will be monitored through the tools described in Component 2. The QSC and QVV already include pharmaceutical management and availability aspects. These tools will be revised by the MOH and the M&E firm to make sure that these aspects are adequately captured.

Procurement Arrangements for Component 3

47. For Component 3, approval for the direct contracting of an agent that will be responsible for the supply, storage, and distribution of pharmaceutical commodities was provided by OPRC on May 26, 2016. The agent will be contracted under a supplier contract based on the Bank's standard contract form of Health Sector Goods. This approach is in line with flexibilities afforded under exceptional arrangements for Investment Project Financing as set out in OP 10.00 paragraph 12 to ensure that procurement processes are aligned with the fragile context of South Sudan.

Annex 3. Financial Management Overview and Detailed Arrangements

Introduction

1. The World Bank's OP 10.00 requires the recipient and implementing agencies to maintain adequate and acceptable FM arrangements that, as part of the overall arrangements in place for implementing the project, provide reasonable assurance that the proceeds of the World Bank financing are used for the purposes for which they are granted. It describes FM arrangements include the planning, budgeting, accounting, internal control, funds flow, financial reporting, and auditing arrangements of the Recipient and entity or entities responsible for project implementation. An FM assessment is therefore conducted with the aim of ensuring that these requirements are met. The FM assessment was conducted in accordance with the FM Manual for Bank-financed investment operations issued (retrofitted) on February 4, 2015, effective from March 1, 2010, the FM Manual for World Bank investment project financing operations, and World Bank guidelines of FM in World Bank investment project financing operations as issued and effective on February 24, 2015. This assessment was conducted by the MOH of South Sudan.

2. The review reveals that the FM capacity of the MOH is weak and likely to affect the project. Moreover, the current conflict in Upper Nile and Jonglei States, where the project will be implemented, the resulting access difficulties for fiduciary staff to most of the implementation areas, and the unstable local currency of the country make the FM risk rated High. As a result, mitigation measures/action plans are developed to address these concerns which are explained below.

Country Issues

3. A Public Expenditure and Financial Accountability Assessment has been carried out for the Government of South Sudan and four subnational governments—Jonglei, Unity, Western Equatoria, and Northern Bahr-el-Ghazar States. The report indicates that the budget is prepared with regard to government policies and that there is an ongoing installation of integrated FM system, an electronic payroll system, and an improved internal and external audit system. It, however, noted that downstream project FM areas, such as budget execution, accounting, and some internal control systems, are still characterized by significant weaknesses, resulting in budgets that are not credible. It indicated that aggregate and spending agencies' expenditure out-turns being significantly different from the approved budgets; constitutional and legal controls on changes in approved budget not fully adhered to; low in-year predictability of availability of funds; build-up of payment arrears; non-transparent public procurement system; and non-robust internal control system among other things. The counties included in this FM assessment are yet to go through any significant project FM reform.

Project FM System

4. FM for the project will be carried out by the PMU that will engage a professionally qualified FMS and project finance officer and also include an assigned government accountant to ensure the use of country systems. The staff will be supported with the current FM Manual that includes guidelines on project FM and training on FM. This manual will apply to the AF.

5. The Audit Chamber has the constitutional responsibility for external audit but currently has limited capacity. The project will support the Audit Chamber to engage an EAA to ensure that staff of the Audit Chamber are able to carry out the project audit and to provide an independent opinion on the reliability of the financial statements produced for the project, the systems and internal controls used by the project, and the eligibility of the expenditures incurred. The TOR for hiring the EAA will be reviewed and cleared by the World Bank ahead of the audit.

Budgeting Arrangements

6. The PMU, working closely with the CSDO and relevant implementing entities and partners, will prepare the budget, the work plan, and cash flow forecast for each component and submit for the necessary approvals from the line ministry (MOH) and the World Bank's task team leader of the project. Under the current parent project, this aspect has been handled well and the same arrangement is expected to continue in the AF. Budget monitoring arrangements, which include periodic comparisons and tracking of actual expenditures against budgets, reporting on major deviations, and taking actions to remedy the situation, will continue to be applicable for this AF. Budget monitoring of the existing project was found to be weak, and it is agreed that this will be strengthened for the AF through the enhanced FM capacity at the PMU.

Accounting Arrangements

7. The current project Operations Manual under the parent project including the project FM Manual will be updated where necessary to reflect any changes due to the AF (especially the new Component 3: Pharmaceutical Commodities) and relevant accounting procedures. The project will continue to be accounted for on a cash basis. These will be supported with appropriate records and documentation to track commitments and to safeguard assets. Accounting records will be maintained in U.S. dollars. The PMU responsible for the project implementation will ensure the following:

(a) All important business and financial processes are adhered to;

(b) Adequate internal controls and procedures are in place;

(c) Unaudited IFRs are prepared on time;

(d) The financial information required by the PMU from the CSDO and the other service provider for component 3 is provided promptly;

(e) The financial statements are prepared on time and in accordance with generally acceptable accounting standards; and

(f) The external audit is completed in time and audit findings and recommendations are implemented expeditiously.

8. The lessons learned include most of the audit recommendations not being implemented in time. It is expected that for the AF, the MOH will move quickly to implement some of the critical and internal control issues identified during implementation.

9. The chart of accounts will facilitate the preparation of relevant reports and financial statements, including information on total project expenditures; total expenditure on each project component/activity, and analysis of the total expenditure into various categories of goods, training, consultants, and other procurement and disbursement categories. Efforts will be made to ensure that project FM records will be maintained using the government computerized system and necessary training carried out for the accounting staff. All transactions will be properly accounted for and recorded. Under the current parent project, the project closely followed the government chart of accounts, but they did not use the government computerized system. It is expected that in the AF, the PMU should work together with the MoFEP to actualize the use of the government computerized system**.**

Internal Control and Internal Auditing

10. The project Operations Manual that includes the project FM Manual exists but it will be reviewed and updated to incorporate relevant internal control procedures and acceptable control procedures for approval and payment processes. These procedures require that the implementing ministry certifies the completion and acceptance of goods or services before requesting for payment. For instance, under component 3, the PMU will ensure there is adequate proof of delivery of pharmaceutical commodities supplied to the health facilities before processing payments to the contracted service provider in line with the contract. The Bank will review the TOR and contracts of the service provider to ensure that such aspects are included. The project accountant will also ensure that the contracts are consistent with the invoices and payment request before processing them. The PMU will monitor and report on the use of project funds, including the fiduciary standards complied with and the reliability of the FM system. The Fixed Assets Register relating to the project will be prepared by the project and shall be updated. Physical verification/count of assets is carried out periodically. A Contracts Register will also be maintained in respect of all contracts with consultants, contractors, and suppliers. The PMU will prepare contract status reports quarterly as part of the IFRs. Control procedures over fixed assets and contracts management will be the responsibility of the PMU.

11. Furthermore, the Project has added a new component for the procurement and distribution of pharmaceutical commodities, which will be undertaken by one single agent; only one firm has been identified as having the capacity to carry out this activity worth US$15 million. In addition, the agent will have to supply and distribute pharmaceuticals by August 2016 which means the entire process will need to be completed in a short period (less than 3 months). There are a number of fiduciary risks in this process including the risk of procuring/distributing substandard/expired medicines; over billing and short or under delivery. The mitigations measures for this are that (a) the TOR/contract of the CSDO will be revised to include responsibility of verifying that the bills of the agent in terms of delivery before payment by PMU; (b) the Internal Audit to be assigned by MoFEP will give particular attention to this component and will review on sample basis including spot checking to ensure that there is performance as per contract including delivery and (c) the PMU will recruit independent agent for ensuring medicines are not sub-standard and expired and are indeed fit for consumption.

12. The lesson from the existing project is that there were challenges in the internal controls where adequate controls were lacking under the current PMU. The accountants who were seconded by the MOH to the PMU did not take up the assignment because they expected salary

top-ups that are not eligible under Bank policy of top-ups to government officials. This left the project with one person—the FMS who carried out transactions from initiation to completion. In addition to staffing, as noted earlier there were also challenges in rectifying audit findings on time. In the AF, FM proposes for secondment of an accountant from the MOH and a hiring of an international FMS as well as national finance officer at local terms. Coupled with the use of internal audit from the MoFEP, this will provide some acceptable internal controls over financial transactions.

13. The MoFEP's internal audit at the national level will review the activities of the project and report on a semiannual basis to the MOH and the World Bank.

Financial Reporting Arrangements

14. Quarterly unaudited IFRs will continue to be prepared by the PMU/FMS for the purpose of monitoring the implementation of the project and submitted to the MOH and the World Bank within 45 days of the end of each fiscal quarter. This report must cover all IDA funds received for the project as a whole as well as counterpart funds received under the project, if any. It includes a statement showing period and cumulative inflows by sources and outflows by main expenditure classifications; beginning and ending cash balances of the project; and supporting schedules comparing actual and planned expenditures. Expenditures will be classified by component and by category and most importantly these actual expenditures will be compared with respective budgets. A semiannual cash forecast statement should also be included. Under the parent project, there were also no major issues in reporting. It was agreed that the current IFR format or template will be used for the AF, however some amendments will be made to the format in view of the additional peculiarities/features of the AF. This amendments will be done and agreement will be reached on the format/content, between the Project and the World Bank, one month after of project effectiveness.

15. The PMU/FMS is responsible for providing overall consolidated financial reports as defined in the relevant covenants. The accounting system to be put in place will ensure that financial reports will be designed to provide relevant and timely information to the project management, implementing agencies, and various stakeholders monitoring the project's performance. It is expected that all levels of implementation will maintain adequate filling and archival system of all accounting and relevant supporting documents for review by the World Bank's FM team during supervision mission and also for audit purposes. Under the parent project, there was adequate record keeping and this is expected to be sustained in the AF.

16. The PMU/FMS will also prepare annual project financial statements (PFS) for the project. The content of the statements will be documented in the project audit. The PFS will be prepared in accordance with acceptable accounting standards. The PFS shall include adequate notes and disclosures.

Auditing

17. The Audit Chamber has the constitutional responsibility for carrying out all audits in South Sudan. The World Bank, through the Multi-donor Trust Fund, has supported the Audit Chamber in developing its capacity. However, this is not fully developed. To continue to support

the strengthening of country systems, the project audit will be carried out by the Audit Chamber with support from an audit agent. The TOR for the EAA will be shared with and cleared by the World Bank prior to the commencement of the audit. The project will be required to support the financing of this external audit. The audited project annual project financial statements (PFS) together with any additional information required will be submitted to the World Bank within six months after the end of the financial year. The audit will be in conformity with the World Bank's audit requirements and in accordance with internationally recognized auditing standards. The auditor will express an opinion on the financial statements in compliance with International Standards on Auditing. The external auditors will also prepare a Management Letter giving observations and comments and providing recommendations for improvements in accounting records, systems, controls, and compliance with financial covenants in the Grant Agreement. It was agreed that the current project audit TOR will be used for the AF, with some amendments in view of the additional peculiarities/features of the AF. These amendments will be done and agreement will be reached on the TOR, between the Project and the World Bank, one month after of project effectiveness.

18. The NAC has done well in auditing World Bank-supported projects. There have not been any delays in submission of audit reports to the World Bank. The audit reports on the parent project for the fiscal year ended June 30, 2015, was submitted within the six months period. The audit report was unmodified, but there were internal control and compliance issues noted in the Management Letter. As noted earlier, there were difficulties in addressing these findings on time. There was a marked improvement in the quality and content of the audit. It is expected that this will continue under the AF with the expected support from AF to the NAC to engage an EAA.

19. The CSDO will be audited separately for the funds transferred to them under this AF by an external audit firm to be agreed between the CSDO, the MOH, and the World Bank. The TOR for the audit of the CSDO will be submitted to the World Bank for No objection to be reviewed and cleared by the World Bank in the usual manner.

Fraud and Corruption

20. Possibility of circumventing the internal control system with colluding practices, such as bribes, abuse of administrative positions, misprocurement, and so on, is a critical issue and may include (a) late submission of supporting documents; (b) poor filing and records; (c) lack of system integration; (d) lack of budget discipline; (e) unauthorized commitment to suppliers, bypassing budget and expenses-vetting procedures; and (f) unsecured safekeeping and transportation of funds. These are mitigated as follows: (a) specific aspects on corruption auditing will be included in the external audit TOR; (b) the internal auditor at the national level will report directly to the MoFEP as well as present semiannual reports to the MOH and the World Bank; (c) the FM Manual (as part of Operations Manual) should be approved soon after project effectiveness; (d) the FM Manual will be finalized before any disbursement to the projects; (e) strong FM arrangements (including qualified FMS, periodic IFR including budget execution and monitoring); and (f) measures to improve social accountability and transparency are built into the project design.

21. Under the parent project, there were no reported cases of fraud and corruption, and it is expected that the AF will not have any such cases.

Funds Flow and Disbursement Arrangements

22. Project FMS at the PMU shall submit withdrawal applications to the World Bank based on advances, reimbursements, direct payments, and special commitments.

23. The Project will use report-based disbursements through quarterly IFRs.

24. The AF will use the existing designated account (DA) and the existing local currency South Sudanese pound bank accounts for disbursements.

- Advances into the DA will be based on 6 months payments upon submission of monthly invoices, which is approved by the head of the PMU—program coordination.

- Payments to the CSDO shall be either by direct payments or through the IDA and upon submission of an approved request by the program coordinator. It is important to note that the Bank will recognize the eligible expenditures as documented when funds are received by the CSDO. For Bank reporting purposes, the PMU will recognize the PBC with the CSDO as expenditures when funds are received by the CSDO and confirmation of the same is obtained. The IFRs will therefore include such transfers as expenditures.

- A separate category will be set up for Component 3.

25. Detailed disbursement arrangements will be documented in the Disbursement Letter.

Summary of Key Risks and Mitigating Measures

26. **Risks:** The macroeconomic and fiscal situation remains extremely fragile. The move by the Bank of South Sudan to move from a fixed exchange rate to a managed floating exchange rate regime has brought the parallel market exchange rate closer to the official one. However, the new regime has seen a continued depreciation of the South Sudanese pound against the U.S. dollar. This will present the project with challenges in budgeting and disbursements in local currency. This has also introduced marked inflationary trends in South Sudan. Also only one commercial bank holds the DAs for Bank-supported projects in South Sudan (CfC Stanbic Bank), presenting a monopolistic situation when projects are negotiating for exchange rates to transfer funds to the South Sudanese pound account, in addition to the high bank charges. In addition to these systemic issues, the FM system is weak. Capacity is low to prepare budgets that lay down physical and financial targets in sufficient detail to monitor subsequent performance and to properly account and report on funds utilization. Furthermore, difficulties for the internal audit function and FM teams to access Upper Nile and Jonglei States (where most of the fighting between the Government and the opposition forces takes place) for FM supervision and monitoring. The involvement of CSDOs as in the main parent project could cause risk in the use of resources for the purposes intended, unless well managed and followed up with frequent FM monitoring. The new component 3 also poses additional risk as to whether the pharmaceutical commodities are reaching the intended beneficiaries. The procurement and distribution of pharmaceuticals in the counties will be undertaken by one single agent. In addition, the agent

will have to supply and distribute pharmaceuticals in a short period of time. Hence a risk of procuring and distributing substandard or expired medicines, over billing, and short or under delivery could exist.

27. **Mitigation measures:** The mitigation measures envisaged to address these risks are as follows. The MoFEP with support from the Bank of South Sudan to identify another reputable commercial bank where DAs will be maintained—this will provide some competition to the existing arrangement. The project will also budget and plan to make disbursements in U.S. dollars as much as possible. The situation will be reviewed during the project implementation. The World Bank will provide continuous assistance to ensure that project staff are able to prepare adequate budgets, monitor progress, and adjust when necessary. Quarterly interim financial reports will be submitted, which will include analysis and explanations that show budget utilizations, variance analysis, and so on – all components of good budget monitoring. IFR formats will be reviewed/revised as appropriate to ensure that these ends are met. A strong PMU will be set up during the implementation of the PPA, which will lay a strong foundation for the implementation of the AF. A qualified FMS will be engaged in addition to two national staff: a project finance officer and an accountant to be seconded by the MOH. The Audit Chamber will audit the project activities with support from an EAA. The TORs of the audit of the project as well as the TORs of the EAA engagement will be reviewed to ensure that the project peculiarities will be well captured by the audit. The works performed by the service providers like the CSDO and the additional one to be recruited under the new component 3 will also be subjected to audit. The Directorate of Internal Audit of MoFEP will post internal auditors to the MOH who will be reviewing the internal controls of the project starting from the MOH up to and including the operations of the project at the field level. Project internal audit report will be prepared on a semiannual basis and submitted to the MOH and the World Bank. The PMU will ensure there is adequate proof of delivery of pharmaceutical commodities supplied to the health facilities before processing payments to the contracted service provider in line with the contract. For the CSDOs, it is envisaged that the project will closely follow up on them. The CSDO will be audited separately for the funds transferred to them under this AF by an external audit firm to be agreed between the CSDO, the MOH, and the World Bank. The TOR for the external audit of the CSDO shall be agreed between the Government and the CSDO with the Bank providing a 'no objection'. In addition, the regular FM reports from the CSDO shall be submitted to the PMU for review. The quarterly IFRs will also include a schedule or statement showing the movement of the funds transferred to the CSDO. A further mitigation measure placed here is the use of internal auditors for intensive follow-up with the CSDO and the other service provider (under component 3) to ensure funds are used for the intended purposes. In regards to component 3, the mitigation measures envisaged include: (a) the TORs/contract of the CSDO will be revised to include responsibility of verifying the bills of the agent in terms of delivery before payment by the PMU; (b) the internal audit to be assigned by MoFEP will give particular attention to this component and will review on a sample basis including spot checking to ensure that there is performance as per contract including delivery; and (c) the PMU will recruit independent agent for ensuring medicines are not sub-standard or expired and are indeed fit for consumption. The Bank will conduct semiannual supervisions/implementation support missions to follow up on these issues including providing close support.

28. FM risk is rated **High.** Action plans targeted toward the project are also planned to address these risks.

Action Plan

29. The action plan given in Table 3.1 indicates the actions to be taken for the project to address the weaknesses that have been identified and to ensure that the FM system is robust and strengthened. Some of these activities and actions could be completed during the PPA period and before the AF effectiveness, and these will be monitored on an ongoing basis during implementation.

Table 3.1. FM Action Plan

	Action	Responsibility	Due Date
1	Appoint a qualified and experienced project FMS at the PMU	MOH/PMU	1 month after effectiveness
2	Appoint a qualified national project finance officer at the PMU	MOH/PMU	1 month after effectiveness
3	Designate a Government accountant and internal auditor to support the project at the PMU	MOH/PMU	1 month after effectiveness
4	Update the current FM Manual and project Operations Manual to reflect the new components if necessary	MOH/PMU	1 month after effectiveness
5	Procure desktops and install an accounting software, including training of staff	MOH/PMU	1 month after effectiveness
6	Reconcile the current DA and South Sudanese pound accounts of the parent project and advise the Bank of signatories and other banking information. The same bank accounts will be used for the AF	MOH/PMU/FMS	Prior to Disbursement
7	Support the Audit Chamber to engage EAA to carry out project audit	MOH/PMU	2 months after effectiveness
8	Strengthen the internal audit oversight by MoFEP internal auditors by conducting audits regularly and reporting on a semi-annual basis as described above	MOFEP and MOH/PMU	Assignment by 1 months after effectiveness and first report by 6 months after effectiveness
9	Agree on the revised IFR format and audit TOR	MOH/PMU	1 month after effectiveness
10	Agree on the TOR for the audit of the CSDO	MOH/PMU	1 month after effectiveness
11	Regarding the new component 3 risk as to whether the pharmaceutical commodities are reaching the intended beneficiaries, the following are agreed: a. The PMU will ensure there is adequate proof of delivery of pharmaceutical commodities supplied to the health facilities before processing payments to the contracted service provider in line with the contract. b. The TOR/contract of the CSDO will be revised to include responsibility of verifying the bills of the agent in terms of delivery before payment by PMU. c. The internal audit to be assigned by MoFEP will give particular attention to this component and will review on a sample basis including spot checking to ensure that there is performance as per contract including delivery. d. The PMU will recruit an independent agent for	MOFEP, WB and MOH/PMU	a. Ongoing b. 1 month after effectiveness c. 1 month after effectiveness d. As per dates stated in Procurement plans e. Ongoing f. Ongoing

	ensuring medicines are not sub-standard or expired and are indeed fit for consumption. The World Bank will conduct semiannual supervisions/implementation support missions to follow up on these issues including providing close support. e. The Bank including the FM team will review relevant TORs and contracts to ensure that such aspects are included. f. Bank FM supervision will focus on this activity.		

Conclusion and Supervision Plan

30. The FM risk is High. During implementation, and on the basis of the risk rating, there will be two on-site visits to ascertain continued adequacy of arrangements, supplemented by desk reviews of IFRs, monitoring reports by M&E, and interim and annual audit reports. The FM supervision mission's objectives will include ensuring that strong FM systems are maintained for the project. Missions will also include visits to selected project implementation sites to ascertain the impact of their activities on the target groups they serve. In adopting a risk-based approach to FM supervision, the key risk areas of focus will include assessing the accuracy and reasonableness of budgets, their predictability and budget execution, compliance with payment and fund disbursement arrangements particularly with regard to the CSDO, and the ability of the secretariat to generate reliable financial reports.