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February 14, 2019

For meeting of
Board: Wednesday, February 27, 2019

FROM: Vice President and Corporate Secretary

United Nations Children's Fund (UNICEF)
and
International Committee of the Red Cross (ICRC)

South Sudan Provision of Essential Health Services Project

Project Appraisal Document

Attached is the Project Appraisal Document regarding a proposed IDA grant to UNICEF and a proposed IDA grant to ICRC for a South Sudan Provision of Essential Health Services Project (IDA/R2019-0024), which will be discussed at a meeting of the Executive Directors.

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

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Report No: PCBASIC0170484

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A
PROPOSED GRANT

IN THE AMOUNT OF SDR 52.8 MILLION
(US$73.4 MILLION EQUIVALENT)

TO

UNITED NATIONS CHILDREN'S FUND

AND
A PROPOSED GRANT

IN THE AMOUNT OF SDR 23.1 MILLION
(US$32 MILLION EQUIVALENT)

TO THE

INTERNATIONAL COMMITTEE OF THE RED CROSS

FOR THE

SOUTH SUDAN PROVISION OF ESSENTIAL HEALTH SERVICES PROJECT

February 12, 2019

Health, Nutrition & Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective December 31, 2018)

Currency Unit =	US Dollars
SDR 0.71901581 =	US$1
US$1.38 =	SDR 1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Hafez M. H. Ghanem
Country Director:	Carolyn Turk
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Trina S. Haque
Task Team Leaders:	Paul Jacob Robyn, Fatimah Abubakar Mustapha

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
APA	Alternative Procurement Arrangements
BHI	Boma Health Initiative
BPHNS	Basic Package of Health and Nutrition Services
C4D	Communication for Development
CBA	Cost-benefit Analysis
CEA	Cost-effectiveness Analysis
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CEN	Country Engagement Note
CERC	Contingent Emergency Response Component
CHD	County Health Department
CMR	Clinical Management of Rape
CMU	Country Management Unit
CPA	Comprehensive Peace Agreement
CRSV	Conflict-related Sexual Violence
CSDO	Coordination and Service Delivery Organization
CSO	Civil Society Organizations
DFID	Department for International Development
DHIS	District Health Information System
DRC	Democratic Republic of the Congo
EPI	Expanded Program on Immunization
ESMF	Environmental and Social Management Frameworks
EVD	Ebola Virus Disease
FCV	Fragility, Conflict and Violence
FM	Financial Management
FMFA	Financial Management Framework Agreement
FY	Fiscal Year
GDP	Gross Domestic Product
GEMS	Geo-enabling for Monitoring and Supervision (GEMS
GPS	Global Positioning System
GRM	Grievance Redress Mechanism
HACT	Harmonized Approach to Cash Transfers
HCI	Human Capital Index
HCP	Human Capital Project
HMIS	Health Management Information Systems
HNP	Health, Nutrition and Population
HPF	Health Pooled Fund
HRRP	Health Rapid Results Project
ICER	Incremental Cost-effectiveness Ratio
ICR	Implementation Completion Report
ICRC	International Committee of the Red Cross

IDA	International Development Association
IDP	Internally Displaced People
IFR	Interim Unaudited Financial Report
IHL	International Humanitarian Law
IMF	International Monetary Fund
IP	Implementation Partner
IPC	Infection, Prevention and Control
IPF	Investment Project Financing
LTA	Long-term Agreement
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MDTF	Multi-donor Trust Fund
MHPSS	Mental Health and Psycho-Social Support
MoH	Ministry of Health
MoF	Ministry of Finance
MoU	Memorandum of Understanding
MWMP	Medical Waste Management Plan
NGO	Non-governmental Organization
OP	Operational Policy
OPCS	Operations Policy and Country Services
PAD	Project Appraisal Document
PBA	Performance-based Allocation
PDO	Project Development Objective
PFM	Public Financial Management
PFMA	Public Financial Management Act
PfRR	Partnership for Recovery and Resilience
PHC	Primary Health Care
PIU	Project Implementation Unit
PPSD	Project Procurement Strategy for Development
SAI	Supreme Audit Institution
SCD	Systematic Country Diagnostic
SDR	Special Drawing Rights
SGBV	Sexual and Gender-based Violence
SPLA-IO	Sudan People’s Liberation Army in Opposition
SPLM	Sudan People’s Liberation Movement
ToR	Terms of Reference
TPM	Third-party Monitoring
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
US$	United States Dollar

USAID	United States Agency for International Development
VSL	Value for Statistical Life
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

TABLE OF CONTENTS

DATASHEET

BASIC INFORMATION

Country(ies)	Project Name
South Sudan	South Sudan Provision of Essential Health Services Project

Project ID	Financing Instrument	Environmental Assessment Category
P168926	Investment Project Financing	B-Partial Assessment

Financing & Implementation Modalities

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

Expected Approval Date	Expected Closing Date
27-Feb-2019	31-Dec-2021

Bank/IFC Collaboration

No

Proposed Development Objective(s)

The Project Development Objective is to increase access to an essential package of health services in the Republic of South Sudan, with a particular focus on the former states of Upper Nile and Jonglei.

Components

Component Name	Cost (US$, millions)

Delivery of Essential Health Services	93.00
Monitoring, Evaluation and Learning	4.00
Emergency Preparedness and Response	3.00
Repayment of Project Preparation Advances	5.40

Organizations

Borrower:	International Committee of the Red Cross UNICEF
Implementing Agency:	International Committee of the Red Cross UNICEF

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	105.40
Total Financing	105.40
of which IBRD/IDA	105.40
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	105.40
IDA Grant	105.40

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
National PBA	0.00	105.40	0.00	105.40
Total	**0.00**	**105.40**	**0.00**	**105.40**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2019	2020	2021	2022
Annual	4.50	29.66	70.00	1.24
Cumulative	4.50	34.16	104.16	105.40

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?	
a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF	Yes
b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment	Yes
c. Include Indicators in results framework to monitor outcomes from actions identified in (b)	Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
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	
10. Overall	● High

COMPLIANCE

Policy

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

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[✓] Yes [ ] No

Have these been approved by Bank management?

[✓] Yes [ ] No

Is approval for any policy waiver sought from the Board?

[✓] Yes [ ] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Performance Standards for Private Sector Activities OP/BP 4.03		✓
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09		✓
Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10	✓	
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓
Projects in Disputed Areas OP/BP 7.60		✓

Legal Covenants

Sections and Description
For ICRC: Schedule 2. Section I.B.3.: The Recipient shall carry out Part 1.2 of the Project in health facilities already selected in agreement with the Association, and the Recipient shall obtain the Association's prior written consent before implementing Part 1.2 of the Project in additional health facilities.

Sections and Description
For ICRC: Schedule 2. Section I.D.3.: The Recipient shall ensure that their Respective Part of the Project is carried out with in accordance with the Environmental and Social Management Framework and the Social Assessment, which shall be updated by the Recipient in the event the Recipient proposes to the Association any change in selected facilities.

Sections and Description
For ICRC: Schedule 2. Section I.D.5.: The Recipient shall inform the Association of a Significant Event as soon as reasonably practicable, but no later than seven (7) calendar days, after the occurrence of the event.

Sections and Description
For UNICEF: Schedule 2. Section I.A.4.: The Recipient shall carry out its Part 1.1 of the Project in the former states of Upper Nile and Jonglei, and in the event that any activity is proposed to be implemented in areas beyond the said former states, the Recipient shall obtain the Association's prior written consent before commencement of implementation in said areas.

Sections and Description
For ICRC: Schedule 2. Section I.D.3.: The Recipient shall ensure that their Respective Part of the Project is carried out with in accordance with the Environmental and Social Management Framework and the Social Assessment, which shall be updated by the Recipient in the event the Recipient proposes to the Association any change in selected facilities.

Sections and Description
For UNICEF: Schedule 2. Section I.D.5.: The Recipient shall inform the Association of a Significant Event as soon as reasonably practicable, but no later than five (5) calendar days, after the occurrence of the event.

Sections and Description
For UNICEF: Schedule 2. Section I.E.1.: With respect to Part 2.1 of the Project, the Recipient shall carry out the performance monitoring in accordance with terms of reference agreed with the Association and procure a monitoring agent in accordance with the provisions of Section III of this Schedule.

Sections and Description
For UNICEF: The Recipient agrees that the Association shall, in accordance with Section 2.07 of the General Conditions, withdraw and pay to itself from the proceeds of the Financing the amount required to repay the outstanding balance of the Preparation Advances. The amount so withdrawn by the Association to repay the Preparation Advances shall not be considered as having been received or expended by the Recipient. (UNICEF FA,

Schedule 2, Section V, A, 1)

Conditions

Type	Description
Effectiveness	In accordance with the provision of the General Conditions, the Financing Agreement with ICRC will become effective upon submission to IDA of the legal opinion of the General Counsel of ICRC relating to the Financing Agreement.
Type	Description
Disbursement	Under Category (2) no withdrawal shall be made, for Emergency Expenditures under Part 3.2 of the Project unless and until the Association is satisfied that all the following conditions have been met in respect of the said activities: (i) the Recipient has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include said activities in the CERC Part in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof (ICRC FA, Schedule 2, Section III, B, 1, (b)(i)) (ii) the Recipient has prepared and disclosed all safeguards instruments required for said activities, and the Recipient has implemented any actions which are required to be taken under said instruments, all in accordance with the provisions of Section I.B.4 of Schedule 2 to this Agreement (ICRC FA, Schedule 2, Section III, B, 1, (b)(ii)) (iii) the Recipient's Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section I.B.4 of this Schedule 2 to this Agreement, for the purposes of said activities; (ICRC FA, Schedule 2, Section III, B, 1, (b)(iii)) and (iv) the Recipient has adopted a CERC Operations Manual in form, substance and manner acceptable to the Association and the provisions of the CERC Operations Manual remain - or have been updated in accordance with the provisions of Section I.B.4 of this Schedule 2 so as to be appropriate for the inclusion and implementation of said activities under the CERC Part (ICRC FA, Schedule 2, Section III, B, 1, (b)(iv))

Type	Description
Disbursement	Under Category (2) for Emergency Expenditures under Part 3.2 of the Project unless and until the Association is satisfied that all the following conditions have been met in respect of the said activities: (i) the Recipient has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include said activities in the CERC Part in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (UNICEF FA, Schedule 2, Section IV, B, 1, (c)(i)) (ii) the Recipient has prepared and disclosed all safeguards instruments required for said activities, and the Recipient has implemented any actions which are required to be taken under said instruments, all in accordance with the provisions of Section I.B.4 of Schedule 2 to this Agreement; (UNICEF FA, Schedule 2, Section IV, B, 1, (c)(ii)) (iii) the Recipient's Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section I.B.4 of this Schedule 2 to this Agreement, for the purposes of said activities; and (UNICEF FA, Schedule 2, Section IV, B, 1, (c)(iii)) (iv) the Recipient has adopted a CERC Operations Manual in form, substance and manner as agreed with the Association and the provisions of the CERC Operations Manual remain or have been updated in accordance with the provisions of Section I.B.4 of this Schedule 2 so as to be appropriate for the inclusion and implementation of said activities under the CERC Part (UNICEF FA, Schedule 2, Section IV, B, 1, (c)(iv))
Type	Description
Disbursement	Notwithstanding the provisions of Part A above, no withdrawal shall be made: (b) for the purpose of any payment to persons or entities, or for any import of goods, if such payment or import is prohibited by a decision of the United Nations Security Council taken under Chapter VII of the Charter of the United Nations; or (UNICEF FA, Schedule 2, Section IV, B, 1, (b))
Type	Description
Disbursement	All withdrawals shall be made on the basis of the interim unaudited financial reports referred to in II.B.2 of this Schedule and under such other terms and conditions as agreed between the Association and the Recipient and as specified in the Disbursement and Financial Information Letter. (UNICEF FA, Schedule 2, Section IV, B, 2)

Type	Description
Disbursement	Without prejudice to the provisions of Section 6.07 (newly re-numbered as Section 6.05) of the General Conditions, in the event that the Association requests a refund of any portion of the proceeds of the Financing that has been used in a manner inconsistent with the provisions of this Agreement, the Association and the Recipient will adopt the procedures set forth in paragraph 9 of the FMFA. (UNICEF FA, Schedule 2, Section IV, B, 3)
Type	Description
Disbursement	It is understood that the Recipient shall not be responsible for, and shall have no obligation to initiate or continue implementation of, the pertinent activities under Parts 1.1, 2 and 3 of the Project unless the proceeds of the Financing allocated to such activities have been made available to the Recipient. Notwithstanding any suspension of the Financing or any portion of the Financing under this Agreement, the Association will make available to the Recipient the portion of the proceeds of the Financing required to meet the obligations entered into by the Recipient prior to the date on which the Recipient shall have received the notice of suspension. (UNICEF FA, Schedule 2, Section IV, B, 4)

I. STRATEGIC CONTEXT

A. Country Context

1. **Long before independence, South Sudan (known as the Southern Sudan region) experienced significant levels of fragility, conflict and violence (FCV).** There was not only conflict with the North, which lasted close to half a century, but also significant inter- and intra-communal tensions. The secession from the North came after decades of fighting, followed by a brief period of the Comprehensive Peace Agreement (CPA, 2005-2011) with the final decision to declare independence being made in January 2011 through a referendum. South Sudan descended into this latest manifestation of violence two years after it gained independence. Basically, the country has been through two generations without much investment in development.

2. **At independence in 2011, South Sudan was one of the most fragile countries in the world.** In late 2013, the political settlement brokered within the ruling Sudan People's Liberation Movement (SPLM) fell apart. An armed conflict ensued, primarily between the Sudan People's Liberation Army (SPLA) government forces and Sudan People's Liberation Army in Opposition (SPLA-IO). While there was a period of optimism brought about by the signing of the Agreement on the Resolution of the Conflict in the Republic of South Sudan in August 2015, open conflict escalated in Juba in July 2016 and rapidly spread throughout the country. The renewed conflicts from December 2013 through July 2016 have undermined the development investments and gains achieved since the CPA and independence, worsening the humanitarian situation.

3. **In 2018, peace talks facilitated by regional and international partners have led to a draft peace and power-sharing agreement that was signed in August 2018, which was followed by a peace celebration in Juba in October 2018.** The Revitalized Peace Agreement, signed in September 2018, provides an opportunity for potential progress, yet the effects of the protracted conflict are still affecting the majority of the country's population. The agreement proposes a reorganization of the government with three vice-presidents and the establishment of new states across the country. Currently the progress made through the talks has produced some level of optimism in the country, and weapon-wounded casualties have seen a decline since the cease-fire was achieved in June 2018. Yet the international community remains highly concerned by past failed attempts at ending violence and fighting, and despite the recent progress made in the peace agreement, funding for development assistance continues to decline in favor of programs more linked to emergency and humanitarian assistance.

4. **Despite an abundance of natural resources and potential oil wealth, South Sudan's economy is in crisis, with output contracting, and inflation and parallel exchange market premiums soaring.** Real gross domestic product (GDP) has contracted by 11 percent in fiscal year (FY)16 and 6.9 percent in FY17 due to the ongoing conflict, oil production disruptions and below-average agriculture production, and is projected to further contract by 3.5 percent in FY18. Monetization of the fiscal deficit has led to high inflation, such that annual inflation reached alarming triple digit levels to about 650 percent in September 2017, and the year-on-year annual Consumer Price Index (CPI) increased by 88.5 percent between June 2017 and June 2018. The South Sudanese Pound has depreciated by 790 percent (July 2018) since the move from a fixed exchange rate arrangement to a managed float in January 2016. Declining oil production and revenues have put additional pressure on the economy already weakened by the civil war. Oil production is estimated to have decreased to about 46.3 million barrels in 2017, down from 60.2 million barrels in 2014, which was already less than half of the peak production before independence in 2011. According to International Monetary Fund (IMF) and

World Bank projections, oil production is expected to remain between 46.5 and 47.8 million barrels per year for the 2018-2021 period.

5. **The majority of South Sudanese have lived in poverty for generations.** In 2016, it was estimated that 66 percent of the population lived below the poverty line (US$1.90 per day). This is a considerable increase in poverty from an already high level of 52 percent in 2009. Poverty incidence varies across the country, with the highest rate of 81 percent in Eastern Equatoria and the lowest rate of 40 percent in Central Equatoria. Poverty in urban areas of South Sudan increased from 49 percent in 2015 to 70 percent in 2016. Inequality amongst the poor also worsened, and the poverty severity index doubled from 0.10 in 2015 to 0.20 in 2016. Poverty manifests itself in all dimensions: lack of access to clean water, access to health and education and a non-existent safety net to cushion the most vulnerable.

6. **Estimates of the effects of the conflict range significantly across studies but remain systematically high.** According to the Uppsala Conflict Database Program, violence and conflict have claimed 4,289 lives between independence (2011) and 2016,[1] while a recent study by the London School of Hygiene and Tropical Medicine estimates that nearly 400,000 lives have been lost since 2013 due to the conflict.[2] In addition, the deepening economic crisis has exacerbated humanitarian needs nationwide. The open conflict, coupled with economic mismanagement and failed state-building efforts, has caused an erosion of the already limited physical and social infrastructure. Of the country's 12.5 million people, there are an estimated 7.5 million people in need of humanitarian assistance, 6 million of whom are severely food insecure. As much as 85 percent of the working population is engaged in non-wage work, chiefly in subsistence agriculture and livestock rearing (about 78 percent of the working population), which is severely undermined by conflict and drought. Fifty-one percent of the population is under 18 years of age and more than 50 percent of the population between the ages of 15 and 24 is unemployed. Given there are limited opportunities for young people outside war, a significant proportion of young men are recruited into the various armed factions. Ongoing fighting and surges of violence in new areas have forced more than 4 million people to flee their homes. As of September 2017, refugees and asylum seekers reached up to 2 million, with nearly 85 percent estimated to be children and women. Of these people, one million have fled to Uganda alone. The number of Internally Displaced People (IDP) is estimated at 1.85 million (United Nations Office for the Coordination of Humanitarian Affairs, UNOCHA, July 2018), with many originating from the former states of Jonglei and Upper Nile.

7. **The majority of the population of South Sudan faces acute barriers to accessing basic services.** Whether it be ever-evolving allegiances and battle lines in a complicated conflict, geographic accessibility including long distances, seasonal shifts in delivery challenges, or an overall lack of basic infrastructure, the situation in South Sudan is dire, prompting a large humanitarian effort that provides a lifeline for most basic needs. Most of the health and education services are provided through or by non-governmental organizations (NGOs), many of which have been operating in the Southern Sudan region for decades before independence.

[1] Uppsala Conflict Database Program, www.ucdp.uu.se, accessed May 14, 2018. It should be noted that the number of conflict-related deaths for Afghanistan, a country implementing a similar health sector program, has witnessed 70,718 deaths during the same period.
[2] Checchi, F, et al. September 2018. "Estimates of crisis-attributable mortality in South Sudan, December 2013-April 2018. London School of Hygiene and Tropical Medicine.

8. **Working conditions and safety of aid workers is a long-standing concern, with South Sudan being called the most dangerous place in the world for aid workers for several years in a row.**[3] The statistics on aid workers in South Sudan are extremely bleak: in the past few years, dozens of aid workers have been kidnapped, and a substantial number of health facilities and schools have been destroyed. There is a concern that the situation is worsening as aid workers become targets for looting and extortion of food and fuel.[4] Working conditions for aid workers remain a significant challenge, resulting in greater inaccessibility, less information on realities on the ground, and less aid reaching the most in need.

9. **Women are highly disadvantaged, with lower levels of education relative to men and greater barriers to benefitting from economic activities.** Women and girls face a disproportionate burden of violence. The roles and responsibilities of South Sudanese women have evolved throughout periods of conflict and peace, though insecurity has left many households to be headed by women, undermining their safety and overall well-being. The normalization of sexual violence as a weapon against women is made worse by the stigma associated that prevents survivors from seeking health and legal services. Similarly, entrenched patriarchal norms perpetuate acceptance of intimate partner violence, as well as other harmful practices such as Female Genital Mutilation.

10. **There is a very high incidence of sexual and gender-based violence (SGBV) in South Sudan and widespread impunity for SGBV offenses.** Conflict-related sexual violence (CRSV) remains a common tool used in South Sudan, impacting not only women targeted by the violence, but also households and entire communities where these women reside. The United Nations Independent Commission on Human Rights in South Sudan has referred to "epic proportions" of sexual violence in the conflict.[5] While difficult to get national level estimates due to chronic underreporting, there is a consensus among actors working in the country that SGBV rates are very high. A large number of women report cases of rape, sexual assault, domestic violence, forced and early marriage, sexual exploitation and abuse. SGBV affects mostly women and girls (representing 98 percent of known victims), but also men and boys.[6] As a weapon, SGBV destroys family and community cohesion and undermines processes of reintegration and rehabilitation, impoverishing women and their families. The high prevalence of SGBV in the country heightens the risk of HIV among SGBV survivors. Access to health and counselling services for victims of rape and other forms of gender-based violence are extremely limited.

11. **While peace talks through various avenues continue, there are concerns about the increasingly challenging conditions for delivery of assistance to those most in need, as large areas remain inaccessible apart from a few actors.** The cost of delivering assistance, providing security for staff and safeguarding the beneficiaries (and non-beneficiaries) of assistance remains high, particularly in areas affected by conflict or in control of armed forces. There is, however, an understanding that despite the significantly higher costs of providing basic

[3] Voice of America, "South Sudan - The Most Dangerous Country for Aid Workers", September 11, 2017.
[4] Between 2011 and 2015 there were 10 states nationwide. In 2015 they were divided into 28 states, followed by an additional division in 2017, resulting in currently 32 states in the country. The former states of Upper Nile and Jonglei now constitute seven states: Boma, Jonglei, Eastern Bieh, Western Bieh (Fangak), Latjoor, Eastern Nile, and Western Nile. These states will be referred to in this document as "former states of Upper Nile and Jonglei."
[5] UN independent Commission on Human Rights in South Sudan, December 2016.
http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20979&LangID=E, March 2017.
[6] GBV Sub-Cluster Strategy South Sudan 2017
https://reliefweb.int/sites/reliefweb.int/files/resources/gbv_sub-cluster_strategy_final_1.pdf.

assistance to the most vulnerable in these areas, it remains essential to ensure that critical assistance is provided to meet health needs for women and children who bear the brunt of the effects of the conflict.

B. Sectoral and Institutional Context

Health sector outcomes

12. **In 2018 the World Bank Group launched the Human Capital Project (HCP).**[7] It makes the case for investing in people through country engagement and analytical work, while raising awareness of the costs of inaction and bolstering demand for interventions that will build human capital. The project emphasizes the importance of sustained leadership and coordination across all levels of government—including tackling complex issues such as inadequate or inefficient spending, governance and service delivery challenges, population dynamics, fragility and conflict, and gaps in infrastructure. The first pillar of the HCP is the Human Capital Index (HCI). The index measures the human capital of the next generation, defined as the amount of human capital that a child born today can expect to achieve in view of the risks of poor health and poor education currently prevailing in the country where that child lives. Although caution should be given to the quality of data for South Sudan, for the first year of rankings (2018), South Sudan ranked second to last globally (156 out of 157 countries), with an index score of 0.30, ranking only higher than Chad. The results of the HCI highlight the importance and urgency to invest in health, education and overall human development outcomes in the country.

13. **South Sudan has some of the worst health outcomes in the world (Table 1)**. Child mortality and morbidity rates are high: under-five mortality is 91 per 1,000 live births while neonatal mortality is 39 per 1,000 births; child malnutrition is severe, with underweight prevalence at 23 percent of children (UNICEF, 2016). Maternal mortality is among the highest in the world, estimated at 789 per 100,000 births. Endemic diseases pose a heavy burden, particularly malaria, which accounts for 20–40 percent of all health facility visits. The health care system is extremely stretched: only about 40 percent of the population can access health care within a 5-kilometer radius. Life expectancy of 56 years is low.[8]

Table 1: Key Health Outcomes in South Sudan

Indicator	South Sudan (2016)	East/Southern Africa (2010-2015)
Maternal Mortality Ratio per 100,000 live births	789	417
U5 mortality Rate per 1,000 live births	91	67
Contraceptive prevalence rate	4 percent	40 percent
Percent (%) of children under 5 wasted	23 percent	6 percent
Immunization coverage of DTP3	26 percent	80 percent
Mothers receiving at least 4 antenatal care visits	17 percent	45 percent
Percentage (%) of births attended by a trained health professional	19 percent	49 percent

Source: UNICEF,2016. State of the World's Children.

[7] The World Bank, The HCP (2018). Available at: https://openknowledge.worldbank.org/handle/10986/30498.
[8] UNICEF, State of the World's Children 2016 (2016). Available at: https://www.unicef.org/sowc2016/.

14. **As highlighted above, South Sudan is one of the most dangerous places in the world to give birth, having one of the highest maternal mortality ratios globally.**[9] Approximately 86 percent of deliveries happen at home. The Caesarean section rate is very low at 1 percent of deliveries, giving an indication of limited access to Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) which is currently only available in three urban centers. Women have on average five children, a direct result of only 4 percent using modern contraceptive methods (UNICEF, 2016). Early marriage and early first pregnancy are both common risk factors in the country. In addition, there is a lack of trained traditional birth attendants, who if trained and deployed in communities could be an important actor to reduce geographic barriers during the rainy season as well as the general long distances to health facilities.

15. **The survival outcomes of children in South Sudan are also among the worst in the world. Neonatal, infant and under five mortality rates are very high.** Thirty-nine newborn babies out of every 1,000 die in the first 28 days of life with the main causes being low birth weight and premature birth, injuries sustained during birth, and infections. Close to 10 percent of children die before the age of five, mostly from preventable conditions such as diarrhea, pneumonia and measles (UNICEF, 2016). This is in part due to extremely low immunization coverage and high mortality linked to infectious diseases. Malaria is endemic across South Sudan and nearly half (44 percent) of all children who seek medical attention will have malaria and many more will be infected but have minor symptoms.[10] Lack of access to essential maternal and child care, such as prenatal care, skilled delivery and post-natal care and immunization, are significant, with some of the lowest results in terms of population coverage in the world.

16. **Acute malnutrition remains a major public health emergency in South Sudan.** As of August 2018, 6.1 million people, nearly 60 percent of the country's population, were estimated to be severely food insecure. Close to 50,000 people in Jonglei, Lakes, Unity and Upper Nile states, as well as in Western Bahr el Ghazal's Greater Bagarri area, are facing catastrophic levels (infection prevention and control, IPC 5) of acute food insecurity due to poor harvests, conflicts and lack of humanitarian access (USAID, 2018). The magnitude of this is unprecedented with malnutrition a contributing factor in nearly 1 in 2 (45 percent) of all child deaths (UNICEF, 2017).[11]

17. **Coupled with the conflict, the country is constantly battling disease outbreaks.** There has been a dramatic increase in the scale and frequency of outbreaks of epidemic prone diseases, due to poor sanitation, lack of access to safe water and crowded living conditions. Preventable and curable diseases, such as malaria and cholera, have become major causes of death in the country. This has especially affected displacement sites where malnutrition and poor immunity makes young children and pregnant women particularly vulnerable. Since 2011, South Sudan has experienced some of longest and deadliest cholera outbreaks recorded in the country. Between June 18, 2016, and June 25, 2017, more than 17,242 cholera cases were reported including at least 320 deaths, with a case fatality rate of 1.8 percent, exceeding the World Health Organization (WHO) emergency threshold of 1 percent.[12]

[9]UNICEF, Monitoring the Situation of Children and Women,2017 (2017).
[10] Government of the Republic of South Sudan, Ministry of Health, 4th Annual HMIS Report (2015).
[11] UNICEF, Monitoring the Situation of Children and Women,2017 (2017). Available at http://data.unicef.org/topic/nutrition/malnutrition/.
[12] UNOCHA, South Sudan Humanitarian Bulletin, June 2017.

Health system and service delivery challenges

18. **The Public Expenditure Review for South Sudan's health sector, conducted in 2016, shows that public financing for health has been a low priority for the government and continues to decline with time.**[13] Since the CPA, the share of health in overall government expenditure has been decreasing from 3.8 percent in 2006 to 2 percent in 2015. The commonly cited government expenditure figure of 4 percent is based on the approved budget, not on actual expenditure. Social budget allocations remain low while aid as a percentage of the government budget has risen significantly over the last few years. Health has consistently been a low priority in terms of government budget allocation and expenditure, being among the three sectors receiving the lowest resources since 2007. This low level of expenditure is the result of prioritizing the security sector (47 percent of total expenditure) over human development needs. On the other hand, the role that humanitarian and development actors play in financing and delivering health services also allows the Government to prioritize other sectors when allocating public resources.

19. **Household out-of-pocket expenditures on health exceed government expenditure, potentially reaching as high as 79 percent of total health expenditure**. Robust data on household health-related expenditure is unavailable, but estimates suggest that the amounts are quite high, especially in urban areas. High out-of-pocket health expenditures are a significant constraint to accessing healthcare, also reinforcing inequities across socioeconomic groups, increases household vulnerability to catastrophic expenditure, and undermine the principles of universal health coverage.

20. **Service delivery for a fragile, conflict and violence affected state like South Sudan remains an important challenge.** Several states, including those in the former states of Upper Nile and Jonglei, are in active conflict or experience periodic flare-ups of violence, resulting in health systems doubly burdened by acute surges in trauma and injuries and by supply disruptions. In such settings, vulnerable groups, especially those targeted due to tensions between ethnicities, and others who may already be disadvantaged, often end up being disproportionately excluded from receiving services. In addition, significant disadvantages arise due to political affiliations, which change often in unpredictable ways, as allegiances shift between different sides in the conflict.

21. **Provision of the most basic services has largely been provided by non-state actors since well before independence and continues as such today.**[14] Although the establishment of a national health system started with the CPA in 2005, progress never really picked up pace. Whatever efforts made between 2005 and 2013 were slowed by the resumption of violence. At independence, the country had extremely low ratios of qualified health workers to population, with services mostly provided by humanitarian and other non-state actors. This continues to be the case, both due to ongoing conflict, as well as overall limited government capacity. There is a severe shortage of skilled human resources to respond to frontline health needs. It is estimated that there is only one doctor per 65,000 patients and one obstetrician/gynecologist per 200,000 people. There are no pediatricians in South Sudan (WHO, 2016). There are, however, some positive trends, with the number of midwives increasing significantly since 2010, from only 8 in 2011 to over 600 trained with essential professional midwifery competencies (United Nations Population Fund (UNFPA), 2018).

[13] World Bank, South Sudan Health Expenditure Review, May 2016.
[14] The WHO estimates that around 80 percent of health services are delivered by NGOs. WHO, 2014. Cooperation Strategy 2014-2019: South Sudan. WHO Regional Office for Africa.

22. **High levels of insecurity have dramatically reduced the capacity of the health care system to deliver services.** There are numerous reports over the past few years of health facilities being attacked, damaged and looted. Among the approximately 1,500 public health facilities in South Sudan, over 50 percent need significant investments to be able to deliver a basic package of health services. Approximately 376 (26 percent) are in good condition, 347 (23 percent) require minor renovation, 274 (18 percent) require major renovation and 490 (33 percent) need complete replacement.[15] The former states of Jonglei and Upper Nile have the highest percentage of non-functional facilities in the country. In Unity state, for example, there is only one county hospital for more than one million people. Almost all facilities lack medical equipment, transport and communication, water and power supplies. The Government currently does not have the capacity to deliver health services independently, and almost all health facilities are supported by NGOs.

23. **There remain significant concerns with regards to the safety of service providers, and in many areas of the country aid organizations need to negotiate with arms bearers to get access to at-risk populations.** Oftentimes emergency operations need to be organized during short-term lulls in fighting, with all inputs for service delivery (health professionals, essential commodities, etc.) being flown in by air and wounded patients evacuated to a safer location by helicopter or plane. The availability of essential health services remains highly limited. As of April 2018, only 3.7 percent of the 1,332 reporting facilities provide the full-service package as per the Ministry of Health (MoH) Basic Package of Health and Nutrition Services (BPHNS).16 Furthermore, only 52.4 percent of reporting facilities were providing half the required services. For example, Outpatient Therapeutic Programs and Targeted Supplementary Feeding Program for nutrition are only offered by 35.5 percent and 43.5 percent of health facilities, respectively.

24. **Disease surveillance systems are extremely weak, leaving the population at high risk for outbreaks, epidemics and even cross-border pandemics.** With the 2018 Ebola outbreaks in the North Kivu province of neighboring Democratic Republic of the Congo (DRC), the risk of severe disease outbreaks occurring in South Sudan has risen significantly higher. As of November 24, 2018, a total of 412 cases of Ebola Virus Disease (EVD) have been reported in DRC, of which 365 are confirmed and 47 are probable. Total deaths amounted to 236. Significant efforts have been made by the Government and international partners to strengthen public health preparedness and readiness of South Sudan's health system to respond to an eventual outbreak in the country. As of November 22, 2018, out of the total funding requirement of US$16.3 million for preparedness activities, US$9.4 million has been mobilized, representing 57 percent of the total required.[17] Despite these efforts, the country remains on high alert, with a suspected case in Yei River State in mid-November causing international concern. While laboratory test results for the suspected Ebola case that were conducted in Uganda concluded the case as negative for the DRC Ebola strand, the event highlighted how the porous border between South Sudan and DRC and limited capacity to respond to disease outbreaks leave South Sudan in a situation of extremely high risk. Additional efforts will be needed to support the country's efforts to be fit to respond to any potential public health emergency. The proposed project aims to contribute significantly to filling gaps in financial and technical support for public health emergency preparedness and responses in South Sudan.

25. **The overall response to SGBV remains inadequate in reach, quantity and quality.** The availability of trained medical personnel to handle Clinical Management of Rape (CMR) and basic psycho-social support continue to

[15] South Sudan Health Sector Development Plan, 2016-2020.
[16] WHO, Health Service Functionality Bulletin, April 2018.
[17] South Sudan Ministry of Health, Weekly Update on Ebola Virus Disease (EVD) Preparedness for South Sudan, November 26, 2018

be insufficient, with almost no health professionals being trained in appropriate counseling and psycho-social support throughout the country. Specialized mental health expertise is almost entirely absent from the context, with currently only one South Sudanese psychiatrist working in the entire country. Some organizations have integrated Mental Health and Psycho-Social Support (MHPSS) into the package of services they support but remain at small-scale, high cost and mostly provided by international staff, limiting their ability to be expanded to meet the needs of the population.

Development partners and the World Bank's engagement in South Sudan's health sector

26. **Over the past few years, a limited number of large-scale programs were the main source of financing the delivery of health services in South Sudan, including support provided by the Health Pooled Fund (HPF),**[18] **and the World Bank.** As part of the agreement reached in 2012, to ensure distribution of support to providing health services across the country, the main donor-funded programs support health service delivery in the 10 former states: The HPF, managed by Department for International Development (DFID) and currently under preparation to start HPF3 in early 2019, covers Central, Western and Eastern Equatoria, Lakes, Warrap, Unity, Western Bahr-el-Ghazal, and Northern-Bahr-el-Ghazal, while the World Bank supports the former states of Jonglei and Upper Nile through the Health Rapid Results Project (HRRP, P127187). Critical functions of the health system depend on these programs, including the recruitment and training of health care workers, payment of salaries, procurement and distribution of pharmaceuticals, and monitoring and evaluation (M&E). Critical support is also provided by United Nation (UN) agencies, bilaterals and NGOs, but not at the same scale as that provided by HPF and the World Bank. In many parts of the country, interventions financed by HPF and the World Bank are the only support available.

27. **The World Bank has been engaged and supporting the health sector since before South Sudan became independent.** During the CPA period the World Bank, together with other partners, was among the first to provide system building support and contributed to the setup of the first MoH in Southern Sudan, defining its structures and the development of the health strategies. Under the Multi-donor Trust Fund (MDTF) for South Sudan, several operations were processed to support the development of the country's health sector. These include the Southern Sudan Umbrella Program for Health System development (P120464), the MDTF HIV/AIDS Project (P106927), and the first financing of HRRP. The Implementation Completion Report (ICR) rating of the HIV/AIDS project was Unsatisfactory, deemed to be due to the ambitious nature of the programs, which did not always take into account the complex nature of the operating environment. The first Additional Financing (AF) of the HRRP was the first International Development Association (IDA)-supported operation in the World Bank's South Sudan portfolio. The health portfolio has since grown to include a second AF of HRRP and the new operation proposed here. The ICR for the HRRP is currently being finalized, and several of the key lessons learned from the project have been integrated into the design of the new operation.

28. **The Coordination and Service Delivery Organization (CSDO)-type model, which includes an international NGO that subcontracts NGOs and county health departments (CHD) to channel resources and provide support to service providers for the delivery of a defined package of health services, is implemented across HPF and HRRP zones with similarities in the packages of services delivered and modalities for**

[18] The HPF is a multi-donor trust funding managed by DFID and received financial support from the Governments of the UK, US, Canada, Sweden and the European Commission. The HPF program uses similar implementation arrangements as the proposed project, where resources are not channeled through government but directly to partner non-governmental organizations who provide direct support to services providers.

implementation. Under the HRRP implementation arrangements, the MoH entered into a performance-based contract with an international NGO contracted to be the CSDO for the former states of Upper Nile and Jonglei. The contract, signed between the MoH and the CSDO, was based on a fixed budget, calculated from the historical cost of providing services. The CSDO-contracted NGOs and CHDS to deliver services in public facilities. Upon submission of quarterly reports, the CSDO received a lump sum payment based on satisfactory performance on specific indicators. Results were counter-verified by a third-party monitor and based on results achieved, the performance-based variable portion of the payment was made. In addition, the HRRP supports the procurement and distribution of pharmaceutical commodities in the two former states, and remains the primary source of essential health commodities, apart from those provided through humanitarian organizations providing emergency health support.

29. **Experience from the health portfolio in South Sudan highlights key risks that require careful and measured approaches.** These include: escalating violence limiting access to opposing sides; inability to target across warring sides; the "element of surprise" and arrival of unanticipated shocks; safeguarding against abuses; attacks on and displacement of civilians visiting facilities; looting of commodities and destruction of facilities; lack of local information on power dynamics in a particular area and how it affects access; lack of information on who is who leading to contractual relationships with beneficiaries of project proceeds that are questionable, and potentially linked to government forces; direction of war; governance; and corruption. Several of these risks, along with mitigation measures, are discussed under the Risks section.

Lessons learned from the World Bank's previous engagement in South Sudan

30. **The proposed project takes on board over a decade of World Bank experience working South Sudan, both in the health sector, supporting two of the most conflict-prone states in the country, as well as service delivery in other sectors in other states.** The World Bank has been part of donor coordinated efforts to provide basic services in South Sudan since the time of the CPA. In addition to lessons from the health sector, the project also draws on lessons from the portfolio, including the Social Safety Nets (which includes cash payments to beneficiaries despite the challenging environment). The South Sudan Country Engagement Note (CEN) (FY18-19) provides several key lessons from across the portfolio which have been taken in to consideration in the proposed operation. First, there is recognition that, to ensure any significant impact on service delivery, there is need for flexibility both at the strategic and operational level in order to increase speed in delivery of services, accountability and citizen engagement, and strategic partnerships given the enormity of needs, the geographical scope and limited resources. Also, with relations between traditional donors and the Government strained, the worsening humanitarian situation and very low level of investment in human capital by the government, donors have shifted their focus to humanitarian relief, following the resumption of the conflict, rather than long-term development assistance. Hence the World Bank Group is in a unique position, considering the existing complex donor relationship with the Government, to contribute to the discourse on the humanitarian-development nexus and to help articulate a path to recovery and development.

31. **Since the launching of HRRP in 2012, the World Bank has been supporting the most fragile former states of Jonglei and Upper Nile, which are amongst the most affected by the conflict, population dislocation, and economic conditions.** The HRRP was designed to address critical health care needs and constraints in two of the most challenging states in South Sudan**.** Not only are these historically the most conflict-affected states

(proximity to border with the North), but they also received little investment in infrastructure because of the challenging swampy terrain and seasonal heavy rains, and as such are the most difficult to access physically.

32. **While the project was designed to support services in a period of conflict (mostly intra- and inter-communal clashes, as well as a number of smaller rebel movements), the design was not necessarily tailored for the more acute levels of violence that have affected the two former states for the past few years.** This violence has led to large parts of the former states of Upper Nile and Jonglei being under control of armed forces, including both Government or opposition-supported groups, resulting in significant access challenges for Government and implementing partners. After two AFs and several restructurings, the project is expected to close on April 30, 2019.

33. **The challenging environment and security risks have resulted in the World Bank's inability to visit project sites for most of the project's duration, with no World Bank missions allowed outside of Juba.** Even during times of relative peace, travel to the most remote areas of South Sudan was a challenge. Rains made large swathes of land inaccessible for six months of the year, dirt landing strips turned to mud paths and navigation over the Nile requires use of hired boats. Due to improved mobility, dry seasons have often seen upsurges in violence. Given these constraints, various third-party monitoring and verification mechanisms were put in place to ensure the results reported have been achieved.

34. **Despite providing essential support to the delivery of health services in some of the most challenging environments in South Sudan, implementation provides several key lessons that have been factored in to the proposed project's design.** Although the CSDO model was designed before the December 2013 crisis to respond to the context of endemic violence, limited access and infrastructure, and population mobility, the upsurge in violence has led to an increased need for life-saving health services in a context where insecurity and instability have generated additional challenges in providing support. Based on the data received from the CSDO, since the project started implementation, 43 out of 248 facilities have been looted or physically damaged by violent groups, several facilities had been victims of violent attacks resulting in severe injuries or even death, and essential medicines not arriving at their intended destination has remained a constant problem. While the project has been successful in delivering basic health care to close to three million people, the ongoing conflict has resulted in the destruction of facilities, displacement of qualified health workers, shortages of essential drugs, and significant portions of the populations of the former states of Upper Nile and Jonglei becoming inaccessible to project interventions. As a result, project gains have been handicapped and the ability of the project to deliver all its anticipated benefits has been significantly curtailed.

35. **Another significant challenge the health project has faced relates to capacity constraints within the Project Implementing Unit (PIU) to provide the required oversight of large contracts including the CSDO contract, contracts for procurement of pharmaceuticals and the Third-party Monitoring (TPM) contract.** Major weaknesses observed include: (i) frequent payment delays to the CSDO and its implementing partners due to submitting incomplete documentation and justification for payment and (ii) insufficient oversight of the PIU on the performance of the CSDO and downstream implementing partners, making data and reporting coming from the field unreliable. Those weaknesses resulted in incidences of ineligible expenditure growing over time, audit qualifications as well as numerous urgent requests for contract extensions**.**

36. **The environment in which the project is being implemented has significantly deteriorated over the past year, with risks and implementation challenges continuing to grow over time.** While the HRRP has surely

contributed positively to providing health services in the two states, results from the project show that coverage remained reduced due to various challenges: (i) upsurge in instability and violence not allowing the CSDO to provide services in multiple localities; (ii) inability to monitor and verify results in the majority of the two states (verification and monitoring teams are often not allowed into opposition-held territory or cannot go there due to the insecurity); (iii) perceived (and probable) non-neutrality in service delivery support across areas held by the Government and opposition forces; (iv) ineffective implementation and coordination between the CSDO and its implementation partners (IPs) (national and international NGOs) leading to a wide variety in quality and comprehensiveness of support; and (v) limited oversight and ability of the Government to provide satisfactory justification/evidence of supplies, drugs and services arriving at their intended destination.

37. **In addition, it has become clear that a different mix of approaches is needed to support health services to the extent necessary in inaccessible areas affected by conflict or held by the opposition.** United Nations Children's Fund (UNICEF) has acknowledged that there are certain parts of the former states of Upper Nile and Jonglei that remain inaccessible to them. As such, an alternative approach to supporting these zones must be adopted if the World Bank aims to support the entirety of the two states and not just areas that are more accessible. Only a few actors are able to reach these areas, and even fewer can implement within the specific circumstances found there. Given their unique approach to service delivery, their mandate of neutrality and focusing on populations that no one else can reach due to violence and conflict, the World Bank explored, through country-level consultations health sector partners that were effectively able to deliver services in these challenging areas. While more than one potential entity was identified, the International Committee of the Red Cross (ICRC) was the only organization that was deemed to have the capability to ensure services are delivered to these highly vulnerable populations and willing to take on the mission through the proposed operation.

38. **Despite the challenging environment, the results from the HRRP are notable.** The project's Results Framework, pulling from data reported from the MoH through the CSDO's quarterly reports, shows that as of June 2018 the project has contributed to over 107,000 children being fully vaccinated (DTP3) in their first twelve months, 180,000 pregnant women receiving antenatal care services, tripling the rate for outpatient visits per capita per year (from 0.1 contacts per year to 0.35), 524,000 children receiving Vitamin A doses, 161,000 children under five years of age receiving measles vaccinations, 16,000 birth deliveries attended by skilled personnel, and purchased and distributed over 2.5 million long-lasting insecticide-treated bed nets. The project also contributed significantly to strengthening health information and reporting systems in the country.

39. **In order to avoid a gap in service delivery for the approximately 3 million people residing in the former states of Upper Nile and Jonglei, in July 2018 the MoH transitioned to a five-month contract with UNICEF to step in to the role to coordinate and channel resources for the delivery of health services.** Through a project restructuring processed in July 2018, an additional US$4.5 million was allocated to Component 1 to allow for an additional three months of support to the provision of health services to approximately 220 health facilities in the two former states. UNICEF rapidly stepped into the role of CSDO, quickly subcontracting the 17 IPs (mostly previously engaged by the prior CSDO), resulting in only minor disruptions in service delivery in the former states of Upper Nile and Jonglei. Resources from HRRP allowed UNICEF to continue through October 2018, with UNICEF mobilizing additional resources through DFID funding for the period November 2018-January 2019. This has created a situation where in February 2019 the two former states face another risk of

having essential health services interrupted. Given that the World Bank has committed to continuing to support these two former states through the new operation, there is an urgent need to process the new operation as quickly as possible.

Revitalizing the World Bank's engagement in South Sudan's health sector through a new operation

40. **The Government of South Sudan has requested the World Bank to provide financing directly to organizations to carry out operations for the benefit of the people in South Sudan, due to capacity constraints of the Government to effectively manage and implement operations.** Under these circumstances, World Bank financing will be provided directly to the UN, international NGOs and humanitarian organizations that work in health service delivery for the benefit of affected communities. This implementation arrangement is the most feasible possibility for the World Bank to engage in South Sudan at this point, and the alternative of 'non-engagement' would have extremely negative consequences for the population. The Government has experience with this approach in the health sector, as the implementation arrangements for UNICEF in the proposed project are similar to the HPF's implementation arrangements. For this to happen, there will be a need for the Board of the World Bank Executive Directors approval of waivers for IDA grants being made directly to Recipients such as ICRC and UNICEF. The set of three waivers being sought are described in the Project Appraisal Summary section of the project appraisal document (PAD), and the specific rationale for UNICEF and ICRC being selected as direct Recipients of IDA are outlined in the section on Implementation Arrangements.

41. **Consistent with this vision, and given the substantial health needs in the country that urgently need to be addressed, the proposed operation will entail:** (i) a surge of high-impact, immediate response and early recovery interventions in areas significantly affected by the conflict that remain inaccessible to more development-oriented assistance approaches, and; (ii) a continuation of broad support to primary care centers and secondary care hospitals, focusing amongst others on the former states of Upper Nile and Jonglei. This approach will strategically address existing gaps in service delivery and health needs for both conflict-affected and the general population, while maximizing the World Bank's comparative advantage and value addition by making resilience building a key underpinning of the interventions proposed to be financed under the operation.

42. **Lessons from the HRRP provide key lessons and experiences that have oriented the decision to change implementation arrangements where partner agencies become direct Recipients of IDA.** The World Bank's engagement going forward through the proposed operation will be an important but temporary arrangement to support South Sudan's health sector. A key departure will include implementation arrangements that engage UNICEF and ICRC directly, and will leverage the comparative advantages of ICRC and UNICEF to ensure services are delivered to target populations in a neutral, flexible and rapid manner, with a particular focus on at-risk and vulnerable populations. The importance of leveraging these actors and providing an immediate flow of funds is necessary to sustain existing momentum and to scale up ongoing activities while avoiding interruption to service delivery supported by HRRP. The arrangement will ensure maintenance of key health infrastructure and human resource capacity and continue to preserve a level of service delivery that can be picked up by Government at a future date.

43. **The proposed engagement with ICRC and UNICEF in South Sudan through this operation falls within the context of a broader effort between the World Bank and partners to collaborate in fragile state and conflict-**

affected settings. In May 2018 the Chief Executive Officer of the World Bank Group and the President of the ICRC signed a Memorandum of Understanding (MoU) to promote cooperation between the World Bank and the ICRC. The MoU identifies three broad themes for cooperation: (1) operational collaboration; (2) knowledge and expertise exchange; and (3) coordinated efforts to shape the global humanitarian and development agenda. The proposed project is also well aligned with UNICEF's broader engagement with the World Bank Group. The World Bank Group and UNICEF signed a Strategic Partnership Framework (SPF) in March 2017, which provides for more systematic collaboration in agreed outcome areas such as health and nutrition and beyond, including programmatic cooperation; data, research and knowledge exchange; social protection; fragility, refugee and migrant children, and enhanced country-level collaboration. Furthermore, the Ministry of Finance (MoF) has requested that IDA financing for all new operations under preparation through 2020 in South Sudan will be channeled through and implemented by public international, regional or non-governmental or other organizations.

44. **The proposed project will address the health challenges in the country and implementation bottlenecks by:** (i) ensuring greatly improved geographical coverage of essential health and nutrition services in the two former states by providing direct service delivery support to health facilities; (ii) introducing flexible and dynamic approaches to service delivery such as outreach activities to high risk communities and IDPs; (iii) training and deployment of community health workers for preventive and basic curative services (and supporting the scale-up of the national Boma Health Initiative(BHI)); (iv) training of lifesaving health professionals that are almost nonexistent in the country; including on counseling and treatment for SGBV victims; (v) ensuring robust monitoring and verification measures are in place to proactively track results and monitor progress; and (vi) filling critical resource gaps in support to public health emergency preparedness in South Sudan, given the ongoing Ebola outbreak in bordering DRC. Both ICRC and UNICEF have a strong focus on rural populations and hard-to-access areas where vulnerability is acute, allowing the project to target some of the most at-risk populations in the country. Beneficiaries will include the general population of the former states of Upper Nile and Jonglei (through UNICEF), including areas severely impacted by conflict (through ICRC), as well as target populations affected by the conflict outside of the two priority former states (through ICRC). Both organizations also have expertise in supporting disease surveillance and response efforts both globally and in South Sudan, including efforts related to Ebola preparedness and response.

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

46. **The proposed project is being processed under procedures specified under Paragraph 12 (Projects in Situations of Urgent Need of Assistance or Capacity Constraints) of the World Bank Policy and Directive for Investment Project Financing (IPF) 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.

Strengthening national systems and capacity through the proposed operation

47. **The proposed project includes several important capacity building measures to strengthen the country's national health system.** Under Component 1 the project has a strong focus on building capacity of service delivery platforms and the health system at decentralized levels (community, health facility and county level) through training in clinical protocols and guidelines, Health Management Information System data management, supervision skills, supply chain management; planning and coordination skills of county health department teams; and national information and monitoring systems.[19] Through Component 2 the project will support the Government's national M&E systems. The Government's capacity for public health emergency preparedness and response, with a particular focus on supporting the national EVD Response Plan, will be strengthened through Component 3. In addition, the partnerships with UNICEF and ICRC allow for activities under the project to be complemented by other capacity building and health system strengthening initiatives that are part of these organizations' engagements in the country.

48. **The proposed project invests significantly in building capacities of health service providers and managers at the operational level to contribute to a stronger and resilient health system in the country.** By agreeing on the proposed package of interventions conjointly with ICRC and UNICEF, the project will harness the unique capabilities of both organizations to implement activities linked to the project development objective. Neither organization had planned or would have been able to implement the proposed activities at an equal scale without the partnership being established by the proposed project. Going forward, while the project aims to fill critical resources gaps in the short- to medium-term, IDA resources will also play a role in long-term financing sustainability. The World Bank will proactively explore long-term financing opportunities that goes beyond the South Sudan's IDA Performance-Based Allocation (PBA).

49. **The lasting impact of the project after its duration will be a stronger and more equitable system for providing health services as resources will be channeled to the intended project beneficiaries, target populations and service providers addressing their health needs.** This will contribute towards a stronger public health system and longer-term sustainability of efforts. The rationale for prioritizing these endeavors in the short-term is based not only on the urgent health needs the project aims to address, but also the limited results on institutional capacity building efforts, most importantly ensuring health services are delivered to vulnerable populations. The project will continue engagement with the Government to ensure that it can eventually take back responsibilities for service delivery in the future.

C. Relevance to Higher Level Objectives

[19] Activities to be implemented by ICRC and UNICEF under Component 1 that build capacity among health service providers and lower-level managers include: (i) training and support in managing medical stocks, supplies and pharmaceuticals; (ii) training in treatment for most frequent diseases and care in line with national guidelines; (iii) training and support to antenatal care, post-natal care, safe deliveries and Basic Emergency Obstetric and Newborn Care; (iv) training and support for the BHI to improve community involvement/ownership in health care; (v) training in CMR and psychosocial support for victims of Gender-based violence, including conflict related sexual violence; (vi) support to re-establish routine EPI activities; and (vii) strengthening referrals to secondary/hospital care where needed.

50. **The proposed investments are aligned with the South Sudan CEN FY18-19[20] endorsed by the Board in January 2018.** The Systematic Country Diagnostic (SCD) for South Sudan[21] underscores the importance of preserving the availability of and access to service delivery in contexts of fragility. The proposed operation is in line with the government's Health Sector Development Plan and the Health Sector Strategic Plan (2015-2019) and the BHI, whose objectives to "increase the utilization and quality of health services, with emphasis on maternal and child health;" to "strengthen institutional functioning including governance and health system effectiveness, efficiency, and equity;" and community health system (the reform) as a means to equitably engage communities in health promotion at household level. The new CEN proposes a strategy with two objectives: (i) support basic services provision for vulnerable populations; and (ii) support to livelihoods, food security and basic economic recovery. UNICEF's Country Programme, 2019-2021 also aligns with the proposed investment and national health sector plans. The UNICEF Country Programme contributes to the National Development Plan, 2018-2021 as it aims to implement cross-sectoral, integrated program at the national and subnational level to increase capacity and resilience of partners and systems at the local, community and household levels. The UNICEF Health program contributes to health system strengthening and combines life-saving interventions with mobile outreach and community-based services to enhance community resilience, in line with the Government's BHI.

51. **The project is well-aligned with development partners approaches and focus to support the most vulnerable populations affected by conflict.** The content of the proposed operation is in line with the World Bank's engagement in the country and approach to support in FCV settings. The project will support capacity building efforts to a level that is absolutely necessary to ensure that services are provided to the level and quality required for medical services provision and supervision. Specific to South Sudan, the proposed project is also closely aligned with the Partnership for Recovery and Resilience (PfRR) agenda, launched in 2018 between UN agencies, bilateral and multilateral agencies, and NGOs. The PfRR aims to reduce vulnerability and build resilience against multiple shocks through a four-pillar approach: (i) rebuilding trust in people and institutions; (ii) reestablishing access to basic services; (iii) restoring productive capacities; and (iv) nurturing effective partnerships. The proposed operation touches on all four pillars of the PfRR by supporting the delivery of essential health services in highly vulnerable areas of the country.

II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

The Project Development Objective (PDO) is to increase access to an essential package of health services in the Republic of South Sudan, with a particular focus on the former states of Upper Nile and Jonglei.

PDO Level Indicators

52. **The proposed PDO indicators, classified by project objectives, are the following:**

[20] Report number 120369
[21] Report number 99383

(a) Number of people who have received essential health, nutrition, and population (HNP) services;[22]
    a. Number of people who have received essential health, nutrition, and population (HNP) services - Female
    b. Number of children immunized;
    c. Number of women and children who have received basic nutrition services;
    d. Number of deliveries attended by skilled health personnel;
(b) Number of curative consultations provided for under 5 children;
(c) Number of health facilities with essential medicines available;
(d) Number of health facilities providing at least 75 percent of the essential package of health services; and
(e) Proportion of disease outbreaks detected and responded to within 72 hours of confirmation.

B. Project Components

53. **The project includes several components that respond to critical needs in South Sudan's health system, including support to delivering health services in some of the most challenging environments in the country, strengthening public health emergency preparedness and response systems, with a particular focus on EVD, and contributing to building a more robust and harmonized national M&E system.** It is necessary that the project includes a level of flexibility in the geographical targeting of supported interventions, due to the ever-evolving state of the conflict and unpredictability of violent events outside of the two former states. In addition to providing general service delivery support to the former states of Upper Nile and Jonglei, the project will specifically target vulnerable populations, such as women, children and populations affected by conflict and violence. The importance of leveraging partnerships with institutions that can ensure services are provided even during surges of violence and conflict will be essential to achieving the objectives of the operation. The immediate mobilization of resources to support the provision of essential health services is necessary in the context of the operation to sustain existing momentum and scale-up ongoing activities, while also avoiding interruption to service delivery supported by HRRP.

54. **The project will have a strong focus on rural populations and hard-to-access areas where vulnerability is acute, allowing the project to target some of the most vulnerable populations, such as women, victims of violence and children.** Beneficiaries will include the population of the former states of Upper Nile and Jonglei, including areas severely impacted by conflict, as well as target populations affected by the conflict outside of the two former states.

Component 1: Delivery of Essential Health Services (US$93 million equivalent)

55. **Component 1 will support the provision of a defined package of essential health services, targeting the populations of the former states of Upper Nile and Jonglei, and other vulnerable communities affected by conflict and violence.** The package will include maternal and child health services such as vaccinations, prenatal care, skilled birth attendance, neonatal care and preventive and curative health and nutrition services.[23] Priority services also included in the package include mental health and psycho-social support

[22] A composite indicator with the sum of: (a) children immunized; (b) women and children who have received basic nutrition services; and (c) deliveries attended by skilled health personnel.
[23] The Ministry of Health's official the BPHNS (draft 2011 and 2018 versions) is long and overly ambitious, covering NCDs and more. The component will support high impact essential services distilled from the comprehensive MoH BPHNS package, taking into account: (i)

services and services serving victims of SGBV, such as CMR. Component 1 will support the delivery of these services at primary care facilities and strategically identified secondary hospitals, complemented with community outreach and mobile health services to increase and expand equitable coverage and access, especially for remote or hard to reach communities.

56. **Component 1 will channel resources through partner agencies ICRC and UNICEF, where the World Bank will lead the coordination of these organizations in the delivery of the package of essential health services in the two former states and other areas in the country acutely affected by the conflict.** Implementation strategies will include: (i) direct service provision of said agencies using their own staff; (ii) sub-contracting local and international NGOs (IPs) to support the coordination and delivery of health services; and (iii) strengthening the management capacity of CHDs and local service providers where possible.

57. **Partner agencies will improve access to services despite seasonal accessibility challenges.** Excessive reliance on fixed health facilities will leave many people in the two states without physical access to PHC services. Thus, the project will have to strengthen outreach activities, particularly during the dry season. The dry-season campaigns are aimed at improving the coverage of basic services such as immunization, vitamin A supplementation, and anti-malaria treated bed nets. Part of the coordination role of the chosen partners will be to mobilize all the available commodities, vehicles and human resources required to implement the outreach activities and supplement these resources where needed.

58. **To align with other donor financing in the country such as the HPF and fill critical resource gaps, as with HRRP, the primary geographical focus for the operation will be the former states of Upper Nile and Jonglei.** Yet as the security situation in the country remains unpredictable and the need to deliver health services in conflict-affected areas may arise outside these two former states, the component will also finance the delivery of primary and secondary care by ICRC in areas affected by conflict and instability. To align with the financing and delivery of basic services by HPF3 in the eight former states, UNICEF's geographical coverage will remain within former Upper Nile and Jonglei, covering more accessible areas where ICRC will not be operating. The World Bank will facilitate close coordination of the two partner agencies for best service coverage and to respond to anticipated movement of population given the security situation context.

Delivery of high impact essential health services in the former Upper Nile and Jonglei States (US$61 million)

59. **Under this component, UNICEF will support the delivery of cost-effective, high impact essential health services to the general population living in the former Upper Nile and Jonglei States.** The target population is approximately 1.8 million people living in the former Upper Nile and Jonglei States. This includes about 85,000 pregnant women; 82,000 children under one; and 382,000 children under five (National Bureau of Statistics, 2015).

60. **The package of services and scope of activities to be supported by UNICEF includes:**
    (a) **Child health services:** Health education; routine immunization (including via outreach); integrated management of neonatal and childhood illnesses (IMNCI) and rapid response and referral for complicated cases; insecticide bed net (LLITNs) distribution; vitamin A supplementation; promotion of adequate infant

consultations with stakeholders, especially with a view to alignment with the HPF3; (ii) support that will be provided from other partners (e.g. OFDA, ICRC, UNFPA, WHO); (iii) resources available; (iv) intrinsic capacity of human resources for health available in South Sudan to deliver the services; and (v) prioritization of services with the greatest impact, especially for women and children.

and young child feeding behaviors; and nutrition screening and referral to adjacent nutrition therapeutic programs.

(b) **Maternal and neonatal health services:** Health education; antenatal care (ANC4+: ANC profile will include Hb, urinalysis, rapid diagnostic testing for malaria, HIV and syphilis); antenatal care interventions (2 tetanus toxoid, deworming, iron folate supplementation, intermittent preventive treatment for malaria, and insecticide bed net distribution; skilled delivery; postnatal care of mothers and newborns; family planning; and referral (if required) for secondary health services.

(c) **Basic and comprehensive emergency obstetric and newborn care:** To be delivered at the PHC Center and hospital level.

(d) **Sexual and gender-based violence services:** Identification, counselling, management and proper referral for victims of SGBV, including rape victims;

(e) **Procurement and distribution of essential medicines and supplies:** Vaccines; vitamin A; oral rehydration solution (ORS) and zinc; medicines for deworming; antibiotics; and other essential medical supplies.

(f) **Emergency preparedness and response:** Building the capacity of partners to detect, assess and respond to health needs in the event of emergencies and disease outbreaks. UNICEF will integrate emergency preparedness and response into planning, capacity development, monitoring, and coordination. Kits and emergency health supplies will be prepositioned especially during the dry season (in secure warehouse locations), and contingency plans and standby agreements will also be put in place with local partners to provide rapid surge capacity where needed.

(g) **Disease surveillance and outbreak response:** In line with the nationwide Integrated Disease Surveillance Response (IDSR) and Early Warning Alert and Response (EWARS) systems, partners will collect data from health facilities; and participate in field investigations and activities to respond to outbreaks such as cholera, viral hemorrhage fever, and malaria. UNICEF South Sudan will adopt an integrated approach, combining water, sanitation and hygiene (WASH), health and Communication for Development (C4D) to ensure effectiveness and efficiency of outbreak preparedness, response and control interventions. Preparedness efforts are continuously being carried out, including through training of government and partner staff as well as through timely procurement and prepositioning of supplies to the three field offices in the project areas to enable swift access by partners. Outbreak response will aim to respond to outbreak alerts through case management, surveillance, cold chain and vaccine management for the conduct of emergency immunization campaigns, social mobilization and risk communication.

(h) **Quality improvement and supervision:** In-service training (with a focus on competency-based training); continuous quality improvement activities; infection prevention activities; supportive supervision; and promotion of procedures for proper waste management and disposal of sharps and other waste.

61. **The main strategy is to support an agile mix of static PHC services that is complimented by regular outreach (especially during the dry season) to increase and expand equitable coverage and access, especially for mobile or hard to reach populations with intermittent periods of stability and weather-constrained access.** These front-line interventions will be supported in specific areas with the roll-out of community-based health services, such as the BHI (including integrated community case management), in order to bolster community resilience and basic services provision, even while communities are exposed to shocks and cannot be accessed. This combined with emergency preparedness and response will ensure service continuity. Moreover, innovative new cold chain devices (such as the Arktek cold box) will be used to ensure the delivery of safe, potent vaccines at service delivery points. It will also be essential to make additional efforts to address the plight of women and child survivors and that life-saving services be extended to improve accessibility. UNICEF's Health and Child Protection programs will work closely to ensure an integrated approach to improve

the well-being and safety of women and children through administration of CMR services, access and provision of confidential and sensitive health services to survivors of all forms of SGBV. In summary, three main delivery strategies will be adopted:

(a) **Directly supporting service delivery:** In close collaboration with the MoH, State MoH and county health officials, UNICEF will provide implementing partners (NGOs) with technical assistance, supplies and financial support, as part of overall capacity development to strengthen the delivery of basic health services to children and women, with priority given to the poorest and most marginalized communities. This will entail a mix of national and international NGOs identified through an open selection process.
(b) **Enhanced routine outreach:** Health teams attached to health facilities will be supported to expand coverage and access to health services in areas with intermittent periods of stability and access. This would provide a broader package of services in a more systematic manner to locations outside the catchment areas of the fixed/functional health facilities and to displaced populations, especially where there is a deficit of health and nutrition services. These outreach services will be provided monthly where possible (at minimum every 2–3 months).
(c) **Advancing community health through the BHI:** Targeting communities far away from existing health facilities through the BHI, a network of trained community health workers (CHWs) will be responsible for delivering a standard integrated package of promotional, preventive, and selected curative health services. Delivered at the household level, these services will focus on Child Health, Safe Motherhood, and basic Community Surveillance. As such, CHWs will be trained on disease surveillance and the reporting of service delivery data and vital statistics.

62. **This component will also address the limited availability of qualified professionals trained in SGBV who are offering services to victims by investing heavily in training, sensitization and monitoring.** In collaboration with other development and humanitarian partners working in South Sudan's health sector, many who already have a significant program addressing SGBV in South Sudan, the project will significantly scale-up attention and efforts to improve access to services for SGBV victims. For example, the project will support the work of Gender and Social Inclusion experts at UNICEF to scale-up training programs of health professionals and expand the network of service providers offering SGBV counseling and treatment services in former Upper Nile and Jonglei.

Delivery of essential health services to highly vulnerable and conflict-affected populations (US$32 million)

63. **Accessibility to provide health services in areas acutely affected by the crisis remains a significant challenge in South Sudan, with only a few actors in the country have been able to find ways to allow them to cross boundaries between Government and opposition-held areas to deliver services.** Component 1 will also support the delivery of a multidisciplinary response to urgent health needs arising out of the conflict in the country, with a particular focus on zones that remain inaccessible to other parties. These activities will be implemented by ICRC, given ICRC's proven ability to deliver both basic services and life-saving interventions, even during upsurges in violence.

64. **The conflict and violence-affected population (resident and displaced) from the catchment areas supported by ICRC will benefit from support to PHC services and have access to essential, quality curative and preventive health care services with functional infrastructure and management, adequate resources and trained staff providing treatment and care in line with national standards.** The activities implemented by

ICRC will ensure that the targeted populations are being cared for in well-functioning, equipped and staffed primary and secondary care facilities. Project support will allow for these facilities to function normally and provide effective health services to the community through trained staff, in line with national standards. Residents and/or displaced populations from the catchment areas of the facilities supported under this component will have access to preventive and curative services, in a timely manner, including referral to secondary care when needed.

65. **The scale-up of support to health facilities in the project's targeted areas through activities implemented by ICRC will be significant.** Prior to project preparation, in the areas targeted by the project, ICRC supported 12 primary care centers and no hospitals. With the support of the IDA financing mobilized through the project, in 2019 and 2020 ICRC will support 25-30 primary health care centers and two secondary care hospitals for acute health needs, critical to reduce the number of life-threatening complications (such as hemorrhage, eclampsia, obstructed labor, sepsis, or unsafe abortion and immediate emergency care for newborn babies) during and after childbirth, along with enhanced referral services between primary care and secondary care. Mental health and psychosocial support programs for victims of violence, including of conflict-related sexual violence, will be expanded from the 5 primary care facilities where currently available to all primary and secondary care facilities supported by ICRC within the project area. The catchment area population served by ICRC within the project area will increase from 120,000 persons in 2018 to between 500,000 to 600,000 persons in 2019 and 2020.

66. **The component will support both the delivery of the package of essential services and capacity building efforts.** Activities in supported health facilities and hospitals will include: (i) training and support in managing medical stocks, supplies and pharmaceuticals; (ii) treatment for most frequent diseases and care in line with national guidelines; (iii) training and support to antenatal care, post-natal care, safe deliveries and Basic Emergency Obstetric and Newborn Care; (iv) training and support for the BHI to improve community involvement/ownership in health care; (v) medical care and mental health and psychosocial support for victims of violence, including conflict related sexual violence; (vi) support to re-establish routine expanded program on immunization (EPI) activities; and (vii) referrals to secondary/hospital care where needed.

67. **The scope of health care activities to be supported at the primary care and community level will include:**
    (a) **Curative care:** Patients suffering from the most frequent diseases and/or injuries and/or physical consequences of sexual violence are properly diagnosed and treated, in line with international/national standards.
    (b) **Women of child bearing age:** Women of child bearing age receive qualitative sexual and reproductive health care meeting national standards as a minimum, including: ante- and postnatal care, safe and clean deliveries, basic emergency obstetric and newborn care, post-abortion care, family planning and timely referral in case of complications.
    (c) **Children preventive care:** Children are protected against vaccine-preventable diseases, malaria and malnutrition in line with national standards.
    (d) **Mental health and psychosocial support:** Victims of violence (including sexual violence) have their psychological and/or psychosocial consequences of violence needs met both in health facilities and by community actors.

68. **Mental health and psycho-social support and medical care will be provided to victims of violence and CRSV in a safe environment.** Linkages will be developed between a primary point of contact from the community

to referral services, to ensure effective awareness raising and referral pathway for victims of conflict related sexual violence. The inclusive mental health services package is comprised of:

(a) Assessing mental health and psychosocial needs and available resources and support within ICRC's supported health facilities;
(b) MHPSS capacity-building: training and follow-up supervision for community key actors, health staffs (identified as focal points), on issues such as identification of symptoms, strategies for potential responses and referrals when possible;
(c) Strengthening the technical quality of and access to psychological services and to psychosocial support activities to promote emotional well-being by improving coping mechanisms;
(d) Sensitization and community mobilization through the ICRC supported health facilities to provide information and promote knowledge on MHPSS issues through awareness-raising campaigns and community outreach.

69. **To have an impact on the continuum of care, a package of secondary health services (at the county hospital level) will be developed and implemented by ICRC in conflict-affected and inaccessible areas where referral possibilities are not or are insufficiently available.** While many of these areas are in former Jonglei and Upper Nile, the project will have the flexibility to respond to conflict in both known and unforeseen hotspots throughout the country. Given the complex situation in South Sudan and especially in the non-governmental controlled areas, the approach at the hospital level will remain agile and adaptive in case of a changing security situation.

70. **Component 1 will ensure that the wounded and sick in areas affected by conflict and other emergencies benefit from quality hospital care meeting recognized international standards.** The component will aim to ensure that Health care providers, facilities, and transport services are free from violence, including obstruction of access to health care, and that patients from the catchment area of the supported hospitals in need of hospital care have access to hospital services in a timely manner. In case of an emergency and/displacement the affected population receives timely emergency hospital care. The hospital management team of supported hospitals will be tasked with assuring human resources, clinical (including infection control) and material management meeting recognized international standards. ICRC will also implement capacity building strategies so that the health authorities (or liable partner) will have the basic capacity (e.g., access, structures, organization, competencies, tools, resources, network) to handle correctly the functioning of the project-supported hospitals.

71. **At the secondary care level, the supported hospitals will include the following package of services:**
(a) outpatient and emergency services;
(b) surgical service (including obstetrics emergencies);
(c) non-surgical services (including non-surgical obstetrics, pediatrics, therapeutic feeding services, physiotherapy);
(d) clinical support services (pharmacy, laboratory, and imaging); and
(e) non-clinical support services.

72. **Component 1 will finance costs related to: (i) technical supervision, monitoring and oversight by UNICEF of sub-contracted NGO implementing partners; and (ii) cross-sectoral support and program management costs (e.g. transport costs, IT support, monitoring and reporting) for ICRC and UNICEF.**

Component 2: Monitoring, Evaluation and Learning (US$4 million equivalent)

73. **Component 2 will finance costs related to a national unified monitoring approach (co-financed with DFID and HPF3), as well as specific monitoring of project activities in areas accessible for independent monitoring.** The project will ensure that independent and credible data on health service delivery are generated. This is critical to enable the World Bank, Government and development partners to have a clear line of sight that resources are reaching the intended beneficiaries and potential harm is minimized. The proposed approach builds on experience from HRRP's external monitoring which included Lot Quality Assurance Surveys (LQAS), Quarterly Verification Visits and health information system assessments and will include contracting of third-party monitor agencies. The monitoring entities' roles will include supportive supervision and monitoring to identify challenges and propose context-appropriate solutions, as well as ex-post fact verification of results provided by project reporting mechanisms.

74. **Efforts have been made to develop a common monitoring mechanism across the HPF and World Bank-supported zones for the period 2019-2020.** The methodology for performance monitoring has been jointly designed by World Bank and HPF contributors and will launch during the first quarter of 2019, when both HPF3 and the proposed operation plan to start implementation. The task team has leveraged resources from the Global Financing Facility and the World Bank to contribute to the design of this shared performance monitoring approach across HPF and World Bank-supported zones.

75. **Key monitoring elements will include**:
    (a) Development of a master health service functionality database, capturing development and humanitarian health services across donors;
    (b) Collection and development of verified data within database to increase confidence in analysis and reported results and provide measures of partner data quality and reporting accuracy;
    (c) Generation of monthly health service functionality bulletin and implementing partner data performance reports;
    (d) Development of service availability and performance indicators, including client satisfaction;
    (e) Quarterly technical review of health service functionality data with development and humanitarian stakeholders; and
    (f) LQAS to measure coverage of key health service delivery indicators.

76. **Cost sharing arrangements have been made with other partners (DFID, HPF3) to finance the national performance monitoring model for the 2019-2020 calendar years.** Component 2 will finance costs related to implementing monitoring activities (a) - (e) in the geographical areas of the former states of Upper Nile and Jonglei, as well quarterly LQAS surveys (activity (f)) nationwide (including HPF3-financed zones).

77. **Enhanced accountability and monitoring mechanisms will be put in place to track and address project performance.** ICRC will submit quarterly financial and progress reports, providing data on the project's Results Framework indicators, as well as narratives on implementation progress and challenges, social and environmental safeguards, and fiduciary aspects. UNICEF will initially submit quarterly financial reports and indicator matrix progress reports as well as bi-annual narrative progress reports providing data on the project's Results Framework indicators, as well as narratives on implementation progress and challenges, social and environmental safeguards, and fiduciary aspects. Partner agencies will be expected to improve on the quantity and quality of health services based on a specific set of measurable indicators that also reflect

the project's results framework. The World Bank will conduct quarterly meetings with partner agencies to review progress based on a pre-identified methodology for reporting and performance monitoring. Innovative technologies such as use of mobile and geotagged data through the Kobo Toolbox platform will be applied to strengthen the quality and comprehensiveness of said third-party monitoring and verification mechanisms.

78. **Alternative monitoring arrangements have been designed for health facilities the ICRC will be supporting.** The rationale includes challenges external monitoring agencies may have in accessing areas where ICRC operates, due to insecurity or violence, and potential sensitivities with target populations and local authorities related to confidentiality of beneficiaries. Given these challenges, a robust monitoring and reporting approach has been jointly designed with ICRC that will maximize use of data, geo-referenced where possible, to provide the clearest objective picture possible regarding implementation of project activities and results achieved. The detailed monitoring arrangements for ICRC are presented in the Results M&E section of the PAD.

79. **In addition to supporting M&E activities, Component 2 will also support activities that aim to generate greater knowledge on service delivery in contexts such as South Sudan, where an agile mix of development and emergency strategies are needed to achieve results.** To better understand the ongoing needs and to design programs on the longer term that may be more development assistance-oriented but still include elements of emergency response, the component will support several implementation research and learning initiatives that ICRC and UNICEF may conduct.

Component 3: Emergency Preparedness and Response (US$3 million equivalent)

80. ***Sub-component 3.1: Public Health Emergency Preparedness (US$3 million).*** This sub-component, implemented by UNICEF, will support the national EVD Preparedness and Response Plan. UNICEF is currently providing surge technical support that participate in the multi-sectoral National and State Task Forces (in high risk areas) as well as technical working groups. The technical assistance being provided by UNICEF to national and state-level partners focuses on risk communication, social mobilization and infection prevention and control through experienced health, C4D and water and sanitation specialists.

81. **Within this context, the following preparedness interventions will be supported through Sub-component 3.1.** The activities, included in the national preparedness and response plan, budgeted at approximately US$650,000, will be financed through retroactive financing to UNICEF**:**

    (a) ***Increase disease risk perception and adoption of prevention and control practices among at risk and affected populations****:* (i) state level sensitization and technical training of religious and community leaders, civil society organizations (CSO), youth and women's groups, private sector, local authorities, and public transporters on their role in disease prevention and control; (ii) community sensitization through Information, Education and Communication (IEC) materials, radio, TV and mobile platforms; (iii) community and group meetings at public points including markets, villages, towns, festivals, funerals, transit points, schools, and social service delivery points; (iv) support risk communication mobile theatre and video shows; and (v) preparation of guidance and materials.

    (b) ***Strengthen capacities of key stakeholders in risk communication related to prevention and control:*** (i) map implementing partners and local communicators in high-risk counties; (ii) sustain the demand and utilisation of services and positive behaviour practices; (iii) train community leaders, religious leaders, traditional healers, and the media at state and national levels; (iv) establish a mechanism for community

surveillance as well as to collect and address rumours; and (v) review/update training curriculum and training aids for the training of the community mobilizers.

(c) ***Preposition/stockpile of critical supplies and improve identified health facilities with IPC services:*** (i) procure and prepositioning of WASH and Personal Protection Equipment (PPE) supplies and standard operating procedures related to prevention and control of EVD outbreak; (ii) provision of water and sanitation services including installation of hand washing facilities in screening points and EVD Isolation Units in Juba, Yei, Yambio and Nimule; (iii) raise awareness on good hygiene practices at health facilities/Isolation Units, and key public places around screening points and isolation units through installation of hand washing facilities; and (iv) training of implementing partners, especially health and WASH personnel, on investigation of alerts and immediate outbreak response, as well as requirements for IPC associated with the preparation of disinfectants of different concentrations, excreta disposal and monitoring of water quality.

82. **To ensure that the project is as agile and responsive as possible to emerging public health emergencies, an additional US$2.35 million will be allocated to this sub-component as prepositioned contingency funds in case of a disease outbreak or public health emergency, whether it be EVD or other.** The funds will be used, after receiving approval from the World Bank task team, as an immediate response while additional response funds, through the Sub-component 3.2 or other means, are being mobilized.

83. ***Sub-component 3.2: Contingency Emergency Response (CERC) (US$0 million).*** *The* objective of Sub-component 3.2 is to improve the country's response capacity in the event of an emergency, following the procedures governed by Paragraph 12 of World Bank IPF Policy (Rapid Response to Crisis and Emergencies). There is a moderate to high probability that during the life of the project that South Sudan will experience an epidemic or outbreak of public health importance or other health emergency with the potential to cause a major adverse economic and/or social impact which would result in a request to the World Bank to support mitigation, response, and recovery in the region(s) affected by such an emergency. In anticipation of such an event, this CERC provides a mechanism for the project to support mitigation, response, and recovery in the areas affected by such event. In anticipation of such an event, this component will allow UNICEF and/or ICRC to receive support by reallocating funds from other project components or serving as a conduit to process AF from the Pandemic Emergency Facility (PEF) or other funding sources for eligible emergencies to mitigate, respond and recover from the potential harmful consequences arising from the emergency situation. Disbursements under this component will be subject to the declaration of emergency and the preparation of an "Emergency Response Operational Manual" (EROM) by UNICEF and ICRC, agreed upon by the World Bank.

Component 4: Repayment of Project Preparation Advances (US$5.4 million equivalent)

84. **The financing processed through this project will also support the repayment of Project Preparation Advances from other projects that were disbursed but for which the projects were never delivered** due to the country context following the July 2016 crisis. The projects include the South Sudan Institutional Development and Capacity Building Project (Preparation Advance No. Q9090), Energy Sector Technical Assistance Project (Preparation Advance No. Q9320), and Agricultural Development and Food Security Project (Preparation Advance No. Q9460). The Ministry of Finance and Planning requested for processing the repayments of these PPAs through the proposed project through a letter dated September 27, 2018.

Table 2: Project Components Costing Table (US$ million)

Project Components	IDA Financing
Component 1: Delivery of Essential Health Services	**93**
Component 2: Monitoring, Evaluation and Learning	**4**
Component 3: Emergency Preparedness and Response	**3**
Component 4: Repayment of Project Preparation Advances	**5.4**
Total Costs	**105.4**

C. Project Beneficiaries

85. **The project beneficiaries are twofold. First, project beneficiaries include the general population of the former states of Upper Nile and Jonglei, with a particular focus on women of reproductive age and children under five.** The former states of Upper Nile and Jonglei have a population of just over 3.5 million (1,434,319 and 1,878,045, respectively), accounting for approximately 28 percent of the total population of South Sudan. Of those, 1,567,436 are female, 407,533 (26 percent) are of child-bearing age, 78,372 (5 percent) are pregnant women, and 313, 487 (20 percent) are children under five.

86. **The second set of project beneficiaries are populations affected by insecurity, conflict and violence, both resident and displaced.** While currently the majority of these populations targeted by the project are located in the former states of Upper Nile and Jonglei, target populations also reside in states such as Western Bahr el Ghazal State, Greater Unity State, and Greater Equatoria State. Given the unpredictability of the environment in South Sudan, geographical areas affected by violence and conflict may also be targeted if the need arises, ensuring that affected populations benefit from support to primary and secondary health care services and have access to essential, quality curative and preventive health care services with functional infrastructure and management, adequate resources and trained staff providing treatment and care.

D. Results Chain

87. **As discussed above, South Sudan health outcomes are among the worst worldwide and the health system suffers from highly acute weaknesses.** The delivery of health services, particularly in the geographical areas targeted by the project, is even more challenging due to the ongoing conflict. To increase the utilization and quality of essential health services, the project will support the delivery of an essential package of health services to targeted beneficiaries, which includes training of essential healthcare cadres to provide life-saving maternal and child services; and support the procurement of essential of pharmaceutical and medical supplies. This will result in improved quality and availability of health services, followed by an uptake in the use of better quality health services. Over the longer term, better coverage of higher quality health services will lead to improved health outcomes among the beneficiary populations. The causal chain for the proposed operation is presented in Figure 2.

Figure 2: Results Chain for the Provision of Essential Health Services Project

Activities	Outputs	PDOs/outcomes	Long-term
Support the delivery of an essential package of health and nutrition services in targeted areas	Improved delivery of health services in targeted areas	Increase the utilization and quality of an essential package of health services	Improved health outcomes of targeted populations
Ensure healthcare cadres of MCH services can deliver services safely	Improved quality of PHC services in targeted areas		
Support procurement of essential pharmaceutical and medical supplies		Strengthen coordination, M&E of project and health services in South Sudan	
Support program M&E	Improved health system M&E systems		

E. Rationale for World Bank Involvement and Role of Partners

88. **As South Sudan is home to some of the world's poorest and most vulnerable populations, the proposed operation is consistent with the World Bank Group's twin goals of eliminating extreme poverty and boosting shared prosperity.** The World Bank's focus on FCV calls for emphasis on preventing and acting early but also to remain engaged during active conflict, and through countries in recovery and transition. Providing assistance in FCVs is also one of the key priorities under IDA 18. The project will provide essential support to some of the most vulnerable populations in the country, let alone the world, and by ensuring continuity in the provision of basic services will contribute to broader public goods in the country.

89. **Without the World Bank's support through the proposed operation, there would be significant financial gaps for providing life-saving health services in the former states of Upper Nile and Jonglei.** While the ongoing conflict has impeded HRRP's achievements in improving health service delivery outcomes, the results achieved so far show significant contributions of the project to ensuring essential health services are available in the two beneficiary states. The proposed project provides a unique opportunity for the World Bank to (i) continue providing essential support to vulnerable populations in states highly impacted by the conflict; (ii) learn and improve on lessons from the HRRP; and (iii) continue to partner with others in support of the health services provision in South Sudan.

90. **The project will support efforts for greater alignment of partners engaged in the health sector.** To the extent possible, the package of services supported by the project will be harmonized with the package supported by HPF3 in the other former eight states. The proposed project, like HPF3, will have an emergency contingency mechanism embedded in the project (Component 3) to allow for rapid reallocations and reprogramming to emergency health services in the case of an upsurge in conflict and humanitarian needs.

91. **Finally, the World Bank will continue to coordinate with donors, development partners and international NGOs and partners in the country, not only for alignment in approaches and policies but for better**

collaboration on the ground. They provide technical assistance such as program design and training (BHI, GBV training, Community Integrated Management of Childhood Illnesses, etc.). Several UN agencies (UNICEF for example) have field offices in each of the former 10 states and have significant logistical capacity (technical staff, offices, transport, etc.) on the ground. Their reporting and communication mechanisms provide an opportunity not only for receiving up-to-date information on implementation realities on the ground, but they also work closely with periphery levels of the MoH such as County Health Teams. The World Bank will work closely with these partners for effective coordination on the ground and piggybacking of each agency's comparative advantages.

F. Lessons Learned and Reflected in the Project Design

92. **Given South Sudan's poor health outcomes, and its population's low access to and utilization of health services, the proposed strategic approach is highly relevant.** Lessons incorporated into the proposed project design were derived from previous and ongoing World Bank health operations in South Sudan, and from regional experience in strengthening health services. The principal challenges in South Sudan are to rapidly improve service delivery so as to improve the lives of citizens while at the same time building capacity of essential public services and systems. Despite the highly unstable environment, the World Bank has a comparative advantage (and remains part of the World Bank's key missions) to address challenges at the humanitarian-development nexus and aim to ensure life-saving services are available to the population while investing in capacity for the delivery of essential services for the future, independent of the unpredictability of the country context. Making progress on this dual challenge provides the rationale for this project.

93. **Experience from implementation of HRRP, as well as previous World Bank operations in the health sector through the MDTF, have provided a number of valuable lessons in working in a fragile context.** Despite the escalation of violence and increased of fragility during the project implementation, the project remained focused and clear about the trade-offs that needed to be considered between responding to needs and working towards sustainable changes. For instance, through M&E support provided at the county level, the MoH has been able to build its county monitoring system and produce monthly and annual MoH Health Management Information Systems (HMIS) reports. This has helped to generate key information about the health status of the population and which enabled the MoH and key partners to monitor the progress of their interventions and identify areas for improvement. Robust monitoring, verification and reporting mechanisms will be included in the proposed operation and build upon the abovementioned experiences from past operations.

94. **There is a need to adapt development interventions to the volatile and fragile context of South Sudan.** The HRRP project showed that the project design should include elements of flexibility and adaptability. Following the escalation of violence in December 2013 in the two states supported by the project, the need for health care services increased tremendously due to the growing number of IDPs fleeing violence and treatment of trauma cases. Moreover, the control of counties changed frequently between the Government and the opposition. These two main changes in the local context required a quick response. Therefore, the strong focus on local service delivery that was built in the project has allowed the CSDO to maintain neutrality in the face of ethnic and political conflict. The experience from HRRP showed that having just one CSDO has limited the project's ability to be agile in responding to evolving health needs and the government's ability to proactively manage contracts. The new operation addresses that by having two partners to cover the targeted population, each with their own comparative advantages. The combination of ICRC and UNICEF will allow for

quick adaptation and flexibility in project interventions in response to the ever-evolving situation in South Sudan, in particular in the former states of Upper Nile and Jonglei.

95. **World Bank projects in South Sudan should be able to demonstrate the capacity to adapt in response to changes, to help maintain service delivery, and mitigate the risk of heightened humanitarian crisis due to service collapse.** The World Bank approach should identify a list of early and longer-term actions when disruptions/risks appear and provide guidance for addressing changes in the fragile context. The approach should consider a short and realistic list of adaptations that could guide programs in response to changes within the protracted crisis (such as: program aspects that need to be reduced in case of insecurity, or supervision modalities if access becomes more limited).[24]

96. **Taking into consideration the abovementioned lessons, the proposed project has incorporated the following elements in its design and implementation arrangements, with the intention of building on past experiences:**
    (a) *Ensuring greatly improved geographical coverage of services:* To address the coverage issue, the project will support the largest possible geographical coverage of the former states of Jonglei and Upper Nile and strengthen outreach activities, thereby reducing gaps in service delivery. Despite everything, this project and others have introduced the idea of contracting of services, which would have potentially taken the country many decades to get to without the World Bank's support.
    (b) *Greater flexibility for addressing emergency health needs:* Both the overall project (through the CERC component) and the engagement of partners, will include emergency contingency mechanisms for rapid reallocation of resources to provide new and urgent health needs of populations affected by conflict, epidemics or natural disasters.
    (c) *Enhanced monitoring:* The project will strengthen national mechanisms for M&E of services, both in terms of quantity and quality. To improve monitoring, the project will invest heavily in data collection, analysis, and use, so as to maintain a focus on tangible results. Various performance monitoring mechanisms will be included to ensure that data reported is valid and target populations are actually benefiting from the financed interventions.
    (d) *Community feedback:* The community engagement supported by HRRP has already made progress on raising awareness and increasing service uptake. The planned enhancement of this community focus in the proposed operation, such as mobile outreach and systematic beneficiary feedback mechanisms, is likely to increase health outcomes for the people. The new operation will engage communities using the BHI initiative to ensure citizen voices are heard and incorporated in service delivery, and special surveys to capture community feedback. Community involvement, such as work with Community Health Committees and Health Facility Management Committees, will also ensure some degree of engagement in implementation.
    (e) *Modernize verification of delivery of pharmaceuticals:* Drug procurement and distribution is currently functioning quite well up until "last mile delivery," the latter constituting an unsolved problem. Stock outs are frequent, mainly due to the significant inefficiency in the timing of procurement of drugs and medical supply. Moving forward, the new operation will ensure that monitoring mechanisms, such as geotagged images and barcode scans, ensure clarity in the delivery and availability of critical inputs to health services, despite the World Bank's limitations in being able to conduct hands-on monitoring and supervision.

[24] South Sudan Education Note- Proposed Engagement Strategy and Next Steps.

97. **Ensuring a quick disbursing mechanism and working through specialized existing partner agencies for an effective emergency response.** Lessons learned from HRRP as well as other countries (Yemen, Somalia) reflect the critical importance of the World Bank's partnerships with the existing UN agencies and other partner organizations for ensuring basic service delivery during periods of conflict or urgent needs. As mentioned above, under the ongoing HRRP, after closure of the CSDO contract with an international NGO, UNICEF was able to rapidly step in to take over coordination and service delivery responsibilities for greater Upper Nile and Jonglei. Their responsiveness and ability to mobilize implementing partners, critical inputs and financing resulted in avoiding a gap in service delivery for the two former states, resulting in continuity of project implementation and achievement of results.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

98. **The IDA grant Recipients for this operation are ICRC and UNICEF. Both organizations have a strong focus on rural populations and hard-to-access areas where vulnerability is acute, allowing the project to target some of the most vulnerable populations in South Sudan.** While each organization will be responsible for a defined set of activities and geographical coverage, based on the project design and their institutional comparative advantages, together they will ensure an essential package of health services is provided to the project's target populations. Both organizations have significant experience supporting health service delivery in the targeted areas. Beneficiaries will include the greater population of the former states of Upper Nile and Jonglei, as well as specific target populations acutely affected by the conflict outside of the two priority former states. They will have sufficient autonomy in implementation, allowing them to respond in a flexible manner to ever-evolving conditions in the two former states.

99. **While the package of health services to be supported by ICRC and UNICEF will be similar in many ways, given the context-specific realities of South Sudan, each organization will adopt adaptive strategies to ensure these essential services are delivered.** The importance of leveraging these actors and providing an immediate flow of funds is necessary in the context of the operation to sustain existing momentum and scale up ongoing activities while also avoiding interruption to service delivery supported by HRRP.

100. **The project will use various mechanisms to target the worst off and use the comparative advantages of ICRC and UNICEF to ensure prioritized populations benefit from improved access to essential health services.** Those affected by conflict, displaced or isolated due to seasonal weather will be prioritized both in terms of financing as well as content of service delivery support. The project will ensure that similar essential packages of health services are provided to target populations in both government- and opposition-held territories. The prioritization of support efforts by ICRC and UNICEF will be based on population health needs, beneficiary eligibility criteria, without discrimination and independent of political/group affiliation. In addition to their main activities supported by the project, UNICEF and ICRC will coordinate with humanitarian agencies to identity and serve health needs for IDPs that might be in displacement camps.

101. **The project will ensure neutrality and impartiality in providing service delivery support to target populations with the clear objective of improving access to services for all people in the target former states.** Services will be delivered to populations without discrimination and independent of geographical location or political/group affiliation. The experiences from HRRP regarding how to manage this in the current

context, such as the delivery of pharmaceuticals to both sides, medical airlifts from wounded on both sides, negotiating access across conflict borders, and facilitating agreements for safe passage will all be integrated into the approach to service delivery in the target zones. These lessons will be clearly outlined in the ICR for HRRP currently under preparation.

102. **The project is designed to harness the comparative advantages of ICRC and UNICEF by using their proven service delivery strategies in the country to meet the objectives of the project.** UNICEF will follow its own procurement procedures as Alternative Procurement Arrangements (APA) allowed by the World Bank New Procurement Framework Policy[25] Section III. F.[26] For the ICRC, the IDA grant will only finance staff, utilities and operational costs directly and indirectly related to the program defined under this project. As such, IDA financing will not be used for any procurement within the defined scope of activities implemented by ICRC. This implementation arrangement is recommended by the Project Procurement Strategy for Development (PPSD) based on the fact that the procurement procedures of UNICEF were assessed and found acceptable to the World Bank under other agreements, and project financing will not be used for any procurement under the IDA grant to ICRC. This procurement arrangement is considered a fit-for-purpose arrangement.

Rationale for UNICEF to be a direct Recipient of IDA

103. **UNICEF is a development and humanitarian organization with a proven track record of delivering results in 190 countries, including being operational in South Sudan since 1989, and has been supporting health service delivery in former Upper Nile and Jonglei under HRRP with successful results.** The project proposes to use the same implementation arrangements for supporting services in the two former states and would be a continuation of ongoing activities implemented by UNICEF. A change in partner organizations at this time would lead to elevated risks related to disruption of services in the project's target areas. Despite the achievements made by UNICEF under HRRP, UNICEF has not been able to support health services in certain areas of Upper Nile and Jonglei affected by conflict or held by opposition groups. By engaging ICRC, these critical gaps in the two former states will be filled and more comprehensive coverage will be achieved.

104. **Ensuring flexibility and responsiveness of IDA Recipients in implementation will be essential to the success of the project.** It is necessary that the project includes a level of flexibility in the geographical targeting of supported interventions, due to the ever-evolving state of the conflict and unpredictability of violent events outside of the two former states. An important argument for provision of funding directly to both ICRC and UNICEF is to ensure that both Recipients have sufficient autonomy and flexibility to respond to ever-evolving needs that have no geographical limitations. Lines of conflict continue to change, and the two organizations will coordinate efforts to ensure that coverage to the intended beneficiaries is maintained despite changes in accessibility. A situation where ICRC is a direct Recipient of IDA and UNICEF acts as a PIU for the Government may create a situation where one organization may be impeded to respond quickly while the other has the flexibility to do so. The importance of leveraging partnerships with organizations that can ensure services are provided even during surges of violence and conflict will be essential to achieving the objectives of the operation. The immediate mobilization of resources to support the provision of essential health services is necessary in the context of the operation to sustain existing momentum and scale-up ongoing activities, while also avoiding interruption to service delivery supported by HRRP. To ensure sufficient flexibility to quickly respond to urgent needs, in coordination with ICRC, the proposed direct financing to UNICEF is deemed a fit

[25] New Procurement Framework and Regulations for Projects After July 1, 2016
[26] Approval was received from the Corporate Procurement Officer on December 6, 2018.

for purpose arrangement.

105. **The World Bank has experienced significant challenges implementing projects government-managed Project Implementing Units, even if the majority of activities are contracted out to non-state implementing partners.** While the HRRP has surely contributed positively to providing health services in the two former states, results from the project show that coverage remained ineffective due to various capacity challenges, as mentioned in the summary of lessons from HRRP presented earlier in the document. Such implementation challenges have severely impacted the potential achievements of the HRRP which aim to be avoided with the proposed operation. Implementation progress under the ongoing contract between UNICEF and the Ministry of Health has been effective but could have been even better if more facilitation had been provided by technical staff in relevant Government departments. Having UNICEF as a direct IDA recipient would contribute to resolving many of implementation bottlenecks.

106. **UNICEF, with their implementing partners and use of their field offices) and logistics platforms, will provide support to the approximately 200 PHC facilities and several strategic secondary facilities in the counties of the former states of Upper Nile and Jonglei that are currently relatively accessible.** Activities to be managed by UNICEF include contracting of facilities, paying health worker incentives, procurement and delivery of essential commodities, training, coaching, supervision, and facilitating reporting at scale across contracted facilities. It should be noted that many of these health facilities also receive support from other development partners and humanitarian agencies. Coordination efforts between UNICEF, partners and MoH to avoid overlaps and redundancies will be made through meetings at the country and state health bureaus, as well as in the health and humanitarian coordination clusters in Juba. It will also play an overall coordination function to ensure that there are no gaps in service delivery and that duplication of effort is minimized. UNICEF performance, both in terms of implementation successes as well as results in service delivery, will be measured by the performance monitoring entities.

107. **UNICEF has existing institutional and implementation channels for the delivery of essential services and ensuring the availability of critical medicines nationwide.** These implementation arrangements, which have proven successful in the past, have been able to adapt to the context and remain flexible, based on the security situation, health priorities, and strategies for negotiating access to hard to reach populations, to provide the identified package of healthcare services. Therefore, both organizations will work with the existing local health system structures at the governorate, district and community levels to preserve the national capacity and maintain the core functions of the health system.

Rationale for ICRC to be a direct Recipient of IDA

108. **ICRC is a neutral, impartial and independent humanitarian organization, which has a mandate to assist and protect people affected by armed conflict and other violence.** Based on its mandate, ICRC cannot be a Recipient of host-government-managed funding, which would impact negatively its ability to access populations on all sides of the conflict in South Sudan. Experience from HRRP has shown that challenges in equitable provision of health services due to conflict, lead to less than satisfactory coverage by the project. The process for preparing the project began with the World Bank exploring different potential implementation agencies operating in South Sudan who could support meeting the PDO and through consultations in South Sudan identified ICRC as the only actor capable to reach these normally inaccessible areas and willing to engage with the World Bank through the proposed project. By providing direct IDA financing to ICRC, the

project will contribute to enhanced access to areas and populations that were previously difficult to reach, due to the independence, neutrality and impartiality of the partner organization mobilized.

109. **ICRC, using its own internal service delivery mechanisms, will provide support to approximately 25 primary health centers and two secondary hospitals that serve highly vulnerable populations affected by conflict, primarily in the former states of Upper Nile and Jonglei.** The areas that will be covered by ICRC are those that remain inaccessible to other partners due to insecurity, often being controlled by opposition and weapons-bearing parties. ICRC already has a significant presence in former Upper Nile and Jonglei, consisting of a network of sub-delegations and field offices. While accessibility issues cause significant logistical challenges and high costs to guarantee appropriate services are offered, ICRC remains one of few organizations that has the capacity to reach these areas, and willing to scale-up support to beneficiary populations targeted by the project.

110. **While the majority of the proposed locations to be supported by ICRC are in the former states of Upper Nile and Jonglei, about one-third of locations are outside the two former states, specifically in former Western Bahr el Ghazal State, former Unity State, and former Greater Equatoria State.** The process for the World Bank to approve locations where ICRC will implement project activities was discussed and agreed upon between the World Bank and ICRC during appraisal. ICRC has formally provided the list of health facilities to be supported, for which the World Bank has approved and can be found in project safeguards documents. If there is any change in project locations, the revised site list will be submitted by ICRC to the World Bank for review, and non-objection will be provided prior to using project resources being used at the new sites.

111. **Closing date and implementation schedule.** Given IDA resource constraints, the unpredictable setting and urgent health needs in South Sudan, the planned activities under the proposed operation have an estimated budget for 24 months. An additional nine months is added to the project duration to allow for both flexibility to adjust strategies and timelines given the unpredictable environment, as well as to allow for the financial closure undertaken by the partner organizations.[27] Refinancing of Project Preparation Advances from other operations will be conducted through the UNICEF Financing Agreement and processed immediately after effectiveness. Therefore, it is envisaged that the proposed US$105.4 million IDA grants will be disbursed over the period of 24-30 months, with the project closing date being December 31, 2021.

B. Results Monitoring and Evaluation Arrangements

Monitoring Arrangements for the Project

112. **The Results Framework for the proposed project focuses on accountability for results in the delivery of the basic package of health and nutrition services, including emergency services.** The project's approach to results monitoring aims at extending beyond tracking of inputs and outputs by placing a strong emphasis on measuring actual service delivery outcomes. The task team has had extensive conversations with ICRC and UNICEF with regards to their internal M&E systems and has deemed them adequate to monitor and report on project performance. For ICRC, quarterly financial and technical reports will be provided. For UNICEF, detailed technical reports will be provided biannually with narrative updates on the overall project implementation

[27] Under UNICEF rules, there is a financial closure period of twelve months during which the ongoing activities need to be wrapped up (that is, goods delivered to the country, consultants' reports submitted, all invoices to subcontractors paid, and so on).

and results as well as reporting on the project's Results Framework indicators. In addition, to the biannual reports, quarterly matrices will be provided which will contain updated on progress of Results Framework indicators as well as social and environmental safeguards. Both partners will be responsible for the setup of a results monitoring system that will allow reports to be generated for the Results Framework and any related outcome and impact information for the project. The World Bank will share and discuss technical reports regarding the implementation progress with the MoH and other relevant government actors.

113. **Routine monthly and quarterly data collected via facility reports that will be aggregated for the project's quarterly and annual indicators and be linked to the extent possible to the District Health Information System (DHIS) 2 system that is being scaled up with support from various partners (Global Fund, WHO, this proposed project).** Experience from HRRP shows that investments in training and systems development at all levels of the system, particularly the health facility, county and state levels, have contributed significantly to strengthening the national health information system. Given the low levels of functionality of South Sudan's health information system and the specific focus of the project on former Upper Nile and Jonglei, the project did face limitations with regards to strengthening at the central level and having national impact. The proposed project aims to continue investing and supporting the health information system in South Sudan but contribute to the design and functionality of national health information and performance monitoring systems. The project monitoring system will include: (i) identification and consolidation of M&E indicators; (ii) training of service providers and capacity building initiatives conducted by ICRC and UNICEF; (iii) standardized methods and tools to facilitate systematic collection and sharing of information (or using those that already exist where appropriate); (iv) facility on-site verification including patient exit interviews; (v) LQAS surveys to measure population coverage of health services; and (vi) the monitoring mechanism put in place by the South Sudan Country Management Unit (CMU) to monitor all projects in the World Bank's portfolio.

114. **All routine health interventions supported by the project will use the HMIS (to the extent possible DHIS2) in conjunction with data and information provided by implementing partners.** Data from health facilities in the project's targeted areas will be closely monitored by partner organizations, along with corrective actions identified and undertaken. The data for monitoring will come from: (i) the national health management information system (HMIS/DHIS2); (ii) a standardized Supervisory Tool/Checklist to assess and monitor quality of care; and (iii) internal monitoring, auditing and verification mechanisms of UNICEF and ICRC. In addition, there will be a clear M&E plan for implementing partners sub-contracted by UNICEF. These plans will be linked to government health facility catchment areas to ensure that integrated state-level MoH M&E systems are used.

115. **The World Bank will conduct regular "reverse" implementation support missions with UNICEF and ICRC to discuss progress, implementation arrangements, and solution-oriented action plans.** These missions will be conducted biannually in Juba to: (a) review implementation progress and achievement of the PDO and intermediate indicators; (b) provide support for any implementation issues that may arise; (c) provide technical support related to implementation, achievement of results, and capacity building; (d) discuss relevant risks and mitigation measures; and (e) monitor the health system's performance through project data, progress narratives and monitoring reports. Field visits are not expected to become an option during the lifetime of the project, but if they do they will be added to the options for implementation support missions.

Performance Monitoring Arrangements

116. **In addition to internal monitoring mechanisms, the project will deploy to accessible areas an independent monitoring system to assess project implementation and impact in areas where monitoring activities are possible to conduct, where issues related to security and confidentiality are less of a concern.** The monitoring model for South Sudan aims to provide comprehensive, definitive, and routine information on availability and basic performance of health services at health facilities. Monitoring activities will provide information to drive strategic planning and response, encourage partner accountability, and inform targeted distribution of health resource and delivery of health services. The major output of the third-party monitoring will be to provide a definitive, reliable, and up-to-date database and information products on health service availability in South Sudan and in particular in the former states of Upper Nile and Jonglei.

117. **Monitoring activities will be done to monitor health service availability data in accessible areas of the former states of Jonglei and Upper Nile, and to compare the data sets to similarly collected data from the rest of the country.** The design of the monitoring methodology was done jointly between MoH, HPF partners and the World Bank to ensure that comprehensive, definitive and routine information on availability and quality of health services throughout South Sudan. UNICEF will contract the monitoring entities directly in accordance with UNICEF procedures. The detailed monitoring reports will be shared with World Bank by UNICEF. The monitoring entities quarterly reports will be shared with the World Bank and will include recommendations on implementation issues identified during verification visits. Quarterly meetings will be organized between MoH, HPF, World Bank, and partner agencies where the results of health service functionality data will be presented and discussed.

118. **The experience of HRRP has shown that monitoring can be challenging in opposition-held zones and areas affected by violence and seasonal accessibility constraints.** As such, the "harmonized monitoring approach" mentioned above will apply only to more accessible areas in the two former states. In hard to reach areas where the independent monitor may not be able to access, ICRC will apply enhanced monitoring and data collection approaches that triangulate programmatic and georeferenced data on project implementation and results. Concretely, health facilities supported by ICRC will be excluded from independent monitoring activities due to (i) issues related to inaccessibility due to conflict/instability, and (ii) sensitivities surrounding external parties collecting data and anonymity of target populations.

119. **To strengthen monitoring activities in the project zones the project will harness disruptive technologies for FCV contexts in collaboration with the Geo-enabling for Monitoring and Supervision (GEMS) initiative (P167344).** The GEMS method is an ideal add-on to project monitoring as it allows for 'monitoring of the monitors' through a very simple approach[28]. The task team will be able get information from the field in near real-time, rather than just a report. Moreover, the date, time and global positioning system (GPS) data cannot be manipulated, allowing to always know when and where the monitoring was active. A training for the monitoring entities on use of the Kobo Toolbox, organized by the team, took place in December 2018.

120. **The harmonized monitoring approach for HPF and World Bank-supported zones will include the following activities:**
    (a) **Creation of a master health service functionality database, capturing development and humanitarian health services across donors:** Donors, fund managers, government officials, implementing partners, and

[28] Monitoring agents fill in a questionnaire when in the field and all collected data, date/time stamps, GPS coordinates and pictures automatically feed into a central monitoring system.

other key stakeholders will be convened to establish common functionality definitions, as well as standard performance indicators and data collection tools. Efforts will be made to use existing data and data reporting flows as much as possible, though some changes may be necessary to allow for responsible merging of data. Once common definitions for variables are defined, analytical software will be used to clean and merge the respective datasets into one, definitive health service functionality database to produce nationwide analysis on health service availability and functionality. Over time, this database will be linked to DHIS2 and an analytic dashboard will be built to allow for users to view service availability in locations of interest on their own.

(b) **Verified data within database to increase confidence in analysis and reported results and provide measures of partner data quality and reporting accuracy:** Using a pre-defined sampling methodology that will include aspects of stratified random sampling and contingency modelling, the monitoring entities will conduct unannounced health facility verification visits to ascertain implementing partner data quality (i.e. accuracy of health service reports). The verification visits will provide an accuracy rate for health service reporting that will estimate the level of confidence one can place on reports from a specific geographic location or implementing partner.

(c) **Monthly health service functionality bulletin and implementing partner data performance reports:** Based on the routine data collected from implementing partners and the verification visits, the monitoring entities will produce a quarterly bulletin on health service functionality, analyzing reported available health services and examining specific areas of note each quarter. Over time, other datasets, such as immunization coverage and disease surveillance, will be integrated into the bulletin to provide a cross-cutting information product with sophisticated interpretation and analysis.

(d) **Service availability and performance indicators:** The monitoring system will track reported service availability and additional data elements on health service performance, to be collected from each health facility being monitored. These data elements, combined with population figures, will enable the system to compute an essential set of availability and performance indicators.

(e) **Citizen engagement and beneficiary feedback:** The performance monitoring methodology and reports will include citizen engagement mechanisms such as exit interviews conducted during data verification visits. The questionnaires will be customized to capture key domains on satisfaction and perceived quality of care, in order to capture community feedback on service delivery. Results from the quarterly monitoring reports will be used to engage with citizens on key elements related to improving service delivery in targeted communities.[29]

(f) **Quarterly technical review of health service functionality data with development and humanitarian stakeholders:** In the interest of facilitating data-driven decision making and coordination among stakeholders, the monitoring entity will convene quarterly technical review meetings with key stakeholders after the release of each quarterly bulletin and report. These meetings will bring together all relevant stakeholders to discuss the results of the analysis for the respective period and used as a springboard to identify lagging technical domains or geographical areas and identify opportunities for improvement and course correction.

(g) **LQAS to measure coverage of key health service delivery indicators:** National LQAS surveys will be conducted with the aim of producing information that can be rapidly interpreted and used by development partners to identify which counties reach or do not reach anticipated coverage rates for key health services. The LQAS will also be used to estimate coverage proportions at state level with 95 percent confidence intervals that can be used for refining program strategies, strengthen reporting and allocation

[29] Results and achievements from the performance monitoring arrangements, including citizen engagement, are captured in the Results Framework indicator on monitoring reports

of resources for supporting health service delivery. Lastly the LQAS will compare findings from previous surveys to measure key core outcome indicators at county, state and national levels for the purposes of planning, monitoring, and evaluation.

Monitoring Arrangements for Areas with Challenges in Accessibility

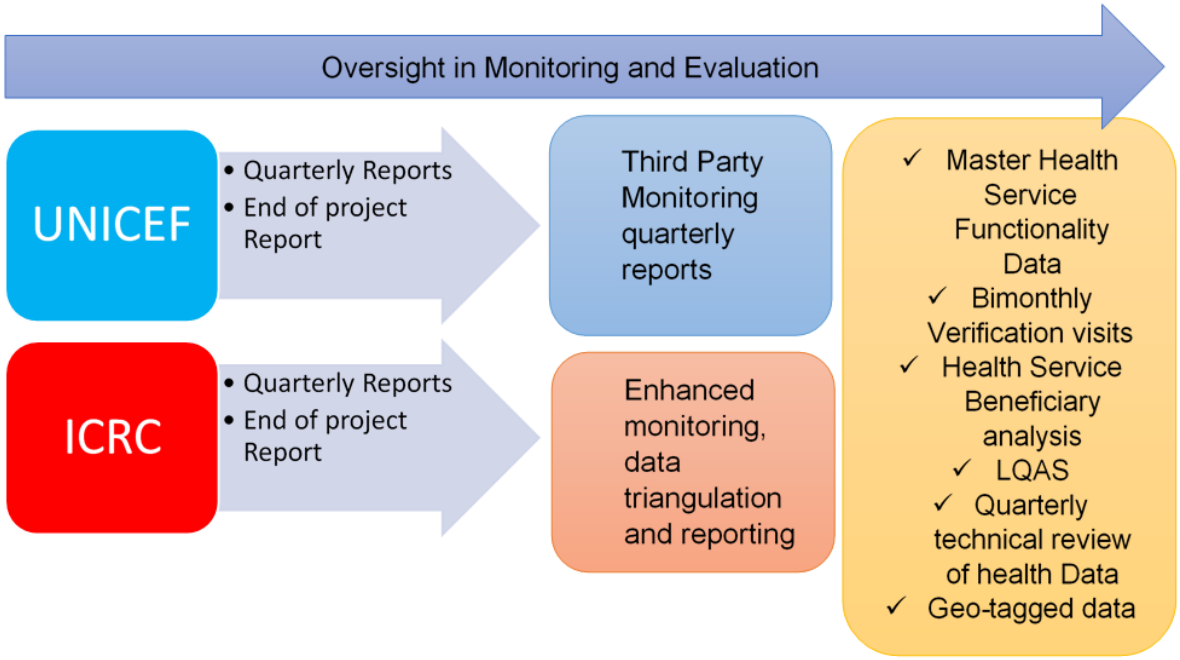
121. **Given the accessibility challenges and confidentiality issues that arise in the geographical areas supported by ICRC, it was deemed unrealistic and inappropriate for an external monitoring agent to engage in these areas.** Given that beneficiaries of this component will be residing in opposition-held areas, or affected by active conflict, when developing monitoring mechanisms for the operation, the project will be particularly mindful of the sensitivity around data harvesting, processing, storage and use, putting the potential threat this could expose the affected population to at the forefront of the intervention.

122. **As such, the World Bank has worked closely with ICRC at both the headquarters and country delegation levels to identify opportunities to use ICRC's robust internal monitoring and reporting mechanisms.** These different mechanisms would allow for triangulation of routine programmatic data (results indicators), georeferenced data on service delivery and delivery of commodities, and beneficiary feedback mechanisms from community members and recipients of services. Newly developed in-house technologies (such as using the Device Magic[30] program) allow for robust monitoring and reporting within ICRC. Data from ICRC programs or assessments collected in the field are sent back to a central office location to be reviewed by stakeholders. With the help of the data being collected through such technology, ICRC is able to evaluate the effectiveness of their assistance programs and make sure that beneficiaries are receiving the necessary resources.

123. **For the World Bank and ICRC's proposed engagement in South Sudan, the line of thought that has been pursued during preparation has been on how to triangulate data, beyond the classic ICRC-generated monitoring and reporting on the provided indicators, to produce a robust monitoring and reporting platform that tracks results achieved in health facilities supported by the operation.** To that end, three processes with regard to results and implementation monitoring will be applied for ICRC-implemented activities. These will include both corroboration of 'hard' inputs (i.e. that health care facilities do exist and that medical supplies have been provided for their functioning), and corroboration of 'soft' inputs (i.e., that health care facilities have been benefitting from ICRC staff's expertise and support). The monitoring mechanisms include the following:
    (a) Geo-tagged pictures of health care facilities (the acceptability of geo-tagged pictures will need to be cleared with the relevant authorities, whilst photography of individuals is prohibited by ICRC rules for security considerations);
    (b) Provision of proof of transfer of medical supplies (i.e. ICRC way-bills and donation certificates signed by the relevant non-ICRC heads of health facilities); potentially additionally triangulated with a geo-tagged proof of (bar-coded) consignments having arrived to the GPS coordinates of the health-care facilities (the acceptability of geo-tagging still needs to be cleared with the relevant authorities); and
    (c) Provision of the ICRC GPS data logs of its vehicles having done the journey to the GPS coordinates of the health facilities.

[30] Device Magic is fully functional in remote locations where there is no cellular or Internet connection.

Figure 5: M&E Framework for Provision of Essential Health Services Project



C. Sustainability

124. **The economic situation in South Sudan will remain bleak for the foreseeable future, which greatly limits the chances of the proposed program being sustainable in terms of public financing once the project closes.** The ongoing conflict and economic mismanagement has forestalled normal economic activities that would otherwise lead to economic transformation of the country where the Government would begin to take a bigger role in service delivery. While dialogue towards peace and shared power is ongoing, the Government of South Sudan and opposition groups are still engaged in conflict, with military expenditures diverting resources from other investments, exacerbating the macroeconomic crisis. Various factors greatly limit the chances of the proposed program being sustainable.

125. **While the proposed change in implementation arrangements will establish a new type of relationship with the Government, the project still maintains a clear intention to strengthen the delivery of essential services, with a focus on strengthening service delivery platforms and coordination mechanisms.** The project has a strong focus on strengthening human resources for health through training service providers in clinical aspects, management, reporting, as well as managers at the periphery (county) and intermediate levels (state) with regards to supervision capacities, supply chain management, planning and coordination skills, information systems and data management, etc. ICRC and UNICEF will use a mix of supporting existing health workers already at health facilities as well as support county health departments and facilities with the recruitment of trained staff. This will contribute towards a stronger public health system and longer-term sustainability of efforts. Finally, the project supports a national performance monitoring system that will significantly contribute the national health information system as well as strengthening alignment of donor financing and unification of processes and tools.

126. **The World Bank Group is proposing to focus on supporting basic needs and livelihoods to help prevent further deterioration in the crisis, in line with the CEN.** The short-term strategy is focusing on protecting basic health needs and strengthening overall resilience. The comparative advantage of the World Bank Group, in this kind of setting, is its ability to strengthen the humanitarian peace-development nexus.

127. **There is strong commitment of partners to continue to support health services to the population of South Sudan.** Using ex-post verification mechanisms including third-party monitoring will ensure credible implementation of the project activities, as well learning from data from the project that will contribute to health sector policies and potential future World Bank engagement in the South Sudanese health sector. The proposed operation not only continues the World Bank's engagement in the sector but will contribute significantly to efforts to improve harmonization and alignment to support the country's health sector, have a greater focus on results, and ensure appropriate risk mitigation mechanisms are in place to guarantee partner investments are indeed reaching target populations.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

Economic analysis

128. **Investing in South Sudan's health sector has the potential for large benefits that fit well into the country's context.** The overall development impact of the proposed operation will be the improvement of the health of women, children and adolescents in the most conflict affected areas of South Sudan. One of the core reasons why there are high rates of maternal and child mortality in the country is the absence of a functional health system. Extended periods of fighting have disrupted livelihoods and businesses resulting in the dire macroeconomic context.

129. **Investing in the health sector goes beyond improving the health system.** will have a direct impact on the health of 3 million people in the former states of Jonglei and Upper Nile (28 percent of South Sudan's population). This operation will be the primary source of financing for the delivery of health services in these two states. For the time being, there is no realistic alternative to this operation for supporting basic health services at scale in the geographical areas targeted by the project. Donor funding for health remains limited and key sources such as HPF and United States Agency for International Development (USAID) are already overstretched supporting other parts of the country. As such, 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 former states will further deteriorate their health status.

130. **The proposed project addresses the largest part of the burden of disease and the most lives lost.** Through its focus on improving maternal and child health, this proposed operation focuses on the most cost-effective activities and interventions focusing on provision of high-impact interventions such as immunization, safe delivery, nutrition, insecticide-treated bed nets, vitamin A, and malaria treatment. The project addresses the most common causes of premature death in the target states of Upper Nile and Jonglei. Its interventions target infectious diseases such as malaria and cholera, maternal and neonatal complications and nutrition deficiencies, access to drugs and medical consumables that together accounts for nearly 70 percent of total

years of life lost. The project targets most of the top 10 causes of premature death in women and children in South Sudan.

131. **The proposed project will support evidence-based cost-effective solutions.** By supporting the delivery of health services at the community, primary and secondary levels, the proposed operation will be supporting a highly cost-effective measure with a well-documented impact on averting maternal and neonatal deaths. In addition, the bulk of the services are to be provided at primary and outreach levels. PHC services have the advantage of being more accessible to communities, and where staff exist, they are less costly and more easily able to provide comprehensive and integrated care. This argument makes the case for focusing on primary care rather than hospital level care wherever possible.

132. **The proposed operation also encourages better record keeping and accountability for results.** Due to its strong in-built M&E tools and systems, the project will support the development of a culture of systematic data collection, analysis and use in decision making. In addition, it will strengthen accountability for achieving results, all areas that are currently weak in the country.

133. **Economic impact of the operation**. The project is designed in part to address market failures in health in South Sudan. Low immunization rates and limited access to services that tackle malaria and other infectious diseases represents market failures due to large externalities from communicable diseases. The economic return of investment in basic primary care, especially for children and mothers, has been extensively demonstrated. Evidence shows that improving health can contribute to economic growth by promoting human capital formation and increasing labor supply and productivity. In Africa and Latin America, child health interventions to improve nutrition, provide vitamin supplementation, promote breastfeeding and institutionalize deworming (all include in the basic minimum package of care) have been shown to produce economic returns as well as health benefits. 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.

134. **Value-added of the Bank's engagement.** The proposed project and World Bank's engagement bring added value to the context in several ways, both in terms of financial contributions to the health sector, but also technical design. Through the proposed project, the Bank is building on both past experience in the country's health sector and improving in design, as well as international experience, leading to the introduction of innovations in service delivery in challenging contexts like South Sudan. The value added of the Bank for the proposed project is also demonstrated by its ability to convene diverse partner organizations together to help support a common goal, improving access to essential health services in South Sudan.

Technical Analysis

135. **The proposed support by partner agencies through the project to the MoH at the national and lower levels will strengthen its implementing capacity in management of health services and will contribute to the sustainability of the program.** This operation has been specifically designed to ensure that the South Sudanese population in the targeted areas continue to have access to critical healthcare services. To guide the design of the operation, several key principles were used in formulating the project activities:
    (a) Achieve a balanced approach on two fronts: (i) providing a package of essential health and nutrition services based on the principle of continuum of care throughout the lifecycle (childhood,

adolescence/adulthood, pregnancy, childbirth, postnatal period), and among models of service delivery (including clinical care settings, outreach, and household and communities); (ii) supporting the primary care facilities and first level referral centers with the basic inputs for maintaining their operational capacity, and (iii) keeping the design flexible enough to respond to the fast-paced changing context during the conflict.

(b) Support the delivery of an integrated package of services building on the experience of the ongoing IDA funded health operations. There are predefined guidelines and protocols for integrated service delivery and facility-based health planning that are suited to South Sudan and are consistent with the current capacities in the country. These standards ensure that: (i) delivery through fixed facilities is based on realistic distribution of services that ensure efficiency and optimum use of the limited resources; (ii) routine outreach and community-based services are planned to complement delivery through fixed services, where appropriate; and (iii) mobile teams respond to the needs of disadvantaged groups in areas lacking functional fixed facility or overwhelmed by IDPs. The project also builds on the balanced concept of using the flexibility provided by working with partner agencies for project stewardship and implementation oversight, while using the experienced and trained capacities working at decentralized state ministry of health and CHD levels.

136. **Partner agencies will engage the decentralized organizational and technical structure of the MoH to**: (a) achieve basic service delivery to the South Sudanese population in general and the disadvantaged groups in particular; (b) maintain, revive and retain the South Sudan health operational capacities especially at the CHD levels; and (c) prevent the collapse of the South Sudanese health facilities and maintain the basic foundations and institutions for the post-conflict recovery phase. The project will also engage, where appropriate and according to the changing situation in the field, a wide network of non-state partners, including community-based organizations and NGOs.

137. **The proposed activities to be supported by the project are in line with national priorities and international standards.** Activities being proposed for the operation will address not just the project development objectives but also national priorities. South Sudan has one of the highest maternal mortality ratios in the world. By continuing to support PHC, the proposed operation addresses key pillars of the South Sudan National Health Strategic Plan, such as reproductive health and nutrition. Project preparation took into account the lessons learnt from the previous project financed by the World Bank and the relevant experiences of international agencies working in South Sudan were considered.

Climate vulnerabilities, mitigation solutions and adaptation measures

138. **This project has been screened for climate change and the following vulnerabilities were identified through the process.** The overall assessment of potential risks in the Summary Climate and Disaster Risk Screening Report is assessed as “high” due to extreme precipitation and flooding, as well as drought. These are likely to impact target beneficiaries in the project’s locations during implementation. Women and children were specifically identified as particularly vulnerable to impacts from climate change. In South Sudan in general and the former states of Upper Nile and Jonglei in particular have both dry and rainy seasons. During the dry season, temperatures can become extreme and affect mobility and operation of both service providers and target beneficiaries by exacerbating future drought risk. Conversely, during the rainy season there is, extreme precipitation and flooding happens annually, which severely affects accessibility to health service providers. These increases in rainfall and flooding may encourage the range and prevalence of infectious disease vectors

including malaria and other diseases. Of note, extreme weather patterns are undermining already vulnerable livelihoods and existing coping strategies, negatively affecting food security and nutrition of the communities in the catchment areas. The project intends to address these vulnerabilities through the following mitigation and adaptation measures.

139. **As described above, the excessive reliance on fixed health facilities combined with the low density of these, together with the low numbers of qualified health workers, presents a significant challenge to service delivery.** These challenges are exacerbated by seasonal flooding and droughts, which together with conflict, has led to an increase in displaced peoples and refugees. This project will implement mitigation solutions to this climate challenge by strengthening outreach activities, particularly during the dry season. In addition, by strengthening the accessibility of PHC services as well as delivery pathway to secondary health care, the geographic scope of essential health services the project will reduce the number of emergency evacuations carried out by helicopter by the ICRC. In addition, these service improvements will also reduce the need for healthcare related transport more broadly, such as ground ambulance trips, staff and service user travel. The estimated savings will be significant. The minor renovations supported by the project will support climate-friendly technologies such as use of renewable energy supply and energy saving appliances, in particular in relation to cooling technologies and the cold chain. Further mitigation benefits will be realized through improved procurement practices that will seek to reduce the embedded carbon in medications and other medical supplies.

140. **In terms of adaptation measures the project will strengthen emergency/disease surveillance preparedness and response capacity to detect monitor and respond to vector borne diseases, many of which are particularly climate sensitive.** This will have additional equity benefits particularly for displaced and vulnerable populations who are also disproportionally affected by climate. In addition, by expanding coverage and access to health service in areas with intermittent periods of access, due to drought and floods, the project will increase the resilience of community's both in terms of the direct provision of health services including nutrition as well as improving the wider environmental and social determinants of health.

B. Fiduciary

(i) Financial Management

141. **Significant risks exist within the country environment which could impact the Financial Management (FM) arrangements of the project.** These include challenges of insecurity that could impede access to the intended beneficiaries and the weak institutional capacity of the Government which could adversely affect service delivery and raise the risk of transparent stewardship of funds. Furthermore, project supervision will be challenging due to insecurity, and the verification of project outputs will be difficult and costly due to the inherent physical and logistical constraints of visiting multiple locations. There are also inherent risks in the project design given the decentralized nature of the project and the fact that it will be implemented in two of the most isolated and conflict-affected former states in South Sudan. The project activities involve provision of basic health care including distribution of pharmaceutical commodities to beneficiary health facilities.

142. **These risks are effectively mitigated through the involvement of UNICEF and ICRC in the implementation of the project.** Both organizations are non-sovereign recipients with strong presence in South Sudan and have the capacity and experience implementing similar projects in the context of South Sudan such as the current

IDA-financed HRRP implemented via a partnership between UNICEF and the MoH. Each agency has demonstrated capacity to carry out procurement of drugs and provide health services in often hard-to-reach areas, including arrangements for effective supervision, monitoring and verification of project outputs in the field. Both UNICEF and ICRC maintain FM arrangements that are capable of providing reasonable fiduciary assurance to the World Bank regarding the use of project resources. In the case of the project, each agency would receive funds via a direct IDA grant. Consequently, the residual FM risk for the project is considered **High**.

143. **The current implementation modality involving UNICEF and ICRC responds to the heightened fiduciary risks and lessons learnt during the implementation of HRRP**. This includes incidences of ineligible expenditures and challenges of monitoring, verification and supervision of health service delivery in the two former states of Upper Nile and Jonglei due to insecurity. In addition, the general accounting capacity in Government as well as internal and external audit oversight needed further improvement. As an integral part of implementation support for the proposed project, the World Bank team will work with all the stakeholders to build long-term sustainable FM capacity in the portfolio. This includes targeted skills enhancement of Government staff in procurement and financial management, knowledge exchange during implementation support missions and participation in progress review meetings.

144. **UNICEF's FM arrangements are well aligned with the World Bank's requirements under World Bank Policy and World Bank Directive on IPF.** The FM arrangements are based on the Financial Management Framework Agreement (FMFA) to which UNICEF is a co-signatory. FMFA allows a UN agency to use its own FM rules and procedures, including recognition of the UN Single Audit Principle. UNICEF maintains adequate accounting capacity, robust internal control framework and effective fiduciary oversight arrangements. These arrangements satisfy the World Bank's requirements for accountability regarding the use of World Bank resources channeled to the project. In addition, UNICEF has the mechanisms needed to access project implementation sites in far-flung areas with insecurity concerns. Consequently, the project will rely on UNICEF's FM systems and capacity including accounting and internal control systems in line with the FMFA. Disbursement of funds will be based on the approved budget agreed with the World Bank and will follow the UN advance system. UNICEF will initially submit quarterly financial reports to the World Bank, which will be used to account for the advances in the World Bank systems. The quarterly financial reports will be submitted within 45 days after the end of the quarter. Based on the outcome of FM supervision of the project during implementation, the periodicity for the submission of the interim financial reports will be adjusted from quarterly to biannual. In addition, the terms of reference (ToR) for the TPM Agent will include confirmation of health service delivery including receipt of pharmaceutical commodities by the beneficiary health facilities. Annual external audit of UNICEF will be conducted by auditors certified by the UN Board of Auditors in line with the Single Audit Principle agreed with the World Bank.

Table 3: Eligible Expenditures for UNICEF

Category	Amount of the Grant Allocated (expressed in SDR)	Percentage of Expenditures to be Financed (exclusive of Taxes)
(1) Goods, non-consulting services, consulting services, training, operating costs under Parts 1.1, 2 and 3.1 of the project.	48,900,000	100%

Category	Amount of the Grant Allocated (expressed in SDR)	Percentage of Expenditures to be Financed (exclusive of Taxes)
(2) Emergency expenditures under Part 3.2 of the project (CERC Part)	0	
(3) Refund/repayment of preparation advances	3,900,000	Amount payable pursuant to Section 2.07 (a) of the General Conditions
TOTAL AMOUNT	**52,800,000**	

145. **ICRC FM arrangements can provide the World Bank with adequate financial reports on the use of funds.** ICRC's cost accounting system allows it to link expenditures, via analytical codes, to specific cost centers, including field structures. For purposes of this project, ICRC will report the costs related to 'Staff Related Expenses', 'Utilities', 'Rentals', and 'Overheads' linked to the health centers selected for the program. These line items will then form the eligible expenditure categories that are linked to the achievement of outputs under the health program. ICRC's accounting and FM systems have the capacity to prepare quarterly and annual financial reports of these selected expenditure categories for purposes of FM supervision and disbursements. No procurement activities will be financed under the ICRC agreement.

146. **As the selected expenditure categories are part of the regular ICRC chart of accounts, the project FM arrangements will be fully mainstreamed into ICRC's regular financial procedures and systems.** ICRC follows its own finance and administration manual which is in line with the International Financial Reporting Standards. ICRC will generate quarterly financial report of the eligible expenditure categories and submit to the World Bank within 60 days after the end of the quarter, to provide accountability over the funds disbursed from the World Bank. The financial reports will be presented in US dollars using the applicable exchange rate between the Swiss franc and the US dollar on the date of receipt of funds from the World Bank. Disbursements will follow the advance method based on a six months cash forecast submitted to the World Bank together with a withdrawal application. The eligible expenditure categories (line items) will be audited as part of regular audit of ICRC annual financial statements and the audit report will be shared with the World Bank within 6 months after the financial year end. In addition, the financial auditors will apply Agreed Upon Procedures (AUP) in accordance with ISRS 4400 to review those specific eligible expenditure categories based on agreed ToR. A report of the outcome of the special review (Agreed Upon Procedures) will be submitted to the World Bank together with the annual financial audit report and management letter.

Table 4: Eligible Expenditures for ICRC

Category	Amount of the Grant Allocated (expressed in SDR)	Percentage of Expenditures to be Financed (exclusive of Taxes)
(1) Staff and operating costs under Part 1.2 and 2.2 of the project.	23,300,000	100%
(2) Emergency expenditures under Part 3.2 of the project (CERC Part)	0	100%

TOTAL AMOUNT	**23,300,000**	

147. **Both UNICEF and ICRC will:** (i) maintain a FM system, including records and accounts, adequate to reflect the transactions related to the activities, in accordance with the respective Grant Agreements; (ii) prepare, on a quarterly/biannual basis, interim unaudited financial reports (IFRs), in accordance with the format agreed with the World Bank, adequate to reflect the expenditures related to the grant. The IFRs will be provided to the World Bank no later than 60 days (45 days in the case of UNICEF) after the end of the reporting period; and (iii) retain, until at least one year after the World Bank has received the final IFR in which the last withdrawal from the Grant Account was made, all records (contracts, orders, invoices, bills, receipts, and other documents) evidencing all expenditures in respect of which withdrawals from the Grant Account were made.

(ii) Procurement

148. **Based on the World Bank fiduciary assessments of ICRC and UNICEF, the World Bank agreed on the following procurement arrangements:**
   (a) **UNICEF**: UNICEF will use their own procurement procedures as APA allowed under Section III. F. of the World Bank: Policy Procurement in IPF and Other Operational Procurement Matters (July 2016). Approval from the Corporate Procurement Officer for use of APA was granted on December 6, 2018;
   (b) **ICRC**: the project will finance ICRC's staff, utilities and operational costs that are directly and indirectly related to supporting the project's activities in South Sudan. Therefore, for ICRC-implemented activities, there will be no procurable items financed by IDA, and thus the World Bank procurement procedure and policy will not be applicable.

149. **The procurement arrangement is recommended under the PPSD.** UNICEF's procurement arrangement is considered a fit-for-purpose arrangement for the project for several reasons:
   (a) The procurement activities proposed under Component 1 are within the mandate of UNICEF, and the same implementation mechanisms as applied in other World Bank financed projects, such as in Yemen, Iraq, and other fragile situations.
   (b) The agency has a strong presence on the ground, have proven that they are well-equipped to work in the challenging environment of South Sudan, and have the capacity to reach project beneficiaries.
   (c) Its experience specifically in implementation of World Bank-financed projects in South Sudan, such as the HRRP and Emergency Food Security and Nutrition Project (P163559), as well as projects in other FCV contexts.
   (d) The proposed implementation arrangement is flexible, and the project will benefit from UNICEF-established partnership agreements with the local partners in health service delivery activities under a threshold as prescribed by the country office.
   (e) UNICEF has a well-established country office with well-staff satellite offices throughout the country, providing Immunization and Nutrition services, and therefore has preparedness and mobilization mechanisms in place, which enable optimal emergency procurement in case of an emergency.
   (f) UNICEF's procurement arrangements provide reasonable assurance that the World Bank's financing will be used for the intended purpose.
   (g) UNICEF has an extensive pool of framework agreements with pre-qualified suppliers in place ("Long-Term Agreements") that can be tapped into for promptly placing the purchase orders for the medical and pharmaceutical items.

150. **Given the World Bank procurement-related dialogue with ICRC on outstanding issues not concluded, no assessment was further conducted for the proposed project, and as such under the proposed project implementation arrangements, there will be no procurable items financed by IDA resources, but rather project resources will finance ICRC's staff, utilities and operational costs directly and indirectly related to supporting the defined health program in South Sudan.** Therefore, the World Bank's procurement regulations will not apply.

151. **A procurement assessment of UNICEF was conducted.** The findings are outlined below.

152. **UNICEF Procurement Rules and Procedures were assessed against World Bank's core procurement Principles and Governance requirements, conducted by Operations Policy and Country Services (OPCS) in May 2017 as part of global World Bank-UN engagement and approval for the Standard Agreement for Delivery of Output.** The findings revealed UNICEF procurement rule and procedures met the World Bank's requirements. The World Bank also conducted supplementary procurement capacity assessment of the UNICEF South Sudan office to manage project procurement with main focus on the staffing and experience, procurement oversight arrangement and general country office procurement performance. The findings and recommendations were discussed, agreed and summarized in Annex 1. The risks and mitigations measures from the findings of the assessments included in Annex 1.

153. **Project Procurement Strategy for Development and Procurement plan.** A draft PPSD for the project was prepared and accepted before negotiations, and in accordance with Paragraph A.3 in Section III of the World Bank procurement guidance: "Procurement in Situations of Urgent need of Assistance or Capacity Constraints," finalization of the PPSD will be deferred to the project implementation phase. UNICEF prepared a draft Procurement Plan (attached in Table A1.5) for activities to be procured under Component 1 of the project, including details of the cost estimates, selection methods and market approach options and the time schedules. The World Bank will clear the initial Procurement Plan for the project detailing the activities to be carried out during the first 12 months. The Procurement Plan shall be updated as necessary and UNICEF will provide biannual updates as part of narrative progress reporting as well as biannual financial reports. Narrative progress reports will be submitted every 6 months.

154. **Procurement Risk:** The overall project procurement risk was assessed to be Moderate based on the country situation. The mitigation measures agreed with the supported agencies are summarized in Table A1.2 of Annex 1.

155. **Frequency of Procurement Supervision**: It is recommended to have one procurement implementation support mission every six months as part of the reverse project monitoring mission to review implementation progress reports from UNICEF to verify compliance to agreed mitigation measures outlined above. As the project will not finance any procurable items through the ICRC Grant Agreement, supervision missions will focus on UNICEF-implemented activities.

C. Safeguards

(i) Environmental Safeguards

156. **Environmental Assessment OP 4.01 is applicable to the project due to delivery of essential health services, to include antenatal and postnatal care, mental health and psychosocial support, expanded program immunization, and treatment for the most frequent diseases.** Potential adverse environmental impacts are expected to be limited, site-specific, and reversible. These impacts are expected to fall within one or more of the following categories: (i) provision, transport, storage, use and disposal of medicines and vaccines; (ii) medical waste management; (iii) worker health and safety; (iv) community health and safety; and (v) minor rehabilitation of current public health facilities. Minor rehabilitation will only occur within the existing footprint of public health facilities and will be limited to works critical to the functioning of the center, e.g. plastering and retiling; replacement of doors, windows, locks; repair of electrical wiring, water pipe inflow and outflows; etc.

157. **Two Environmental and Social Management Frameworks (ESMF) have been prepared, each with medical waste management details.** Each ESMF includes adequate mitigation measures for the rehabilitation work and a template for a Medical Waste Management Plan (MWMP), which is to be used as a basis to prepare adapted MWMPs prior to implementing partner support at each health care facility site The Grievance Redress Mechanism (GRM), as well as other community engagement activities, has been based on Social Assessment work previously conducted on groups present in the former states of Upper Nile and Jonglei. Both Recipients have capacities for applying international safeguards best practices as highlighted by many years of positive contributions in the health sector in South Sudan. Safeguards compliance, including indicators reporting compliance at the level of each health care facility, will be included as a section in the biannual narrative progress reports. Quarterly reports will provide updates on Results Framework indicators and safeguards. The ESMFs include stakeholder consultations held on May 18, 2018 and are documented in both documents. The ESMFs and Social Assessments were reviewed and cleared, disclosed in-country and on the World Bank external website prior to appraisal. The ESMF for UNICEF was disclosed on the World Bank website on November 27, 2018 and disclosed in country on December 11, 2018. The ESMF for ICRC was disclosed on the World Bank website and disclosed in country on December 13, 2018.

(ii) Social Safeguards

158. **Positive social impacts are the core of the project's objective.** It will provide basic social services to the most marginalized and vulnerable populations and provide support for survivors of conflict and GBV. No significant, irreversible social impacts from proposed project activities are envisaged. The project will significantly scale-up attention and efforts to improve access to services for SGBV victims. CMR and basic psycho-social support services are included in the essential package of health services offered at health facilities supported by the project. This includes identification, counselling, management and proper referral for victims of SGBV. Second, the availability of trained medical personnel to provide CMR and basic psycho-social support services to SGBV victims will be increased. Health professionals at facilities supported by the project will be trained in appropriate counseling and psycho-social support. Third, specialized mental health expertise will be expanded within the health workforce, with health facilities supported by the project including MHPSS into the package of services offered and service providers trained in the subject. Finally, Codes of Conduct will be applied and monitored for project-supported staff and included in all contracts of all IPs.

159. **The project will not support any construction of facilities on privately used lands.** However, it will support the renovation of some infrastructure services under component I. Hence, no land acquisition is expected and

OP4.12 on Involuntary Resettlement is not being triggered. Therefore, any activity (subproject) requiring land acquisition which would trigger OP 4.12 on Involuntary Resettlement, would be ineligible.

160. **Most beneficiaries in the project are considered to meet the criteria of OP 4.10 for Indigenous Peoples.** Both implementing agencies have prepared social assessments, and consultations have been conducted to understand communities' views on project intervention and assess their broad support for it. Vulnerabilities and related risks have been identified, including GBV, IDPs, and violent conflicts, and mitigation measures developed, which are embedded in project design and implementation. These include meaningful consultations throughout the project lifecycle, a functioning GRM, Codes of Conduct for project staff, consultants and contractors, awareness campaigns, a minimum of 30 percent female CHWs, a focus on support for survivors of GBV. The two Social Assessments were disclosed before project appraisal. The SA for UNICEF was disclosed on the World Bank website on November 27, 2018 and disclosed in country on December 11, 2018. The SA for ICRC was disclosed on the World Bank website and disclosed in country on December 13, 2018.

161. **As partner entities, UNICEF and ICRC will be responsible in the overall coordination, implementation, and monitoring of social safeguards instruments.** Their monitoring system will also be essential to identify early on any change in risk levels as well as provide insights on how to improve the social sustainability of the Project. The World Bank assessed UNICEF and ICRC's capacities to implement and report on safeguards measures and confirmed their capacity is fit for project implementation. The project will prepare and submit safeguards performance reports to the World Bank on a quarterly basis as well as inform it on any serious social incidents in relation to the project immediately in a timely manner. All parties will thereby strive to provide adequate information while at the same time protect beneficiaries, including confidentiality were necessary. All methods will thereby be adjusted to take into account the specific characteristic of the FCV situations in the project areas.

(iii) Grievance Redress Mechanisms

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

Grievance Redress Mechanisms for UNICEF-supported activities

163. **In line with the Accountability to Affected Populations humanitarian framework and the UN Secretary General's Bulletin, UNICEF South Sudan has established a GRM (typically known by UNICEF as a**

Complaints and Feedback Mechanism) both at central and project level to ensure that beneficiaries may communicate issues and concerns associated with the health care services they are being provided. The GRM has multiple access points (telephone, website, email and postal address), which are provided in the project's ESMF prepared by UNICEF. This information will be posted by the implementing partners at all health facilities. Community engagement and social accountability will also be fostered at the local level though community feedback mechanisms (e.g. Boma Health Committees). The Chiefs of Field Offices and the Chief of the Health Section at UNICEF will have overall responsibility to address concerns brought to the attention of the field office health focal point regarding any environmental and/or social impacts resulting from subproject activities.

164. **Complaints received through any of the above routes will be recorded and documented in the project file and progress reports from UNICEF to the World Bank will include the number and type of complaints and the results of their resolution.** Responsible staff will ensure that complaints and questions are registered, tracked and promptly resolved. Through UNICEF's C4D section and Field Operations Section, the Health Section will coordinate with local field staff and local government officials and community leaders to ensure prompt follow-up action in response to complaints received.

165. **Incident reporting in the conflict-affected context of South Sudan usually involves partners reporting the loss, looting and fraud of cash, supplies and equipment.** Under UNICEF South Sudan Standard Operating Procedures 2017/2025 of September 21, 2017, all UNICEF staff and staff of IPs have the responsibility and duty to actively contribute to preventing, detecting and combatting the risks of loss, incidents and fraud as well as to immediately bring to the attention of UNICEF any knowledge of these incidents.

166. **To strengthen anti-fraud governance, a register of losses, incidents and fraud reported by IPs was introduced in the South Sudan Country Office in August 2016.** This register is updated and managed by the Country Office's programme specialist (Quality Assurance) and captures on a timely basis all reported cases of loss, incidents and fraud related to UNICEF supplies and resources, in UNICEF and IPs. All reported cases of loss, incidents and fraud should be reported and investigated discretely and without prejudice. If a UNICEF or IP staff member is found guilty, disciplinary measures will be pursued as appropriate. Failure to report cases of loss, incidents and fraud is considered misconduct in itself. To bolster this process, the South Sudan Country Office Standard Operating Procedures address timely reporting of loss, incidents and fraud, defines clear and unambiguous reporting channels to strengthen the quality of reports and identifies responsible staff members and their respective accountabilities. This includes ensuring that IPs understand their role and responsibilities and are aware of how to report incidents of theft and looting to UNICEF through a standard incident reporting form. This is reinforced in standard partnership agreements as well as in UNICEF training with IPs.

Grievance Redress Mechanisms for ICRC-supported activities

167. **For ICRC-support activities, grievances will be addressed directly following the direct contact beneficiaries and communities have with ICRC staff, given the proximity sought, or through more formal channels via the ICRC head of the field structure.** Regular exchanges with traditional and official authorities, as well as CHCs of the given project catchment areas, allow for other structured opportunities for grievance expression, redress and monitoring by those involved.

168. **The ICRC's Community-Based Protection workshops in South Sudan often address grievances as part of the concerns raised by the community members the Delegation interacts and discusses with.** The ICRC in South Sudan also collects broader feedback (including grievances) through community-based activities, such as needs assessments for health or economic security, or water and sanitation. The ICRC does its best to respond to complaints and concerns in a timely and comprehensive manner, being sensitive to confidentiality and data privacy as the situation requires. Given the poor telephone coverage in South Sudan, the ICRC does not have a hotline in place to collect feedback/complaints. High levels of illiteracy among beneficiary populations suggests that comment boxes are also not ideal means of inviting and submitting feedback. Of note, the ICRC does have a global secure and protected 'IntergrityLine,' traditional mail and email reporting platform accessible to project beneficiaries.

Waivers and Exceptions Requested

169. **The following waivers are being sought from the IDA Board of World Bank Executive Directors:**

(a) ***Waiver of one of the IDA national allocation eligibility criteria in order to allow UNICEF and ICRC to receive the respective grants out of the IDA allocation for South Sudan.*** Paragraph 6 of Bank Policy - Lending Operations: Choice of Borrower and Contractual Agreements provides: "IDA normally makes credits to member countries only, whether the member itself or another entity is responsible for project implementation, to ensure that the full benefit of the concessionality of IDA resources is accorded to the members." The Government of South Sudan has requested the World Bank to provide financing directly to organizations to carry out operations for the benefit of the people in South Sudan due to capacity constraints of the government to effectively manage and implement operations. Given the situation in South Sudan and that the operation of both UNICEF and ICRC are uniquely placed in accessing the people who need immediate assistance within the territory of South Sudan, the proposed approach will strategically address existing gaps in service delivery and health needs for both conflict-affected and the general population, while maximizing the World Bank's comparative advantage and value addition by making resilience building a key underpinning of the interventions proposed to be financed under the operation. The specific rationale for UNICEF and ICRC being selected as direct recipients of IDA are outlined in the Implementation Arrangements section of the PAD.

(b) ***Waiver of the application of the IDA Commitment Charge to the UNICEF and ICRC for the duration of the Project*****:** Section III.2(b)(iv) of Bank Policy - Financial Terms and Conditions of Bank Financing and Section 3.01 of the IDA General Conditions for Credits and Grants require a recipient of an IDA grant or credit to pay a Commitment Charge on the unwithdrawn financing balance. Given that the current Commitment Charge for FY19 is zero percent and the expected timeframe of the project disbursements is two years, the financial impact of this proposed waiver is expected to be negligible.

(c) ***Waiver of Application of the Anti-Corruption Guidelines to UN Agencies:*** Section 5.14 of the IDA General Conditions for Credits and Grants for Investment Project Financing Projects requires a recipient of an IDA grant or credit to carry out the respective projects in accordance with the Anti-Corruption Guidelines. Due to UNICEF's institutional and policy constraints, the Bank's ACGs are not acceptable to UNICEF.[31] It is proposed to allow UNICEF to use its own procedures for fraud and corruption under alternative

[31] The following key issues are obstacles for the UN to application of the ACGs: (1) the "single audit rule" which prohibits audits of the UN agencies by the Bank, (2) the UN agencies have outstanding agreements with suppliers that they are unwilling to revisit to add third party audit rights for the Bank, and (3) no formal cross-debarment is in place between the Bank and the UN.

arrangements modeled on the integrity provisions of the Fiduciary Principles Accord, to which UNICEF is a party.[32] To preserve the jurisdiction of the Bank to sanction parties that engage in fraud and corruption in connection with the IDA Grant, we will make specific provisions in the relevant legal document. Additionally, the Bank would apply its suspension and debarment list to the portion of the IDA grant that will be made available to UNICEF for eligibility purposes. The Bank will reserve its right to investigate parties other than the UNICEF (e.g., suppliers), but the Bank will not benefit from formal "third party audit rights" embedded in downstream contracts between UNICEF and third parties.

V. KEY RISKS

170. **The overall risk is rated as High.** This operation will support health services delivery in one of the most challenging FCV contexts in the world. Not only will the project support South Sudan, it will target some of the areas most affected by the conflict in the country. The project will be implemented in one of the riskiest contexts in the World Bank's portfolio, and various aspects define the risks involved in supporting a project in South Sudan. Although the recently signed peace agreement has resulted in short-terms gains in stability, the security environment remains highly unstable and unpredictable. This results in greater risks than those found in non-FCV environments. More specifically, the acuteness of the violence and instability in the country set South Sudan apart from other FCV environments with even greater levels of risk.

171. **The risks will be high across the board, as evidenced from the HRRP implementation.** Throughout the implementation period of HRRP, facilities have been attacked and looted with the deaths of patients and health workers as a result. These risks remain a reality for the World Bank and partner agencies providing support to health services across South Sudan, particularly in the two former states of Upper Nile and Jonglei and thus will remain so for the proposed project. Every effort has been made, however, to mitigate potential risks through the proposed project design and implementation arrangements.

172. **Political and governance risks. The Report of the Commission on Human Rights in South Sudan from February 2018 highlights significant atrocities including widespread violence against civilians nationwide.**[33] New armed groups, currently estimated at 40, continue to emerge, mainly as a result of the spread of the conflict to the Equatorias and the northern part of the Upper Nile. The fragile situation has been exacerbated by the creation of 28, and later 32 States. Violence is considered even more significant in the two formers states of Upper Nile and Jonglei due to the ongoing conflict in certain locations. The Revitalized Peace Agreement, signed in September 2018, provides an opportunity for potential progress, yet the effects of the protracted conflict are still affecting the majority of the country's population.

173. **Macroeconomic risks. Despite its endowments in oil, agriculture and other natural resources, South Sudan's economy remains weak due to what many observers describe as economic mismanagement, the war, corruption and rent-seeking behavior** (ranked 179/180 by Transparency International 2017 corruption perception index; ranked 53/54 by the 2017 Ibrahim Index of African governance)**.** South Sudan has one of the least diversified economies in the world, a result of being extremely oil dependent. The large drop in oil prices in 2014 together with lowered oil production due to insecurity significantly reduced fiscal revenues, at

[32] A similar approach was adopted in the Yemen Emergency Health and Nutrition Project to allow WHO and UNICEF, respectively use their own procedures for fraud and corruption instead of the Anti-Corruption Guidelines.
[33] United Nations Report of the Commission on Human Rights in South Sudan, February 2018.

the same time increased military expenditures have deprived South Sudan of foreign exchange. As a result of the large drop, the economy was estimated to have contracted by about 11 percent in FY16 and further contracted by about 6.9 percent in FY17, and the fiscal deficit was estimated at about 14 percent of GDP in FY17. The share of health in overall government expenditure has been decreasing from 3.8 percent in 2006 to 2 percent in 2015. The commonly cited government expenditure figure of 4 percent is based on the approved budget, not on actual expenditure. Social budget allocations remain low while aid as a percentage of the government budget has risen significantly over the last few years.

174. **Technical design of the project and institutional capacity for implementation and sustainability risks. Some sources suggest that humanitarian aid has been deliberately blocked from reaching civilians perceived to be from the 'other side' or based on ethnicity.** People are fleeing as a result, leaving behind ghost towns and unattended crops, further exacerbating the food crisis. Hunger, lack of access to health care and schools are used to break down the other side in this conflict. The rights to life, physical integrity, to adequate food, water, healthcare, adequate accommodation and education are constantly violated.

175. **It is critical to recognize that after over five decades of continuous assistance and presence in South Sudan, international actors and the aid they provide are now an integral part of the local political economy.** There has been increasingly significant threats to the integrity of operations in South Sudan, particularly on issues around insecurity and looting, as trends appear to be worsening. While the attack at the Terrain compound in Juba in July 2016 brought the issue into the international spotlight, there has been no let up since: so far in 2017, 17 aid workers have been killed and detentions are a weekly occurrence. Most recently, the compound of Doctors Without Borders in Maban, Upper Nile, was attacked in July 2018 by looters from the local population, resulting in the organization suspending its activities in the zone. While most incidents affect national aid workers, international staff, including senior managers, have also been attacked and threatened. The overall effect has been to contribute to a climate of fear and insecurity within the humanitarian community.

176. **The targeting of ethnic groups and the complexity of political affiliations increase the complexity of delivering health services.** Experiences from humanitarian organizations provide valuable lessons about how to ensure neutrality and impartiality in the delivery of these services. Despite these lessons and the fact that partner agencies will be non-state actors, the proposed project will still be implemented in concertation with the Government of South Sudan, which carries additional complexity in addressing issues to cover entire target populations and ensuring independence in service delivery.

177. **The risk of disruptions in implementation and activities becoming suspended remains high, despite the mitigation efforts put in place and the building of the proposed project on deficiencies identified under HRRP.** Various mechanisms are proposed, both within agreements with the implementation agencies and across project components (for example, inclusion of a CERC). In addition, robust mechanisms for results monitoring and verification will continue and be strengthened, allowing for additional oversight in tracking project results and the effect of a suspension of project implementation or breakdown in overall service provision.

178. **The technical design of the project addresses these risks by using the comparative advantages of UNICEF and ICRC in order to reduce disruptions or blockages in the provision of life-saving health services.** While existing coordination mechanisms such as the Health Cluster will allow for the two agencies to coordinate

field activities, ICRC and UNICEF will also conduct bilateral meetings specific to service delivery activities supported by the project, to ensure that coverage in the former states of Upper Nile and Jonglei and other targeted areas is as extensive as possible.

179. **Environmental and social risks. Civilians have borne the brunt of the conflict as it evolved to include different ethnic, political, and resource drivers.** Attacks against civilians have not been limited to direct attacks on their lives but importantly has also included the systematic looting and burning of villages, destroying people's sense of security and ability to support and care for themselves. As a result, millions of citizens have been displaced, resulting in untold deaths from starvation, thirst, exposure, and lack of access to medical care.

180. **Sexual and gender-based violence remain acutely prevalent throughout the country.** In the February 2018 report, the UN Commission documented many accounts of rape, gang rape, forced stripping or nudity, forced sexual acts, castration and mutilation of genitalia. Some of the survivors the Commission spoke to had been subjected to sexual violence multiple times. The Commission also met with men and boys who were victims or witnesses of sexual violence perpetrated during detention, or as punishment during military attacks on civilians.

181. **Large-scale abuses have been documented in the specific zones to be supported by the proposed project.** The UN report found reasonable grounds to believe that arms-carriers engaged in killings of civilians, rape and other forms of CRSV, theft or pillage, and destruction of civilian and humanitarian objects, generating mass force displacement of populations.

182. **The conflict has had a significant impact on children, with profound human rights abuses conducted on them.** The Commission paid special attention to violations and crimes against children and documented all the six grave violations against children referred to in the Secretary-General's reports on children and armed conflict: killing and maiming; recruitment or use of child soldiers; attacks against schools or hospitals; abduction; rape and other forms of sexual violence and denial of humanitarian access.

183. **Investments and support to service providers, not only in health but other sectors as well, might heighten the risks of providers becoming targets of attacks, pillaging and violence by armed groups.** Cases of health facilities and hospitals being raided have been documented in South Sudan as well as other FCV contexts in the region. The fact that the project aims to improve the availability and quality of health services inherently means the project seeks to improve facility infrastructure, availability of essential equipment and commodities, and human resources in targeted facilities. The proposed project aims to provide support that is aligned with other engagements of health partners in the country, whether they be emergency-related or basic service delivery support. This includes the provision of support that is both financial (performance payments, hazard pay, salary top-ups, etc.) and non-financial (provision of drugs, equipment, rehabilitation). As such, it is acknowledged that the project may lead to service providers becoming targets of acts of violence.

184. The project addresses the risks of project beneficiaries becoming targets in several ways. First, the proposed interventions and risk mitigation measures are based on best-practices and proven strategies of both development partners (UN agencies, HPF, bilaterals) as well as humanitarian organizations such as ICRC and Doctors Without Borders. Close consultations were undertaken with the health cluster in South Sudan to ensure the proposed project design captures these measures. Second, the selection of ICRC and UNICEF as

direct Recipients of IDA will result in greater flexibility and responsiveness than previous implementation arrangements. It will also lead to enhanced access to areas and populations that were previously difficult to reach, due to the neutrality and impartiality of partner organizations mobilized. Third, service delivery support will be primarily in-kind and will be delivered with the engagement of community leaders and their oversight, which has been identified as a way to reduce risks of pillaging by local populations. Fourth, where possible cash payments will be avoided and any financial payments to service providers will be direct payments to facility accounts at commercial banks or certified credit unions. And fifth, while the banking system remains undeveloped in rural parts of the country, so does the market for essential commodities for which payments would be used to procure. As such, the risk of transporting cash remains low.

185. **Finally, risks related to SGBV remain acutely prevalent throughout the country.** The project has included several interventions to address this, including a significant expansion of training for health workers and provision of services, including mental health and psycho-social support, for victims of SGBV. For example, ICRC and UNICEF will be training health workers in the health facilities they support to provide services to SGBV victims, both in terms of medical services (provision of post-exposure prophylaxis) and mental health and psycho-social support. Currently only a few health facilities offer these services, with the numbers being significantly scaled up through the proposed project. In the case of ICRC, for example, the number will increase from five primary care facilities (PHC) to all 25-30 PHC facilities and the two secondary hospitals to be operational in the project area.

VI. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: South Sudan

South Sudan Provision of Essential Health Services Project

Project Development Objectives(s)

The Project Development Objective is to increase access to an essential package of health services in the Republic of South Sudan, with a particular focus on the former states of Upper Nile and Jonglei.

Project Development Objective Indicators

Indicator Name	DLI	Baseline	End Target
Increase the utilization of an essential package of health services			
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		0.00	1,400,000.00
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)		0.00	800,000.00
Number of children immunized (CRI, Number)		0.00	75,000.00
Number of women and children who have received basic nutrition services (CRI, Number)		0.00	200,000.00
Number of deliveries attended by skilled health personnel		0.00	25,000.00

Indicator Name	DLI	Baseline	End Target
(CRI, Number)			
Number of curative consultations provided for under 5 children (Number)		0.00	1,000,000.00
Increase the quality of an essential package of health services			
Number of health facilities with essential medicines available (Number)		0.00	200.00
Number of health facilities providing at least 75 percent of the essential package of health services (Number)		0.00	200.00
Proportion of disease outbreaks detected and responded to within 72 hours of confirmation (Percentage)		15.00	50.00

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	End Target
Delivery of a package of essential health services			
Number of children aged 6-59 months who received vitamin A supplementation (Number)		0.00	250,000.00
Number of children less than 1 year who received measles vaccination (first dose) (Number)		0.00	75,000.00
Number of pregnant women receiving ANC four visits (Number)		0.00	40,000.00
Number of newborns receiving postnatal visit within two days of childbirth (Number)		0.00	17,000.00
Proportion of gender-based survivors presenting at health facilities provided with clinical management of rape services		0.00	100.00

Indicator Name	DLI	Baseline	End Target
(Number)			
Number of health care workers trained in-service (Number)		0.00	400.00
Number of community health workers trained to implement integrated community case management (iCCM) (Number)		0.00	200.00
Monitoring, Evaluation and Learning			
Proportion of functional health facilities submitting standardized HMIS monthly reports into the DHIS2 or HMIS equivalent system within one month of the reporting month (Percentage)		60.00	75.00
Proportion of health facilities with structured supervision visit within a month (Percentage)		40.00	70.00
Number of monitoring reports submitted (Number)		0.00	6.00
Emergency Preparedness and Response			
Number of state-level Rapid Response Teams trained on investigation of alerts and immediate outbreak response (Number)		0.00	10.00

Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
People who have received essential health, nutrition, and population (HNP) services		Quarterly	UNICEF and ICRC quarterly implementation progress	Data on indicator will be collected from health facility registers and DHIS2 database. ICRC and UNICEF will	UNICEF and ICRC

			reports.	report on indicator in quarterly implementation progress reports.	
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)		Quarterly	UNICEF and ICRC quarterly implementation progress reports	Data on indicator will be collected from health facility registers and DHIS2 database. ICRC and UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF and ICRC
Number of children immunized		Quarterly	UNICEF and ICRC quarterly implementation progress reports	Data on indicator will be collected from health facility registers and DHIS2 database. ICRC and UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF and ICRC
Number of women and children who have received basic nutrition services		Quarterly	UNICEF and ICRC quarterly implementation progress reports	Data on indicator will be collected from health facility registers and DHIS2 database. ICRC and UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF and ICRC

Number of deliveries attended by skilled health personnel		Quarterly	UNICEF and ICRC quarterly implementation progress reports	Data on indicator will be collected from health facility registers and DHIS2 database. ICRC and UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF and ICRC
Number of curative consultations provided for under 5 children	Total number of consultations provided to children less than 5 years of age	Quarterly	UNICEF and ICRC quarterly implementation progress reports	Data on indicator will be collected from health facility registers and DHIS2 database. ICRC and UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF and ICRC
Number of health facilities with essential medicines available	Availability of 5 tracer drugs during supervision visits (oral paracetamol, oral amoxicillin, oral rehydration solution, oral artesunate-amodiaquine)	Quarterly	UNICEF and ICRC quarterly implementation progress reports	Data on indicator will be collected from health facility registers and DHIS2 database. ICRC and UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF and ICRC
Number of health facilities providing at least 75 percent of the essential package of health services	Essential package of services is defined in Annex 6 of the PAD	Quarterly	UNICEF and ICRC quarterly implementation progress	Data on indicator will be collected from health facility registers and DHIS2 database. ICRC and UNICEF will	UNICEF and ICRC

			reports	report on indicator in quarterly implementation progress reports.	
Proportion of disease outbreaks detected and responded to within 72 hours of confirmation	Proportion of disease outbreaks detected and responded to within 72 hours of confirmation	Quarterly	UNICEF and ICRC quarterly implementation progress reports	ICRC and UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF and ICRC

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Number of children aged 6-59 months who received vitamin A supplementation	Number of children aged 6-59 months who received vitamin A supplementation	Quarterly	Primary data source will be Outpatient registers of supported health facilities UNICEF will report aggregate results in quarterly implementation progress	Data on indicator will be collected from health facility registers and DHIS2 database. UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF

			reports		
Number of children less than 1 year who received measles vaccination (first dose)	Number of children less than 1 year who received measles vaccination (first dose)	Quarterly	Primary data source will be EPI registers of supported health facilities UNICEF and ICRC will report aggregate results in quarterly implementation progress reports	Data on indicator will be collected from health facility registers and DHIS2 database. ICRC and UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF and ICRC
Number of pregnant women receiving ANC four visits	Number of pregnant women receiving ANC four visits	Quarterly	Primary data source will be Antenatal Care (ANC) registers of supported health facilities UNICEF and ICRC will report aggregate results	Data on indicator will be collected from health facility registers and DHIS2 database. ICRC and UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF and ICRC

			in quarterly implementation progress reports		
Number of newborns receiving postnatal visit within two days of childbirth	Number of newborns receiving postnatal visit within two days of childbirth	Quarterly	Primary data source will be Postnatal Care registers of supported health facilities and Boma Health Initiative community health worker registers. UNICEF will report aggregate results in quarterly implementation progress reports.	Data on indicator will be collected from health facility registers, DHIS2 database and BHI database. UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF
Proportion of gender-based survivors presenting at health facilities provided with clinical management of rape services	Number of gender-based survivors provided with clinical management of rape	Quarterly	Primary data source will be	Data on indicator will be collected from health facility registers	UNICEF and ICRC

	services		Outpatient registers of supported health facilities. UNICEF and ICRC will report aggregate results in quarterly implementation progress reports.	and DHIS2 database. ICRC and UNICEF will report on indicator in quarterly implementation progress reports.	
Number of health care workers trained in-service	Number of health care workers trained in-service in topics such as safe motherhood, integrated management of childhood illnesses (IMNCI), effective vaccine management and immunization in practice, and malaria testing and treatment	Quarterly	UNICEF and ICRC will report aggregate results in quarterly implementation progress reports.	For UNICEF, data on indicator will be collected from Implementing Partner's implementation reports. ICRC and UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF and ICRC
Number of community health workers trained to implement integrated community case management (iCCM)	Number of community health workers trained to implement integrated community case management (iCCM)	Quarterly	UNICEF will report aggregate results in quarterly implementation	Data on indicator will be collected from UNICEF Implementing Partner's implementation reports and UNICEF will report	UNICEF

			on progress reports.	on indicator in quarterly implementati on progress reports.	
Proportion of functional health facilities submitting standardized HMIS monthly reports into the DHIS2 or HMIS equivalent system within one month of the reporting month	Proportion of functional health facilities submitting standardized HMIS monthly reports into the DHIS2 or HMIS equivalent system within one month of the reporting month	Quarterly	UNICEF and ICRC will report aggregate results in quarterly i mplementati on progress reports.	Data on indicator will be crosschecked in DHIS2 or equivalent database. ICRC and UNICEF will report on indicator in quarterly implementati on progress reports.	UNICEF and ICRC
Proportion of health facilities with structured supervision visit within a month	Proportion of health facilities with structured supervision visit using a standardized Supervisory Tool/Checklist to assess and monitor quality of care within a month	Quarterly	UNICEF and ICRC will report aggregate results in quarterly i mplementati on progress reports.	For UNICEF, data on indicator will be collected from Implementing Partner's implementation reports. ICRC and UNICEF will report on indicator in quarterly implementati on progress reports.	UNICEF and ICRC
Number of monitoring reports submitted	Number of monitoring reports (including both health facility and LQAS) submitted in areas where external monitoring will be conducted. The performance monitoring	Quarterly	Third Party Monitors	Third Party Monitors (health facility and LQAS) will submit quarterly reports on monitoring and verification activities.	UNICEF

	methodology and reports will include citizen engagement mechanisms such as exit interviews conducted during data verification visits. The questionnaires will be customized to capture key domains on satisfaction and perceived quality of care, in order to capture community feedback on service delivery. Results from the quarterly reports will be used to engage with citizens on key elements related to improving service delivery in targeted communities.				
Number of state-level Rapid Response Teams trained on investigation of alerts and immediate outbreak response	Number of state-level rapid response teams, in particular health and WASH personnel, on investigation of alerts and immediate outbreak response, as well as requirements for IPC associated with the preparation of disinfectants of different concentrations, excreta disposal and monitoring of water quality.	Quarterly	UNICEF will report aggregate results in quarterly implementation progress reports.	UNICEF will report on indicator in quarterly implementation progress reports.	UNICEF

ANNEX 1: Implementation Arrangements

COUNTRY: South Sudan
Provision of Essential Health Services Project

Project Institutional and Implementation Arrangements

1. **Project implementation arrangements will utilize the existing structures and processes of the supported partners – UNICEF and ICRC.** The project, as with previous World Bank operations, will also operate within the health sector level coordination mechanisms in the country. Some project-specific functions for oversight and coordination will also be established as required. Informal consultative mechanisms will be established between the ICRC Health Coordinator, the UNICEF Health Coordinator, and the World Bank health task team. Where needed and during official missions, consultations can be elevated to the World Bank South Sudan Country Manager, UNICEF Country Representative, and ICRC Head of Delegation.

2. **Operational Coordination and Harmonization.** Project coordination will be maintained at the program, headquarters, and field levels between the World Bank, UNICEF and ICRC. Coordination will focus on: (i) spatial elements, to avoid coverage gaps and overlaps; (ii) programming and timing of the respective responses of different agencies to maximize effectiveness and complementarities; (iii) harmonization of the support packages across the project's partner agencies, (iv) synchronized timing for reporting on component progress, results and processes, and; (v) progressive determination and resolution of any jointly faced, or coordination-specific, issues and challenges.

Institutional and Implementation Arrangements for UNICEF

3. **UNICEF South Sudan will be responsible for the implementation of a set of activities under the project.** To implement these activities as defined by the project design, the procurement, FM, disbursement, and safeguards procedures of UNICEF as the supported UN agency will apply. Under the HRRP operation, a strong partnership is already in place between the World Bank and UNICEF, which has enabled successful implementation of the project in its final year. Moreover, the activities detailed under Component 1 fall under the scope of UNICEF's health strategy for South Sudan.

4. **UNICEF South Sudan will be in charge of overall coordination and implementation of project activities they are responsible for through its field staff and subcontracts with local IPs (national and international NGOs).** UNICEF's South Sudan Country Office in Juba will provide overall oversight and quality insurance to ensure successful implementation of the project, including all fiduciary aspects, safeguards, monitoring, and reporting of the project's progress.

5. **UNICEF will mainly employ the following approaches for supporting service delivery under Component 1:**
   (a) **NGO partnerships:** Programme Cooperation Agreements (PCA) and/or Small-Scale Funding Agreements (SSFAs) for the period will be established with NGO and international NGO partners, given their comparative advantage in ensuring continuity in service delivery to vulnerable, hard-to-reach and/or conflict affected populations. Engagement is based on rules and procedures that apply to collaborative

actions between UNICEF and civil society organizations, with formalized arrangements with partners that are governed by a PCA or a SSFA, depending on the amount of UNICEF resources provided.

(b) **Direct contracting of suppliers and services providers:** This includes i) procurement and printing services; ii) transportation arrangements of supplies at various levels; iii) technical assistance for operations-related activities; and iv) quality assurance of implementing partners. UNICEF already has existing contracts and long-term agreements with suppliers and service providers.

Institutional and Implementation Arrangements for ICRC

6. **The ICRC, established in 1863, is one of the largest humanitarian organizations in the world, with presence in over 80 countries.** Present in Juba since 1980, the International Committee of the Red-Cross (ICRC) opened a delegation in newly independent South Sudan in mid-2011. It works to ensure that people affected by non-international and international armed conflicts are protected in accordance with International Humanitarian Law (IHL), have access to medical care, physical rehabilitation and safe water, receive emergency relief and livelihood support, and can restore contact with relatives. It visits detainees and seeks to increase knowledge of IHL among the authorities, armed forces and other weapon bearers. It works with and supports the South Sudan Red Cross.

7. **The partnership supported by the proposed operation will result in an expanded footprint in the provision of, and inter-alia, greater access to primary and secondary health-care services, including MHPSS at both levels.** All activities implemented by ICRC under Component 1 will be implemented through direct presence of ICRC staff and exchange with target communities by the staff in the target areas of intervention. The South Sudan Red Crescent Society (SSRCS), different from the ICRC South Sudan Delegation, will not be an implementing partner for activities supported by this project.

8. **Succinctly put, activities implemented by ICRC will contribute to:**
   (a) The conflict and violence-affected population (resident and displaced) from the catchment areas that will be supported, will benefit from support to PHC services and have access to essential, quality curative and preventive health care services with functional infrastructure and management, adequate resources and trained staff providing treatment and care in line with national standards;
   (b) The wounded and sick in areas affected by conflict and other emergencies, benefit from quality hospital care meeting recognized international standards; and
   (c) The provision of medical emergency responses in times of need.

9. **Access to hard-to-reach areas:** The ICRC is able to operate in conflict and violence prone areas, where no other or very few humanitarian actors are present. The ICRC has used its access strategy of having sustained confidential dialogue with all parties to the conflict, supported by its neutral, impartial and independent humanitarian action on the ground, to deliver humanitarian assistance notably in opposition-held areas. This access to hard-to-reach areas and places hosting IDPs has been crucial, given the need for timely provisioning of life-saving health services, preventing further displacement among civilians. In particular, this enables delivery of services to children or pregnant women with severe health risks who find it difficult to survive long journeys in harsh conditions in search of services.

10. **Multidisciplinary programmatic approach**: While the specific program that will be supported by this project has a defined boundary and focuses on delivery of essential health services at the community, primary and

secondary care levels, the ICRC's multidisciplinary approach to health, supported by presence of technical departments like Economic Security (food, non-food and livelihood), Water and Habitat (water infrastructure, treatment, hygiene promotion and engineering), Communication, and Protection allows it to focus not only on health aspects but other interconnected and mutually-beneficial interventions. This multi-disciplinary capacity to respond allows for reduced transaction, consultation and coordination time.

11. **Coordination and complementarity within the health sector:** In South Sudan as in any other country, the ICRC coordinates with authorities, UN and other actors, though it is not coordinated *by* them, to ensure it maintains both the perception and reality of its impartiality, independence and neutrality that could otherwise jeopardize its security and access to conflict-affected communities. However, the ICRC's South Sudan delegation in Juba does proactively coordinate through cluster meetings and bilaterally, with a wide array of relevant humanitarian actors and stakeholders including key UN agencies, embassies, donors, South Sudan nationals, regional and local bodies, and community leaders, to guide ICRCs interventions. This is to ensure not just activity but also geographical complementarity, with an aim to concentrate on those areas which are more difficult to access for other humanitarian partners (particularly IO-controlled areas or areas heavily affected by conflict and violence).

Financial Management

12. **The World Bank FM team assessed the FM arrangements for the implementation of the proposed project.** The objective was to get an understanding of how the FM systems of the two partner organizations, ICRC and UNICEF, will be used to support the implementation of the proposed project. Both organizations maintain robust systems and capacity which can provide reasonable assurance that: (a) funds channeled into the project will be used for the purposes intended in an efficient and economical manner; (b) the project's financial reports will be prepared in an accurate, reliable and in a timely manner; and (c) the project's assets will be safeguarded from loss, abuse or damage.

13. **Significant risks however exist within the country environment which could impact the FM arrangements of the project.** These include challenges of insecurity that could impede access to the intended beneficiaries and the under-developed institutional capacity of the Government which could adversely affect service delivery and raise the risk of transparent stewardship of funds. Furthermore, project supervision will be challenging due to insecurity, and the verification of project outputs will be difficult and costly due to the inherent physical and logistical constraints of visiting multiple locations. There are also inherent risks in the project design given its decentralized nature and the fact that it will be implemented in two of the most isolated and conflict-affected former states in South Sudan. The project activities involve provision of basic health care including distribution of pharmaceutical commodities to beneficiary health facilities. Consequently, the FM risk for the project is considered **High.**

14. **These risks will be effectively mitigated through the involvement of UNICEF and ICRC in the implementation of the project.** Both organizations are non-sovereign recipients with strong presence in South Sudan and have the capacity and experience implementing similar projects in the context of South Sudan such as the current IDA-financed HRRP implemented via a partnership between UNICEF and the MoH. Each agency has demonstrated capacity to carry out procurement of drugs and provide health services in often hard-to-reach areas, including arrangements for effective supervision, monitoring and verification of project outputs in the field. Both UNICEF and ICRC maintain FM arrangements that are capable of providing reasonable fiduciary

assurance to the World Bank regarding the use of project resources. In the case of the project, each agency would receive funds via a direct IDA grant.

15. **The current implementation modality involving UNICEF and ICRC is a direct response to the heightened fiduciary risks that had been noted during implementation of HRRP through the Government.** This includes non-compliance with World Bank FM policies and procedures leading to ineligible expenditures, inadequate arrangements for monitoring and verification of health service delivery in the two states, general weak accounting capacity in Government, and weak internal and external audit oversight making it difficult to confirm utilization of fuds for the intended purpose. As an integral part of implementation support, the World Bank team will work with other stakeholders to build long-term sustainable FM capacity in the portfolio. This includes targeted skills enhancement of staff in procurement and FM, knowledge exchange during implementation support missions and participation in progress review meetings.

Country Issues

16. **A Public Expenditure and Financial Accountability Assessment (PEFA) was conducted in 2011 for the Government of South Sudan and four state governments including Jonglei, Unity, Western Equatoria, and Northern Bahr-el-Ghazal.** The assessment covered country level public financial management (PFM) reforms for the national as well as state governments. According to the report, the country had made progress in some particular PFM areas such as the preparation of the national budget that reflects government policies; the installation of an integrated FM system; the establishment of an electronic payroll system; and establishment of both internal and external audit systems. The Assessment however identified significant weaknesses in downstream PFM areas such as budget execution, accounting and internal control systems. On budget execution, the report notes that aggregate and spending agencies' expenditure outturns are significantly different from the approved budgets; constitutional and legal controls on changes in approved budget are not fully adhered to; and there is low in-year predictability of availability of funds. As a result, budgets prepared by government agencies are not credible. Regarding accounting and internal control systems, the report highlights weaknesses such as build-up of payment arrears; non-transparent public procurement system; and lack of robust internal control system. Apart from the Public Financial Management Act (PFMA) of 2011, no major PFM reforms have taken place in the country. The government, with World Bank support, engaged a consultant to prepare draft PFM regulations but these have not been finalized. IFMIS was implemented and is functional in the MoF and Planning but government financial statements have not been prepared since 2011. There is ongoing World Bank support towards strengthening capacity of the Supreme Audit Institution (SAI).

17. **The country's political environment has been relatively calm since the resurgence of conflict in July 2016 and apparent collapse of the December 2015 peace agreement.** However, there is still inadequate legal framework to support the defective fiduciary oversight. Similarly, the country's overall governance environment is considered weak, due to lack of transparency and accountability over use of public funds and weak oversight. However, following the signing of the Revitalized Peace Agreement in September 2018, prospects have been revived of possible reforms in the country's PFM landscape. The new peace agreement provides for a number of legal and economic reforms including review of the National Audit Chamber Act 2011 to make the SAI more independent, review of the 2011 PFM to strengthen public accountability and establishment of Public Procurement Oversight Authority.

Specific FM Arrangements

Program implementation modality and structure

18. **UNICEF South Sudan will implement the project through implementing partners (national and international NGOs).** Monitoring and quality assurance of implementing partners will be conducted through the Harmonized Approach to Cash Transfers (HACT) framework used by UN agencies, which includes programmatic visits to track results, financial spot-checks, audits, and capacity building activities. In the two former states, program activities will be coordinated by two field offices. In the former Jonglei state, program activities will be coordinated by the field office in Bor South whereas operations in the former Upper Nile state will be coordinated by Malakal field office. The field offices are staffed with technical staff, responsible for day to day program implementation support and oversight of the subcontracted NGO implementing partners. UNICEF Country Office based in Juba will ensure general oversight, regular field visits and technical support to field offices and implementing partners.

19. **UNICEF's FM arrangements are well aligned with the World Bank's requirements under World Bank Policy and World Bank Directive (formerly OP/BP 10.0) on IPF.** The FM arrangements are based on the FMFA to which UNICEF is a co-signatory. FMFA allows a UN agency to use its own FM rules and procedures, including recognition of the UN Single Audit Principle. Under the FMFA, all World Bank FM procedures under the former OP10.0 are waived in favor of the UN rules. However, the World Bank still has the right to request for periodic financial reports to monitor utilization of funds.

20. **ICRC FM arrangements can provide the World Bank with adequate financial reports on the use of funds.** ICRC's cost accounting system allows it to link expenditures, via analytical codes, to specific cost centers, including field structures. For purposes of this project, ICRC will report the costs on specific lines items related to 'Staff Related Expenses', 'Utilities', 'Rentals', and 'Overheads' that are directly and indirectly linked to the health centers selected for the program. ICRC's accounting and FM systems have the capacity to prepare quarterly and annual financial reports for selected line items that are eligible for financing for purposes of FM supervision and disbursements. No procurement activities will be financed under the ICRC component.

Budgeting and disbursement arrangements

21. **For UNICEF, the detailed program budget will be prepared based on the particular activities to be executed over the life of the program and will focus on the achievement of program outputs/deliverables as outlined in the PAD.** This budget will be agreed with the World Bank and monitoring of budget execution will be done through review of statements of comparative budgeted and actual expenditure which will be submitted to the World Bank as part of the biannual financial reports. UNICEF will have budget flexibility within each component to utilize resources as required to achieve project results. UNICEF must request approval from the World Bank prior to moving budget between project components. Variances between actual and budgeted performance above 20 percent will be explained as part of the biannual narrative progress reports.

22. **With regard to ICRC, annual budgets are finalized and compiled at the headquarters based on programs expected to be executed during a particular financial year.** These annual budgets are segregated for each Country Delegation. In the annual budget expenditure is tagged to specific programs (such as public health

support in South Sudan) but the budget is not linked to the amount of funding expected from particular donors or sovereign governments. When funds are received from donors and partners including sovereign governments, these are then allocated against the budget depending on whether the funding is earmarked for specific programs or granted for general support. The budget ceiling for the proposed health project will be agreed between the World Bank and ICRC before each new financial year.

Monitoring and verification arrangements

23. **UNICEF South Sudan conducts M&E of programs through the annual Integrated Monitoring, Research and Evaluation Plan (IMEP).** An online field monitoring tool using tablets, has also been introduced to more effectively monitor the status of program implementation on the ground. In addition, the Country Office continues to use program monitoring visits, along with monthly progress reports from partners to help verify progress and highlight potential program implementation issues. Under Component 2 of the proposed project, monitoring and verification arrangements have been mainstreamed through the hire of monitoring entities. The ToR for the monitoring entities will include confirmation of health service delivery including receipt of pharmaceutical commodities by the beneficiary health facilities. Since ICRC will implement the project-supported activities using its own staff and systems, monitoring and verification of program results is embedded in the program implementation arrangements.

24. **Procurement and distribution of pharmaceutical commodities.** Pharmaceutical commodities will be procured centrally by UNICEF and delivered to its warehouses in Juba and Bor. The commodities will be distributed to implementing partners from these warehouses for onward distribution to the health facilities. The distribution will be tracked through regular monitoring activities while end user monitoring will be conducted during field visits where the team meet with community members to verify and confirm that supplies have reached the intended beneficiaries and assess community satisfaction in regard to service delivery.

Accounting and financial reporting arrangements

25. **ICRC's cost accounting system tracks direct costs and indirect costs and uses an allocation method to assign cost to specific activities.** The assignment of costs is done using analytical codes that tag costs to specific activities, which, for purposes of the Health operation, will tag costs related to the eligible primary and secondary health programs in South Sudan. The activities eligible for financing were selected from ICRC's chart of accounts which all fell within the cost groups labeled 'Staff Related Expenses', 'Utilities', 'Rentals', and 'Overheads'. For purposes of financial reporting, ICRC will generate quarterly reports of total expenditure incurred under each of the selected account codes, which will be financed 100 percent for disbursement purposes.

26. **ICRC will submit quarterly financial reports to the World Bank within 60 days after the end of the quarter whereas UNICEF will submit semi-annual financial reports to the World Bank within 45 days after the end of the six-month period.** The format and content of the financial report has been discussed and agreed with both UNICEF and ICRC. UNICEF will initially submit quarterly financial reports which will include a statement of funds received as well as funds disbursed by both UNICEF cost categories and project components and activities. This will help in linking the reported expenditures with the outputs/deliverables reflected in the technical progress reports. Subsequently, the periodicity for the submission of the interim financial reports

will be adjusted from quarterly to biannual based on the outcome of the FM supervision of the project during implementation, subject to confirming that the FM risk rating has reduced to Moderate. The project components and categories will be in line with the PAD and legal agreement. To enhance accountability over the disbursements, UNICEF will maintain a separate ledger account for recording IDA funds channeled into the project. The biannual narrative progress report will also include a comparative statement of budgeted and actual expenditure to help monitor the rate of utilization of the approved budget. The final set of financial statements, certified by UNICEF headquarters will be submitted to the World Bank by March 30, 2022. Any unutilized balance will be refunded to the World Bank before the disbursement deadline date. The biannual narrative progress reports will also include a summary of any FM challenges noted during the reporting period as well as total commitments made. In view of the increased workload expected to arise during the implementation of the proposed health project, UNICEF South Sudan will consider deployment of an additional qualified staff to support its current FM team in ensuring adequate fiduciary oversight and timely financial reporting.

27. **With respect to ICRC, the financial reporting function is centralized at the headquarters.** Accounting transactions at the South Sudan Delegation are initially reviewed by the Audit and Compliance Unit based in Manilla before consolidation at the headquarters in Geneva. The headquarters then generates periodic financial reports which are shared with the respective donors and development partners. The reports are based on standard templates classifying expenditure along the lines of program activities. For the proposed health program, the Committee will report on the specific eligible expenditure categories ('Staff Related Expenses', 'Utilities', 'Rentals', and 'Overheads') as agreed with the World Bank.

28. **As the selected expenditure items are part of the regular ICRC chart of accounts, the project FM arrangements will be fully mainstreamed into ICRC's regular financial procedures and systems.** ICRC follows its own finance and administration manual which is in line with the International Financial Reporting Standards. The Committee will generate quarterly financial report of the eligible expenditure categories and submit to the World Bank within 60 days after the end of the quarter, to provide accountability for the funds disbursed from the World Bank. The financial reports will be presented in US dollars using the applicable exchange rate between the Swiss franc and the US dollar on the date of receipt of funds from the World Bank. The table below shows a list of the eligible expenditure line items agreed between ICRC and the World Bank.

Table A1.1: Eligible Expenditure Items from ICRC Chart of Accounts

Account Code	Description
900000	Headquarters (Hq Residents) and field Salaries (mobiles)
900100	Reimbursement for NS staff/Hospital staff
900500	Headquarters and Field Social insurance costs
903000	Salaries Residents
903500	Social insurance cost Residents
911000	Mission, Transport & Freight costs
912000	Mission Accommodation costs
924000	Rental of residences for lodging purposes Only
924100	Rental professional Offices
924200	Other rentals of Premises
926000	Rental of means of transport, freight, taxes

927000	Rental of equipment & of IT & telecom
947000	Purchase of IT & Telecom Equipment[34]
960000	Water, Electricity, Gas
961000	Postage account
961100	Voice and Data Transmission
980000	Overhead (6.5%) field cash

Fiduciary oversight and audit arrangements

29. **The ICRC's FM and procurement activities are largely centralized at the headquarters in Geneva, Switzerland.** The South Sudan Delegation (Country Office) only provides support for program activities. The Delegation operates with five accountants and a cashier under the coordination of the Finance and Administration Coordinator. In addition, there are five field offices in Bor (Jonglei), Wau and Rumbek while Malakal and Bentui field offices are currently operating from Juba until the end of 2018 following temporary evacuation. Four of the field offices are supported by mobile Finance and Administration Managers. The Delegation operates with 53 delivery trucks and nine aircrafts (seven planes and two helicopters) including two cargo planes.

30. **Both the internal as well as external audit of UNICEF cover the programs although the external audit is conducted in line with a global risk – based audit plan.** The last internal audit of the UNICEF South Sudan program which was conducted in 2015 raised some internal control weaknesses, particularly in regard to fiduciary oversight of NGO implementing partners. However, the team confirmed that all the recommendations contained in the report had been implemented. In addition, it was understood that the fiduciary oversight of implementing partners follows the provisions of the HACT framework with programmatic visits, spot checks, and audits. The most recent internal audit of UNICEF South Sudan was conducted in August 2018, but the report had not been finalized at the time of this review. Annual external audit of UNICEF will be conducted by auditors certified by the UN Board in line with the Single Audit Principle agreed with the World Bank.

31. **Similarly, internal audit of ICRC follows a risk-based approach in line with global standards.** The last audit of the South Sudan Delegation was conducted in 2016 and covered regular office functions of Finance, Logistics and IT procedures. Follow up of internal audit recommendations is conducted by the Governing Board of ICRC. The Committee is also audited annually by external auditors. The ICRC South Sudan operation will be audited as part of the regular audit of ICRC annual financial statements and the audit report will be shared with the World Bank within 6 months after the financial year end. In addition, the financial auditors will apply Agreed Upon Procedures in accordance with ISRS 4400, to review those specific eligible expenditure categories based on agreed ToR. A report of the outcome of the special review (Agreed Upon Procedures) will be submitted to the World Bank together with the annual financial audit report and management letter.

Fund Flow and Disbursement Arrangements

32. **Under the proposed health program, funds disbursed from the World Bank will be received by ICRC and UNICEF into pooled designated accounts used to receive contributions from all other partners.** In the case

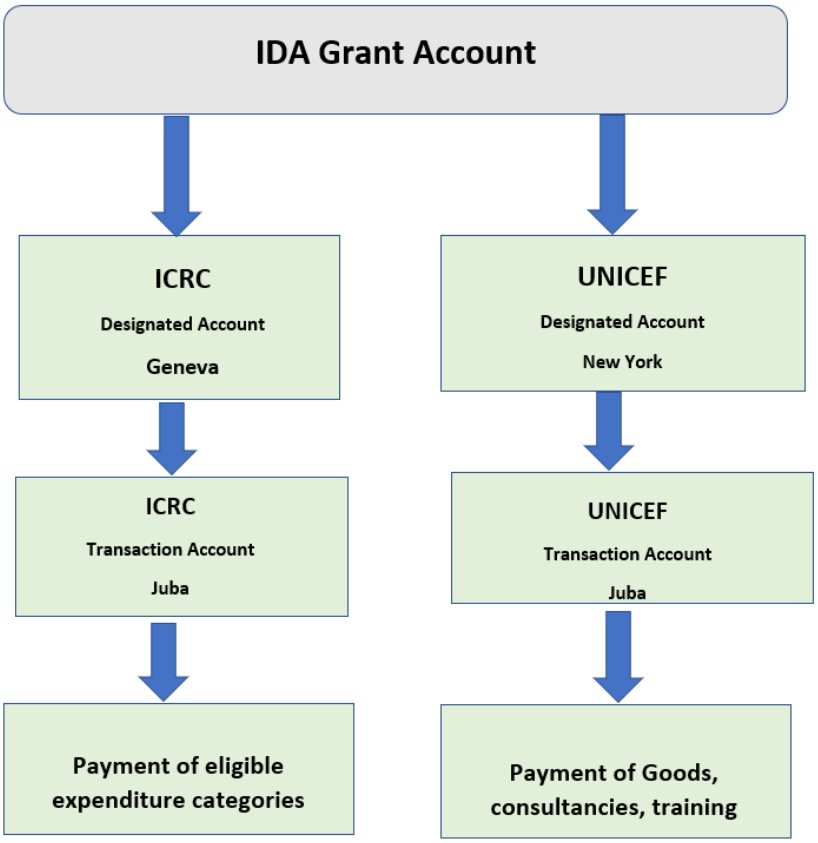
[34] Only rentals

of ICRC, the Committee receives funding from various donors and partners including sovereign governments, into a common pool, for the implementation of identified programs globally. The pooling of funds supports ICRC's policy of neutrality, which allows it to access conflict locations and deliver services, while its accounting and financial reporting system allows for the allocation of costs to the identified programs without reference to the source of funding (individual donors or partners).

33. **Funds disbursed by the World Bank to ICRC will be received into a pool account at the headquarters in Geneva.** ICRC South Sudan will then submit a funds requisition to Geneva for the execution of program activities locally. Under the proposed health program, no procurement activities undertaken by ICRC will be financed by the project or IDA resources. Due to the significant differences that exist between the World Bank and ICRC systems, the program will finance eligible expenditure categories linked to the agreed program objectives. This approach was agreed for Somalia and now South Sudan, where specific eligible expenditure categories from ICRC chart of accounts were identified and agreed upon. The World Bank and ICRC teams agreed on the specific expenditure categories ('Staff Related Expenses', 'Utilities, 'Rentals', and 'Overheads') that will be financed under the health program. The eligible expenditures will be financed up to the funding ceiling agreed with the World Bank in line with the Grant Agreement.

34. **Disbursement of funds to UNICEF will follow the UN advance system based on the approved budget agreed with the World Bank.** The funds disbursed will be accounted for using biannual (initially quarterly) financial reports submitted to the World Bank within 60 days after the end of the quarter.

Figure A1.1: Funds Flow



Conclusion of the FM assessment

35. **The conclusion of the assessment is that the FM arrangements to be maintained by UNICEF and ICRC have adequate capacity.** In the case of both partner organizations, their FM systems and procedures satisfy the World Bank's minimum requirements under World Bank Policy and World Bank Directive on IPF (formerly OP/BP10.00), and therefore are considered adequate to provide, with reasonable assurance, accurate and timely information on the status of the project required by IDA.

Procurement

36. **The proposed project will be implemented through a coordinated support by two selected agencies, UNICEF and ICRC currently providing health support in South Sudan.** Given the ongoing violence and instability, the proposed project is being processed under Paragraph 12 of the World Bank Policy on IPF (Projects in Situations of Urgent Need of Assistance and Capacity Constraints). The Borrower has agreed for IDA to directly sign the Financing agreement with the Agencies and it is proposed that UNICEF and ICRC be the grant Recipient and implementing agencies for the Component 1.1 and 2, and 1.2 of the proposed project, respectively. Further to the World Bank fiduciary assessment of the two agencies, the World Bank agreed on the following procurement arrangements:

(a) **UNICEF**: UNICEF will use their own procurement procedures as APAs allowed under Section III. F. of the World Bank: Policy Procurement in IPF and Other Operational Procurement Matters (July 2016). Chief Procurement Officer (CPO) approval was sought for use of APA prior decision project meeting.

(b) ICRC: The project will finance ICRC's staff, utilities and operational costs directly and indirectly related to supporting the defined health program in South Sudan. Therefore, for activities implemented by ICRC, IDA will not finance any procurement and thus the World Bank procurement procedure and policy will not be applicable.

37. **The Procurement arrangement is recommended under the PPSD.** UNICEF's procurement arrangement is considered a fit-for-purpose arrangement for the project for several reasons: (i) the procurement activities proposed under Component 1 are within the mandate of UNICEF, and the same implementation mechanisms as applied in other World Bank-financed projects, such as in Yemen, Iraq, and other fragile situations; (ii) UNICEF has a strong presence on the ground in the country, have proven that they are well-equipped to work in the challenging environment of South Sudan, and have the capacity to reach project beneficiaries; (iii) UNICEF has concrete experience in implementation of World Bank-financed projects in South Sudan, including the HRRP and Emergency Food Security and Nutrition Project, as well as World Bank-financed projects in other FCV contexts; (iv) the proposed implementation arrangements are flexible, and the Project will benefit from UNICEF's established partnership agreements with local partners engaged in supporting health service delivery activities; (v) UNICEF has an established country office with well-staffed satellite offices throughout the country, and therefore has preparedness and mobilization mechanisms in place, which enable optimal emergency procurement in the case of an emergency; (vi) UNICEF's procurement arrangements provide reasonable assurance that the World Bank's financing will be used for intended purposes; and (vii) UNICEF has an extensive pool of global, regional and local framework agreements with pre-qualified suppliers in place ("Long-term Agreements" (LTA)) that can be tapped into for promptly placing the purchase orders for the medical, pharmaceutical, and other items required by the project.

38. **Procurement, transportation and logistics of pharmaceuticals and medical products envisaged under activities in Component 1 implemented by UNICEF (estimated at US$14 million) will be centralized and managed by UNICEF's Supply Division in Copenhagen through established Long Terms Agreements.** UNICEF LTAs are established through UNICEF's competitive bidding process, which includes rigorous quality assessments of both suppliers and products. All the pharmaceuticals and medical products required for procurement are standard materials for which UNICEF Supply Division in Copenhagen have established LTAs. The ongoing management of these LTAs is also undertaken by UNICEF Supply Division in Copenhagen to ensure that quality is continually maintained to the required high standard. Based on the country experience, the average lead-time for pharmaceuticals supply and delivery to in-country locations is six to eight months. UNICEF's South Sudan office has well-functioning warehouses in Juba, as well as five others in other towns in South Sudan, including in former Upper Nile and Jonglei. In addition, UNICEF will hire a firm for pre-inspection and verification of the supplies and deliveries upon arrival at the warehouses.

39. **Although there are a multitude of NGOs operating in the country, past experience has shown that only a limited number have sufficient experience and capacity and present in the project area.** To ensure the right implementing partners are selected under Component 1, UNICEF will conduct an open national competitive selection process for the approximately 10 NGOs to enter into implementing partnerships (estimated at US$28 million) for supporting service delivery in the two former states. The selection process and management will be governed by UNICEF Procedure of Country Office Transfer of Resources to CSOs. UNICEF will conduct the

selection process and ensure transparent due diligence through reviews by Partnership Review Committees who will provide a written recommendation to the Country Representative. Prior to signature of a partnership agreement by the UNICEF Representative, every partnership selection decision must be endorsed by the Chief of Section, Chief of Field Office as well as a Partnership Review Committee comprised of staff from the program and operations. For partnerships under US$100,000, agreements can be reviewed and endorsed by the Deputy Representative prior to signature by the Representative. In addition, all partnership agreements over US$1 million must be reviewed by the UNICEF regional office prior to finalization. All the selection process and management of the IPs are subject to internal UNICEF audits.

Procurement activities envisaged

Component 1: Support delivery of essential package of basic health and nutrition (US$93 million equivalent):

40. **Under Component 1, UNICEF will receive US$61 million to finance the delivery of an essential package of health services.** The procurement activities under this component will include procurement of basic drugs, vaccines, medical equipment (laboratory and related general equipment for referral centers and PHC facilities), training of community health volunteers, community health workers, and community midwives and health facility-based workers and their supervisors and managers, and different kinds of medical kits for the CHVs, CHWs, CMWs, and for different uses such as diarrheal disease kits, emergency health kits, midwifery kits. It will also include procurement of medical equipment and training of CHVs and CHWs and supplies for community-based services and home-based delivery. The component will also finance recruitment of CSOs and NGOs, implementing partners through UNICEF Cooperation of Partnership Agreements.

41. **Under Component 1, ICRC will receive US$32 million to finance the salaries and utilities supporting the Health program in South Sudan.** Within the arrangements for ICRC-implemented activities financed through the project, there will be no procurable items and thus the World Bank procurement procedure and policy will not be applicable.

42. **Component 2: Monitoring, Evaluation and Learning (US$4 million equivalent):** The monitoring activities of this component will be implemented through the UNICEF Financing Agreement. The Component will finance costs related to independent monitoring, evaluation, and verification of project activities, including Results Framework indicators. Contracts will be signed between UNICEF and the monitoring agencies and the monitoring costs will be channeled through the UNICEF FA. The component will also finance research related work to support any innovative initiatives, both by ICRC and UNICEF.

43. **Component 4: Refinancing of Project Preparation Advances (US$5.4 million equivalent):** No procurement activities required under the component but rather the fund will be used to the repayment of Project Preparation Advances from other projects that were disbursed but for which the project was never delivered.

44. **The implementation support and project management costs are all integrated into project components.** The components will cover management costs such as: (a) general management support (indirect) costs for UNICEF and ICRC; (b) direct management and supervision costs required to support the implementation of the Project (including the use of remote monitoring technology); (c) independent audits of ICRC project activities, if required; and (d) the application of GRMs for ICRC and UNICEF supported activities, to document any possible complaints and ensure follow-up.

Procurement Assessment of UNICEF to implement the project

45. **A procurement assessment of UNICEF was conducted, and the findings outline below:**

UNICEF

(a) **The UNICEF Procurement Rules and Procedures were assessed against World Bank's core procurement Principles and Governance requirements, conducted by OPCS in May 2017 as part of global World Bank-UN engagement and approval for the Standard Agreement for Delivery of Output.** The findings revealed UNICEF procurement rule and procedures met the World Bank's requirements. The World Bank also conducted supplementary procurement capacity assessment of the UNICEF South Sudan office to manage project procurement with main focus on the staffing and experience, procurement oversight arrangement and general country office procurement performance. The findings of the assessment of UNICEF SS capacity and performance summarized below.

(b) **The Supply and Logistics unit has over 19 staff based in Juba and also supported by the Supply Division based in Copenhagen, UNICEF HQ on procurement and supply of health supplies.** The unit is headed by Chief of Supply and Logistics, an international staff heading Procurement of good and services, Contract Management and warehouse management. Two staff national professional officers and the rest assistants, all with average experience of more than 5 years. They receive internal training on how to conduct procurement using UNICEF procedures.

(c) **UNICEF approval level of procurement thresholds at Country Office is governed by Table of Authority (TOA).** All procurement Up to US$50,000 is approved by the Senior Supply and Logistics Manager. From US$50,000 up to US$500,000 approved by the Chief of Operations or/and The Deputy Representative and Procurement Over US$500,000 approved by the Representative. In addition, all procurement value above U$50,000 are reviewed by the Contract Review Committee established at Country office for recommendation to the Representative (Head of Office).

(d) **UNICEF South Sudan has an annual average procurement volume of US$60 million and as per the last audit, the supply and logistics staff are stressed and that affecting the Country office procurement performance.** While additional staffing has already been put in place since the last audit, the current Office Plan for FY19 provides for more staff though the positions are yet to be filled. The procurement volume under the project will nearly double the current office workload and therefore its recommended that additional staff as appropriate be hired to support the current team. UNICEF South Sudan will supplement its existing staffing complement with expertise from other UNICEF offices until planned recruitment activities are completed.

(e) **UNICEF has centralized the procurement of drugs and health supplies to the Supply Division headquarters in Copenhagen through a Long-Term Agreement with prequalified vendors.** The drugs and medical supplies are supplied and prepositioned to Country Office Warehouses, where the distributions within the country are managed by the Country office. Over 30 percent of the project funding will be used for procurement and distribution of pharmaceutical items.

(f) **UNICEF managed warehouses were assessed and found to acceptable.** Records are managed electronically using VISION and SAP systems that allow tracking of all supplies from the time of placing purchase orders through transit and out of the warehouses. The movement of the supplies while at UNICEF warehouse is monitored by the Supply Division headquarters. Due to the logistical and infrastructural challenges in the country, UNICEF pre-positions supplies for 3-6 Months to the Implementing Partners (NGOs). Also, the agency has long-term agreements with local transporters for in-

country transportation and some of the NGOs directly collect the supplies from UNICEF warehouses and transport and distribute by themselves. UNICEF has contracted KPMG for independent verification monitoring supplies at UNICEF managed warehouse. However, the verification does not extend to the NGOs warehouses and usage. Though UNICEF is providing a programmatical monitoring at the NGOS level, the country office was advised to extend the verification to the NGOs storage facilities through the external monitoring contract.

Project Procurement Plan

46. **UNICEF has prepared a Procurement Plan and Implementing Partners Plan (Table A1.3) for activities to be procured under Component 1 of the project, including details of the cost estimates, selection methods and market approach options and the time schedules.** The World Bank will clear the initial Procurement Plan for the project detailing the activities to be carried out during the first 12 months. The Procurement Plan shall be updated during implementation as necessary. UNICEF will submit reports on both the procurement plan and implementing partners plan to the World Bank procurement monitoring and contract implementation information as part of the biannual narrative progress reports.

47. **Procurement Risk:** The overall project procurement risk was assessed to be Moderate based on the country situation. The mitigation measures agreed with the supported agencies are summarized in the table below:

Table A1.2: Procurement Risks and Mitigation Measures

Risk description	Mitigation Measures	Time Frame	Responsibility
Likelihood of inadequate number of UNICEF procurement staff to handle project activities	UNICEF will hire as necessary additional procurement and logistics staff under the project.	Immediately after project effectiveness	UNICEF
Likelihood of delays in procurement process for supply and distribution of large volume of drugs and distribution.	UNICEF to leverage the existing long-term framework agreement at headquarters	During implementation	UNICEF
Likelihood of high costs of NGOs contracts/Agreement price not commensurate to the activities scope given the country's logistical and infrastructural challenges	Advance planning in selection and early involvement of Supply chain unit in the selection and proper market diagnostic to inform the decision	During implementation	UNICEF
Likelihood of drugs procured under other grant used for World Bank projects.	In addition to VISION, UNICEF electronic system capturing the PO and grant references, all the way bill (or equivalent standardized document) signed by Implementing Partners should have Grant reference included	During Implementation	UNICEF

Likelihood of drugs expiry at and misused by the NGOs selected as implementing partners-	An independent verification monitoring the UNICEF managed Warehouse be extended to the NGOs selected and selection process should ensure partner storage capacity. Frequency of monitoring visits to take into account UNICEF's internal guidance which applies a risk-based management approach.	During Implementation	UNICEF

Table A1:3 Procurement /Partners Selection Approaches

	Contract Title, Description and Category	Estimated Cost (US$ million) and Risk Rating	World Bank Oversight	Procurement Approach/ Competition:	Selection Method	Evaluation Method	Contract Award	Contract Completion
1	Pharmaceuticals and Medical Equipment	US$10.2 Moderate		Open International	FA	NA	March 2019	TBD
2	Routine Vaccines	US$0.4		Open International	FA	NA	March 2019	TBD
3	Laboratory Supplies	US$1.0		Open International	FA	NA	March 2019	TBD
4	Printed Materials	US$0.6		National	FA	NA	April 2019	TBD
5	Selection of IPs (est. 10)	US$29.0 Moderate	NA	Open following UNICEF's own procedures	UNICEF CSO selection procedures	NA	April 2019	TBD
6	Performance Monitoring Agency	US$3.0 Moderate	ToR and periodic reporting	International Open following UNICEF own procedures	International Open following UNICEF own procedures	TBD	TBD	TBD

ANNEX 2: Economic Analysis

COUNTRY: South Sudan
Provision of Essential Health Services Project

Economic Analysis

1. **The economic analysis of the Project draws on empirical evidence to demonstrate that the expected benefits outweigh the costs of the proposed interventions and that the Project is financially sustainable.** Detailed economic and financial analysis has been conducted and include: (i) a cost-effectiveness analysis of the project (what is the incremental cost effectiveness ratio?); (ii) a cost-benefit analysis of the project (how much does the project cost per saved life year?) and (iii) a financial analysis (how financially sustainable is the project?).

Cost-effectiveness analysis

2. **The methodology for the cost-effectiveness analysis follows Shephard et al. (2015).[35] It implies weighting benefits (expressed in terms of effectiveness) and costs (expressed in monetary units).** Costs include those related to the interventions included in all four components of the project. Gains will be expressed in terms of lives saved because of the supported interventions. To determine these gains, the expected number of lives saved by the project will be compared to a status-quo scenario. The output of the cost-effectiveness analysis is an incremental cost-effectiveness ratio (ICER), which reflects the change in cost divided by the change in the amount of lives saved because of the implementation of the project.

Incremental costs

3. **The first step of the cost-effectiveness analysis is to determine incremental costs, i.e. costs of the targeted interventions had the project not existed versus cost of the interventions with the actual support of the project.** As interventions supported by the project are new, we will take the full cost of the project as the incremental costs. The assumed implementation pace of the project is linear, and the total cost of the project is US$105.4 million, over a 28-month implementation period.

Discounting

4. **We calibrate the discount rates to convert the stream of future costs and benefits into present value by following the 2016 OPSPQ guidance note[36].** Standard welfare analysis implies that the net benefits of a project at different points in time should be valued according to their marginal impact on welfare at the time they occur. The basic underlying assumption is that the marginal value of an additional dollar of net benefits is smaller when the recipients of those benefits are richer. Calibrating the relevant country specific discount rate requires a view on how much richer (or poorer) future beneficiaries of the project will be compared with current beneficiaries. This first needed ingredient is simply an assumption about future growth. Current IMF real growth projections are around -5.8 percent at the 2021 horizon (IMF, World Economic Outlook). Discounting also requires a view on how fast the marginal value of an additional dollar of benefits decline as recipients become richer. This parameter is the elasticity of marginal utility of consumption which is typically assumed to lie between 1 and 2 for standard utility functions.

[35] Donald Shephard, Zeng W. and Nguyen H.T.H (2015) Cost-Effectiveness Analysis of Results-Based Financing Programs: A Toolkit. World Bank HNP Discussion Paper.
[36] Aart Kray (2016) Discounting Costs and Benefits in Economic Analysis of World Bank Projects. OPSPQ Guidance Note.

Table A2.1: Economic Parameters for South Sudan

Parameter	Value
Real GDP growth (annual %, IMF projections)	-5.8%
Population growth	3.0
Real GDP per capita growth	-2.8
Implied discount rate (lower bound, MUC = 1)	-2.8%
Implied discount rate (upper bound, MUC = 2)	-5.6%

5. **Given the broad macroeconomic and demographic parameters in South Sudan, a social discount rate spanning -2 percent to -4 percent is assumed.** In cases like South Sudan, when real GDP projections are negative, it means that the net present value of a future stream of investment is higher than the non-discounted values (because the discount factor is negative). The present value of the project costs is given in the table below.

Table A2.2: Discounted Project Costs (in million US$)

Years	Nominal	NPV	
		-2% disc.	-4% disc.
2019	37.6	37.6	37.6
2020	45.2	46.1	47.1
2021	22.6	23.5	24.5
Total	***105.4***	***116.6***	***129.3***

Incremental gains

6. **To determine the expected incremental gains generated by the Project, we use the Lives Saved Tool (LiST).** LiST is a multi-cause model of mortality which predicts changes in mortality using (i) changes in coverage from RMNACH and nutrition interventions; (ii) country specific health status; and (iii) effect sizes of interventions based on best available evidence. Baseline and target values for intervention coverage supported by the Project were imputed in close line with the results framework. Discount rates were assumed to lie between 2 percent and 4 percent. The table below summarizes the expected gains in terms of deaths averted:

Table A2.3: Summary of LiST Output (deaths averted)

Deaths averted	PESHP
	Total
Neonatal deaths	1,163
Child deaths	1,871
Maternal deaths	95
Total	***3,130***

Incremental cost-effectiveness ratio

7. **The final output of the cost-effectiveness analysis (CEA) is the ICER. The ICER of the proposed package of interventions is defined as the change in cost (with and without the Project) divided by the change in effectiveness.** Table A2.4 below summarizes discounted costs, incremental gains, and the ICERs calculated with a social discount factor spanning -2 percent to -4 percent.

Table A2.4: ICER summary table

Years	NPV (1)		Deaths averted	ICER (1,000 USD)	
	-2% disc.	-4% disc.		-2% disc.	-4% disc.
2019	37.6	37.6	462	8.1	8.1
2020	46.1	47.1	1,039	4.4	4.5
2021	23.5	24.5	1,629	1.4	1.5
Total	***116.6***	***129.3***	***3,130***	***3.7***	***4.1***

8. **The CEA and the ICERs show that the proposed project is cost-effective.** Shephard et al. (2015), and WHO (2011,[37] 2015[38]) provide guidance to interpret ICERs, this guidance is summarized in table A2.5below. According to our parameters and calibration, the ICER for the proposed project varies between 372 and 413 US$. Comparing these values with a GDP per capita of US$237 suggests that the ICERs are comprised between 1.6 and 1.7, and thus the proposed project can be deemed as cost-effective (ICER between 1 and 3 times GDP per capita).

Table A2.5: Cost-effectiveness Thresholds

Threshold	Cost-Effectiveness
ICER < GDP per capita	Highly cost-effective
GDP per capita < ICER < 3*(GDP per capita)	**Cost-effective**
ICER > 3* GDP per capita	Not cost-effective

Cost-benefit analysis

9. **Both CEA and cost-benefit analysis (CBA) provide information on the costs and consequences of investments.** The primary difference is that in cost-benefit analysis, all outcomes are measured in monetary units. In contrast, in cost-effectiveness analysis, the health benefits are measured in a nonmonetary unit such as death averted, while costs and other effects are measured in monetary units.

10. **By using money as a common metric, cost-benefit analysis in principle allows the simultaneous, integrated consideration of multiple consequences, including both health and non-health impacts.** Money is not important per se; it is simply a convenient common metric to measure the trade-offs individuals and societies are willing to make. If an individual chooses to purchase a good or service, he or she presumably values that good or service at least as much as the other things he or she could have used that money to buy. More generally, if a country or other funder chooses to spend more on one initiative, it will have fewer resources available to devote to other purposes – including other initiatives that address the same or similar problems.

11. **We follow the latest best-practice guidelines developed to conduct the cost-benefit analysis for the proposed Project.[39]** A group of experts led by Harvard School of Public Health researchers and funded the Bill and Melinda Gates Foundation have recently developed reference cases and best practice guidelines to conduct thorough and consistent economic evaluation of health-related interventions, particularly in low- and

[37] WHO (2011) Commission on Macroeconomics in Health. Geneva: WHO.
[38] WHO (2015) Cost-effectiveness Thresholds.
[39] The material and references for the BCA guidelines are available here: https://sites.sph.harvard.edu/bcaguidelines/.

middle-income countries. We follow here the cost benefit guidelines of Robinson et al. (2018)[40] and Wong (2018).[41]

12. **As conventionally conducted, cost-benefit analysis is based on respect for individual preferences.** Value is derived from the willingness of the individuals affected to exchange money for the benefits each accrues. Spending on mortality risk reductions means that individuals – and the society of which they are a part – will have fewer resources available to spend on other things. Analysts convert estimates of individual willingness-to-pay (WTP) for a reduction in mortality risk that accrues throughout a population decrease in the expected number of deaths within a timeframe. This central concept in cost-benefit analysis is the value per "statistical" life (VSL). The term "statistical" refers to small changes in the chance of dying. VSL is not the value that the individual, the society, or the government places on averting a death with certainty. Rather, it represents the rate at which individual views a change in money available for spending as equivalent to a small change in their own mortality risk.

13. **When evaluating policies to be implemented in lower income countries, benefit-cost analysts typically rely on one of two approaches:** (1) they use the results of studies conducted in the country of concern if available; (2) they extrapolate from values from higher income countries, adjusting for differences in income. While the first option is preferable when studies from the country are of sufficient quality, the paucity of research in many settings means that analysts often follow the second option. To the best of our knowledge, there are no stated or revealed preference studies conducted in South Sudan that would elucidate the willingness to pay for a reduction in mortality risk for diarrhea, lower respiratory infection or any other disease. The review by Robinson, et al. (2018) also did not identify any South Sudan specific literature either.

14. **Since context-specific analysis of the VSL is not available in South Sudan, we use a benefit-transfer VSL approach whereby:** (i) upper bound estimates of VSL are set at 160* GNI per capita (at PPP factors), (ii) central estimates are set at 100* GNI per capita, and (iii) lower bound estimates are equivalent to 28*GNI per capita. These parameters correspond to (i) US$272,000, (ii) US$170,000 and (iii) US$47,292. We use the lower bound value of the estimated VSL to remain on the conservative side. These VSL values are multiplied by the annual death averted by the intervention to estimate the monetary value of the benefit. The results of the CBA are summarized in Table A2.6 below.

Table A2.6: Cost-benefit Analysis Summary

	Annual benefits from mortality avoided (lower bound VSL) (USD million)	Annual costs (NPV) (USD million)	Benefit to cost ratio	Net yearly benefit (USD million)
-2% discount	154.1	58.3	2.6	95.8
-4% discount	160.6	64.6	2.5	96.0

[40] Lisa A. Robinson, James K. Hammit, and Lucy O'Keefe (2018) Valuing Mortality Risk Reduction in Global Benefit-Costs Analysis. Guidelines for Benefit-Cost Analysis Project, Working Paper #7.
[41] Brad Wong (2018) Benefit-Cost Analysis of a Package of Early Childhood Interventions to Improve Nutrition in Haiti. Guidelines for Benefit-Cost Analysis Project, Working Paper #6.

15. **Overall, the estimated benefits incurred by the proposed project outweigh costs by a factor of around 2.5.**

16. **In terms of value added of the World Bank support to South Sudan on health system performance, in particular service delivery modalities include:** (i) mobilization of resources to fill critical gaps in the health sector; (ii) its technical input based on international experience on health systems strengthening, service delivery in FCV contexts, and capacity to mobilize a wide-range of technical expertise to support key strategies and reforms; but also (iii) its convening role to support mobilization and channel additional resources to scale-up delivery of effective and efficient health services.

17. **Finally, the project will invest significantly in strengthening the delivery of health services, provided both by public and private sector. The rationale for public sector engagement for this Project is based on the role of the government to promote economic and social goals and their spillover effects**. Investments funded through the Project are to strengthen capacity to deliver essential health services, key to provide and promote preventive health services and support improvements in access good quality services. Moreover, these interventions have positive externalities and important spillovers (societal returns of investing in women's and children's health for economic growth).

ANNEX 3: Implementation Support Plan

COUNTRY: South Sudan
Provision of Essential Health Services Project

Strategy and Approach for Implementation Support

1. **The proposed project is an emergency operation processed under Paragraph 12 of World Bank Policy for IPF and OP 2.30 and uses UNICEF and ICRC as Recipients of IDA funds and alternative partner agencies.** The project will be subject to UNICEF's and ICRC's FM and procurement policies and procedures, while the World Bank safeguard policies and procedures will apply. The World Bank will support UNICEF's and ICRC's implementation efforts and help manage key risks to attain the PDO.

2. **UNICEF and ICRC are responsible for the implementation of the project activities in close coordination with the Ministry of Health at the central, state and county levels, as well as other development and humanitarian partners engaged in the health sector in the project's targeted areas.** ICRC will provide narrative progress reports as well as financial reports and financial statements to the World Bank every quarter. UNICEF will provide quarterly financial reports moving to biannual financial reports as well as biannual narrative progress reports complimented by quarterly results matrices. The narrative report will include: a summary of the progress and the context within which the project is implemented; the activities carried out during the reporting period; any challenges encountered and measures taken; changes introduced in implementation, including changes in the budget; achievements and results of the project with reference to identified indicators; and the work plan for the following period.

World Bank Supervision

3. **The World Bank will conduct "reverse" implementation support missions at least biannually to:** (a) review implementation progress and achievement of PDO and intermediate indicators; (b) provide support for any implementation issues that may arise; (c) provide technical support related to project implementation, achievement of results, and capacity building; and (d) discuss relevant risks and mitigation measures; and (e) monitor the health system's performance through progress reports, audit reports and field visits, if and when they become possible.

4. **The World Bank team comprises specialists in the areas of health, nutrition, operations, FM, procurement, social and environment safeguards, legal, and administration.** In addition to staff based in Washington, D.C., key task team staff are based in the World Bank's country offices in South Sudan (fiduciary, technical), Ethiopia (technical, safeguards), and Kenya and Nigeria (technical), which will facilitate implementation support and ad hoc problem solving as needed. With regard to specific technical support, experts may be recruited as deemed necessary during project implementation.

Table A3.1: Implementation Support Plan and Resource Requirements

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First twelve months	Operational readiness	Technical and operational support for addressing early implementation bottlenecks. Fiduciary (procurement, FM, safeguards) and implementation planning and start-up.	US$200,000	Joint supervision, technical support and data sharing.
12-24 months	Implementation, technical and operational support	Specialists as needed.	US$150,000	Joint supervision, technical support and data sharing.
Other				

Skills Mix Required

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Team leadership – technical and operational	12	At least 4 trips per year	Country office based
Technical expertise	6	At least 2 trip per year	Country office based
Legal counsel	1	As needed	Headquarters based
Procurement expertise	4	As needed	Country office based
FM expertise	4	As needed	Country office based
Environmental expertise	4	As needed	Headquarters based
Social development expertise	4	As needed	Country office based
M&E expertise	4	At least one trip a year	Country office based
Operations support	4	At least one trip a	Headquarters based

year

Partners

Name	Institution/Country	Role
UNICEF	Republic of South Sudan	-Grant recipient and implementing agency -Joint missions and technical cooperation -Data sharing -Operational coordination
ICRC	Republic of South Sudan	-Grant recipient and implementing agency -Joint missions and technical cooperation -Data sharing -Operational coordination

ANNEX 4: Map of South Sudan

COUNTRY: South Sudan
Provision of Essential Health Services Project