Report Number: ICRR0023110

1. Project Data

Project ID P168926	**Project Name** Essential Health Services Project
Country South Sudan	**Practice Area(Lead)** Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-D4270,IDA-D4280,IDA-D7670	31-Dec-2021	108,748,975.38
Bank Approval Date	**Closing Date (Actual)**	
27-Feb-2019	31-Dec-2021	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	105,400,000.00	0.00
Revised Commitment	109,448,955.69	0.00
Actual	108,748,975.38	0.00

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Project Objectives and Components

a. Objectives

The objectives of the project were defined by the Financing Agreements of February 28, 2019, between IDA, the International Committee of the Red Cross (ICRC), and UNICEF for the benefit of the people of the Republic of South Sudan as follows: 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.

The objectives were revised by adding a contingent public health emergency response on January 22, 2021, at which time 87 percent of the proceeds were disbursed. The revised objectives were stated as follows: to

increase access to an essential package of health services and respond to health emergencies in the Republic of South Sudan, with a particular focus on the former states of Upper Nile and Jonglei.

There was no need for a split evaluation, as the Additional Financing just expanded the scope of the project, and there were no mixed achievements.

b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

Yes

Date of Board Approval

05-Feb-2021

c. Will a split evaluation be undertaken?

No

d. Components

According to the Financing Agreement (Provision of Essential Health Services Project), there were four components of this project.

Component 1: Delivery of Essential Health Services (estimated US$93.0 million, actual US$84.3 million): This component aimed to deliver essential health services to the populations of Upper Nile and Jonglei states as well as other vulnerable communities affected by conflict and violence. This component aimed to support the delivery of services at primary care facilities and strategically identified secondary hospitals, complemented with community outreach and mobile health services. The component aimed to increase and expand equitable coverage and access, especially for remote or hard to reach communities with a total population of approximately 1.8 million living in these two States. It included about 85,000 pregnant women; 82,000 children under one; and 382,000 children under five years of age (National Bureau of Statistics, 2015).

Component 1 was comprised of two subcomponents. **Sub-component 1.1** covered delivery of high impact essential health services in the former Upper Nile and Jonglei states (US$61 million). It aimed to deliver services in the areas of (i) child health, (ii) maternal and neonatal health, (iv) basic and comprehensive emergency obstetric and newborn care; and (iv) sexual and gender-based violence. This sub-component also aimed to provide goods, training, and technical assistance to enhance (i) emergency preparedness and response, (ii) disease surveillance and early response, (iii) coordinated community-level surveillance systems, and to establish (iv) an early warning system for infectious disease trends prediction.

Sub-component 1.2 covered delivery of essential health services to highly vulnerable and conflict-affected populations (US$32 million equivalent) at two levels. At the primary care and community level, this subcomponent aimed to provide services in the areas of (i) curative care for frequent diseases and injuries; (ii) women wellness care, (iii) child preventive care, including vaccinations; and (iv) mental health and psychological support. At the secondary care level, this component also aimed to provide (i) outpatient and

emergency services; (ii) surgical and non-surgical services; (iii) clinical support services; and (iv) non-clinical support services.

Component 2: Monitoring, Evaluation and Learning (estimated US$4.0 million, actual US$2.6 million): This component was co-financed with the UK's Foreign, Commonwealth and Development Office (FCDO) and Health Pool Fund (HPF3). It aimed to support the establishment of a national, unified monitoring approach, and a third-party independent monitoring of accessible project areas to ensure the generation of credible health service delivery data. This component was also expected to ensure that independent and credible data on health service delivery were gathered to enable the World Bank, Government, and development partners to have a clear line of sight that resources were reaching the intended beneficiaries and potential harm was minimized.

Component 3: Emergency Preparedness and Response (estimated US$3.0 million, actual US$13.9 million): This component was comprised of two subcomponents. **Sub-component 3.1** was implemented by UNICEF to provide support for the national Ebola Virus Disease (EVD) Preparedness and Response Plan through provision of required training, technical assistance, and goods. **Sub-component 3.2** was implemented by International Committee of the Red Cross (ICRC) to support the immediate response to an eligible crisis or emergency, as needed.

Component 4: Repayment of Project Preparation Advances (estimated US$5.4 million, actual US$4.4 million): This component aimed to the repayment of project preparation advances made by the Association to the Republic of South Sudan (under Preparation Advance Numbers Q9090, Q9320 and Q9460) for the Institutional Development and Capacity Building Project, Energy Sector Technical Assistance Project and the Agricultural Development and Food Security Project respectively.

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Cost and financing: The original cost at appraisal was estimated at US$105.4 million, financed by an IDA grant, out of which, US$73.4 million were to be administered by UNICEF, and US$32 million by the International Committee of the Red Cross (ICRC). No direct financial contributions from the government were planned or provided. In 2021, an additional funding, to the amount of US$5 million was approved by the Board to provide additional financing for parts 1.1, 2 and 3.1 of the Original Project and to amend specific provisions of the Original Financing Agreement. The actual cost was US$108.7 million.

There were several cross-component readjustments and approval of additional funding. Component 3 was comprised of two sub-components where sub-component 3.2 (Contingent Emergency Response Component, CERC) was a zero-cost mechanism that allowed for the rapid reallocation of funds from other project components in the event of a natural or man-made disaster or health outbreak, or crisis likely to imminently cause a major adverse economic and/or social impact. The first CERC activation was on September 9, 2019, to reallocate US$7.9 million from Component 1 to Subcomponent 3.2 to support EVD preparedness activities. The second CERC activation was on April 6, 2020, to reallocate US$5.0 million from Component 1 to Subcomponent 3.2 and reprogram US$2.6 million remaining from the previously triggered CERC for EVD preparedness towards the COVID-19 response (total of US$7.6 million). The CERC was activated to support the National COVID-19 Preparedness and Response Plan in coordination with other development partners (project paper, p8).

Dates: The Provision of Essential Health Services Project (PEHSP) was approved on February 27, 2019, and became effective on March 11, 2019. A Mid-Term Review was undertaken on December 2, 2020. The project closed on December 31, 2021, as originally planned.

3. Relevance of Objectives

Rationale

Investing in South Sudan's health sector had the potential for large benefits that fitted well into the country's context. According to World Bank Country Engagement Note (2021), South Sudan remained one of the poorest countries in the world with an estimated 80 percent people living in poverty in 2020, and more than half of the population needed humanitarian assistance, particularly in conflict-prone pockets of Jonglei and Upper Nile. South Sudan had the world's highest maternal mortality ratios, weak disease surveillance systems for outbreaks, and epidemics. Effective service delivery for a fragile, conflict and violence affected country like South Sudan thus remained an important challenge. Several states, including those in the former states of Upper Nile and Jonglei, were in active conflict and experienced periodic flare-ups of violence, resulting in health systems severely burdened by acute surges in trauma and injuries, and by supply disruptions (PAD, p 14).

The project objectives were highly relevant to the health needs of South Sudan and fitted squarely within the government's health sector reform agenda. The PDO-1 was directly aligned with South Sudan's 2016-2026 National Health Policy, the 2017-2022 National Health Sector Strategic Plan, and the 2018-2021 National Development Strategy. PDO-2 fitted with the World Bank's COVID-19 Strategic Preparedness and Response Program (SPRP) which was approved on April 2, 2020. Bank's immediate adjustments to the portfolio to respond to the emerging needs was also timely during COVID-19 pandemic to protect human capital and household welfare from heavy economic toll.

The PDOs were in full alignment with the FY 21-23 Country Engagement Note (CEN). Among three focus areas of the World Bank's current CEN for FY21-FY23: (1) Laying the ground for institutional building; (2) Building resilience and livelihood opportunities; and (3) Providing continuous support to basic service delivery, PEHSP, or 'the Provision of Essential Health Services Project', was one of the only three active projects in South Sudan's portfolio and the only health project at the time of the CEN that was in full alignment with Focus Area 3. It tackled the need for high-impact, immediate response and early recovery health interventions in areas significantly affected by conflict. It provided broad support to primary healthcare centers and secondary care hospitals to the general population of Upper Nile and Jonglei states.

The Project PDOs were also in full alignment with the 2020-25 World Bank Strategy for fragility, conflict and violence (FCV). The PDOs directly addressed two of the four strategy pillars, "Remaining engaged during conflicts and crisis situations" (Pillar 1), and "Mitigating the spillovers of FCV" (Pillar 2).

Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

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.

Rationale

According to the PAD, accessibility to provide health services in areas acutely affected by the crisis remained a significant challenge in South Sudan. Only a few actors in the country had been able to find ways to allow them to cross boundaries between Government and opposition-held areas to deliver services (PAD, p27).

Given this background, and with the critical assumptions of minimal disruption due to conflict, flooding, and sufficient health infrastructure, the causal chain in the **theory of change** stated that the delivery of an essential package of health services to targeted beneficiaries through trained healthcare cadres would result in improved quality and availability of health services, followed by an uptake in the use of better-quality health services in the short and medium terms. It also stated that over the longer term, better coverage of higher quality health services would expectedly lead to improved health outcomes among the beneficiary populations (PAD, p33).

Outputs:

The PEHSP achieved major improvements in availability and uptake of essential health services, and functionality of health facilities. Over the course of implementation, the project -

- Delivered essential health services, such as, basic nutrition services to women and children, immunization vaccines to children through third-party implementing agencies UNICEF and ICRC.
- Provided curative consultations to children under 5 years of age.
- Increased the number of qualified health facility staff through recruitment, capacity building, and training. Collectively, a total of 8,551 health facility staff, and 1,743 Boma Health Worker (BHWs) were trained and deployed to 170 bomas to provide curative, preventive, and promotional services.
- Trained traditional birth attendants to facilitate safe and clean deliveries, assessing newborn health, identifying, and referring complex pregnancy cases, providing counselling on good health practices and promotion of health services in clinics and hospitals.
- Supplied and equipped health facilities with pharmaceuticals, equipment, and essential health commodities. The ICR reported that 147 health facilities had essential medicines available, and 128 health facilities were providing an essential package of health services.

Outcomes:

The PEHSP mostly achieved its targets and surpassed in availability of essential health services. The results were understandably output-oriented in view of the short implementation period in a challenging FCV situation.

- Over the course of implementation, the project delivered essential health services to 958,873 people against a target of 300,000.

According to the ICR, PDO-1 was a composite indicator, comprised of (1) Number of children immunized; (2) Number of women and children who have received basic nutrition services; and (3) Number of deliveries attended by skilled health personnel. The ICR reported that the project provided

- Basic nutrition services to 412,982 women and children that surpassed its target of 200,000.
- Immunization vaccines to 510,953 children that surpassed its target of 75,000.
- 34,938 deliveries were attended by skilled health personnel against its target of 25,000, and
- 2,132,896 curative consultations were provided for under 5 children.
- Multiple visits to 73,748 pregnant women against a target of 40,000.
- Post-natal care to 21,452 newborn children within 2 days of childbirth.
- Clinical management of rape services to 98 percent of gender-based survivors presenting at health facilities

While most of the PDO indicators from the RF (Table 1) highlighted achievements of their target values, two PDO indicators achieved less than 75 percent of their corresponding end targets:

- *PDO1.3:* Only 147 of health facilities against a target of 200 had essential medicines available, suggesting 74 percent achievement of the end target, and
- *PDO1.4: only 128 health facilities, against an end target of 200, achieved their target of providing at least 75% of the essential package of health services.* In other words, the achievement was only at 64 percent.

Despite the lack of full achievement of the end targets of two outcome indicators, progress in increasing access to essential health services was notable and the overall achievement was substantial.

Rating
Substantial

OBJECTIVE 2
Objective
Respond to health emergencies in the Republic of South Sudan, with a particular focus on the former states of Upper Nile and Jonglei.

Rationale
The **theory of change** held that training in disease surveillance and response, risk communication, and provision of supplies for infection control, water, sanitation and hygiene would contribute to facilitating preparedness and response to health emergencies.

Outputs and intermediate results:

The project resulted in important improvements in the availability of the following health emergency outputs with particular focus on the former states of Upper Nile and Jonglei. Over the course of implementation, the project:

- Trained 10 rapid response teams on investigation of alerts and immediate outbreak response.
- Provided in service training to 8,551 health care workers, far exceeding the target of 400 workers.
- Trained 1,743 community health workers to implement integrated community case management.
- Established 100 percent of bomas with health committees against a target of 85 percent.
- Provided measles vaccination to 147,379 children under one year against a target of 75,000.
- Reached to 500,000 people by the awareness campaigns and risk communication activities related to COVID-19. This was a new indicator.

Outcomes:

Outcomes were output-oriented and sought to reflect on the stated objective to respond to health emergencies in the Republic of South Sudan, with a particular focus on the former states of Upper Nile and Jonglei. In that context, the proportion of disease outbreaks that were detected and responded to within 72 hours of confirmation increased from a baseline of 15 percent to 100 percent, exceeding the target of 50 percent. The outbreaks included 9 measles outbreaks and one vaccine-derived polio outbreak. While the project had noteworthy contributions and achievements in responding to health emergencies, there was insufficient information on overall systemic capacities and readiness aspects, including human resources and laboratory capacities, that facilitate effective responses to health emergencies. Therefore, the objective was assessed as almost fully achieved, and rated as substantial.

Rating
Substantial

OVERALL EFFICACY
Rationale
The project almost fully achieved its two objectives to increase access to an essential package of health services and to respond to health emergencies. The aggregation of both achievements indicated a Substantial rating for overall efficacy.

Overall Efficacy Rating

Substantial

5. Efficiency

The PAD's economic analysis carried out a cost-effectiveness analysis (CEA) and a cost-benefit analysis (CBA). Both CEA and CBA provided information on the costs and consequences of investments. The cost-effectiveness analysis methodology considered benefits expressed in non-monetary terms of effectiveness (viz., lives saved because of the supported interventions) and costs of the interventions for all four components of the project expressed in monetary terms. Cost benefit analysis on the other hand, included all outcomes and costs measured in monetary units. Both CEA and CBA showed that the project would be cost-effective. In terms of monetary value, the CBA suggested net yearly benefits to be between 95.8-96 million USD, with benefit-cost ratio between 2.5 and 2.6 at 2 to 4 percent discount rates (PAD, p91-92). It suggested that the benefits from the project would be 2.5 to 2.6 USD for every dollar spent in the project.

The ICR undertook an ex-post cost-benefit analysis to estimate the project's economic return on investment on both the initial IDA grant and the AF, and similarly found the benefits of the project outweighed the costs. All benefits and costs were assumed to result from the project, since the project was the primary source of financing in the Jonglei and Upper Nile states. The estimated NPV to the amount of US$687.6 million with a corresponding IRR of 13.95 percent, and 7.96 BCR at project closing with a 5 percent discount rate, suggested that for every dollar invested, the project yielded a significant economic return. Additionally, investing in South Sudan's health sector has long-term development benefits which was not quantifiable in the economic analysis due to the absence of a functional health system, extended periods of conflict, and longstanding challenges in accessing health services (ICR, p20).

There were implementation aspects that contributed to efficiency as well. The implementing agencies, UNICEF and ICRC, showed high level of readiness in an extremely difficult fragile and conflict prone environment, with periodic political instability, heavy seasonal flooding, inadequate infrastructure and human resource capacity. They worked efficiently even during two suspensions of services due to security incidents, and severe restrictions of movement and ability to operate as a consequence of the COVID-19 pandemic (ICR, p 21).

There were, however, some understandable shortcomings in the efficiency of implementation given the difficult FCV situation. Barring delays in implementation due to restriction in mobility during pandemic, disruption in supply chain and limited transport infrastructure, and high staff turnover in the UNICEF Implementing Partner teams, resulted in low reporting rates, stock management issues, and service delivery challenges. This inefficiency was reflected in the under achievements in the number of health facilities with essential medicines available, and in the number of health facilities providing at least 75% of the essential package of health services.

Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 ☐ Not Applicable

ICR Estimate	✓	13.95	0 ☐ Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Relevance of objectives is rated **High,** as the objectives remained fully consistent with the Bank's South Sudan CEN FY18-19 endorsed by the Board in January 2018 and with the World Bank Strategy for FCV (2020-25). Overall Efficacy is rated **Substantial**, as the project almost fully achieved its objectives. Efficiency is also rated **Substantial** with favorable cost-effectiveness, but with moderate shortcomings in the efficiency of implementation. The overall Outcome is rated **Satisfactory**, indicative of essentially minor shortcomings in the project's overall preparation, implementation, and achievement.

a. Outcome Rating

Satisfactory

7. Risk to Development Outcome

Among the foreseeable risks, the ICR pointed out that the risk to the development outcome remained high with PEHSP's closure on December 31, 2021. The main risk is related to a continued FCV situation. The lack of other large-scale donor or Government financing to support the provision of life-saving health services in Jonglei and Upper Nile may diminish the sustainability of outcomes that have already been achieved.

The ICR (p37) mentioned that PEHSP was not designed as a long-term development project. Rather, PEHSP was processed as an emergency operation to bridge urgent population health needs in the short-to-medium term in Jonglei and Upper Nile states. Because of third-party implementation modality, capacity building and institutional strengthening efforts just focused on NGO/ INGO IPs, health service providers, state officials, and CHDs- rather than on central Government. As a result, the existing roles of the MoH and PEHSP's implementation arrangements did not facilitate the transition to Government-led implementation. Weak fiduciary and management capacity of the government were other issues that might handicap the government to fully lead and manage health operations.

In the context of macro-economic risks, fiscal capacity is another factor that can affect development outcomes.

Among other risks, The ICR highlighted the lack of additional consideration of mitigation measures to de-escalate community tension during suspensions of project activities and consequent IP reputational risks.

8. Assessment of Bank Performance

a. Quality-at-Entry

Key lessons from the South Sudan Country Engagement Note (CEN, FY18-19) from across the portfolio were adequately considered in the proposed operation. A need for flexibility, both at the strategic and operational level, was recognized in order to increase speed in delivery of services, accountability, citizen engagement, and strategic partnerships- given the enormity of needs, the geographical scope and limited resources.

At entry, implementation risks were adequately identified, including supply, and capacity constraints based on lessons learned from previous projects in the country. The project incorporated appropriate mitigative measures to avoid such challenges. The project incorporated lessons learned from the Health Rapid Results Project (HRRP) that indicated reduced coverage due to upsurge in instability and violence, inability to monitor and verify results in the majority of the two states. The proposed project was processed under procedures specified under the World Bank Policy and Directive for Investment Project Financing (IPF, Chapter 12) to respond quickly to critical needs in two of the most conflict-affected states in South Sudan. The PAD (p37) informed that both ICRC and UNICEF were expected to focus on rural populations and hard-to-access areas where vulnerability was acute, allowing the project to target some of the most vulnerable populations in South Sudan. Both ICRC and UNICEF were also expected to adopt adaptive strategies to deliver context-specific essential services despite having similar health packages.

The project also proposed to invest 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. Under Component 1 the project created a strong focus on building capacity of decentralized service delivery platforms and the health system at community, health facility and county level through trainings in clinical protocols and guidelines, Health Management Information System (HMIS) data management, supervision skills, supply chain management; planning and coordination skills of county health department teams; and national information and monitoring systems (PAD, p22).

At entry, there was **significant fiduciary risks** within the country environment which could impact the Financial Management (FM) arrangements of the project. These included 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 non-transparent stewardship of funds. To mitigate these risks, the implementation modality involving UNICEF and ICRC responded to the heightened fiduciary risks and lessons learnt during the implementation of Health Rapid Results Project (HRRP). This included monitoring of 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.

Capacity constraints of the Government to effectively manage and implement operations was recognized and a revitalization of the World Bank's engagement was done through a new operation. It provided financing directly to UNICEF to carry out operations for the benefit of the people in South Sudan. Lessons from the Health Rapid Results Project (HRRP) provided key lessons and experiences that have oriented the decision to change implementation arrangements where partner agencies become direct Recipients of IDA. The proposed engagement with ICRC and UNICEF in South Sudan through this operation was to ensure a broader collaboration effort between the World Bank and partners in fragile states and conflict affected settings. It was also expected to ensure maintenance of key health infrastructure and human

resource capacity and continue to preserve a level of service delivery that the Government could pick up at a future date.

There were however some limitations. The two-year implementation timeline was ambitious because heavy supply-side interventions required sufficient processing time, particularly under macroeconomic, and natural risks which were beyond the control of the project. Given IDA resource constraints and the unpredictable setting and urgent health needs in South Sudan, the planned activities under the proposed operation had an estimated budget for 24 months. An additional nine months was however, added to the project duration to allow for flexibility to adjust strategies and timelines given the unpredictable environment. It also aimed to allow for the financial closure undertaken by the partner organizations.

Quality-at-Entry Rating
Satisfactory

b. Quality of supervision

Supervision inputs and processes were adequate. World Bank team closely coordinated with both UNICEF and ICRC to resolve PEHSP-related concerns and tackle difficult issues. The Bank conducted quarterly and biannual reviews, through emails, and virtual missions to facilitate the regular exchange of information. To ensure continuous monitoring and technical support during COVID pandemic, the Bank also communicated regularly with UNICEF, and ICRC.

The World Bank made strategic decision to procure drugs in advance during the Health Rapid Results Project to PEHSP transition period. Its proactivity in triggering the Ebola Virus Disease (EVD) and COVID-19 CERCs also allowed the project to rapidly reallocate funding to respond to emerging health needs in Jonglei and Upper Nile. The Bank also conducted PEHSP implementation support missions at least annually with both UNICEF and ICRC.

There were however some procurement glitches. Two procurement risks identified during project preparation did materialize during implementation. First, delays in delivery and distribution of basic medicines and pharmaceutical items occurred for tranche two and tranche three due to global supply chain disruptions, COVID-19 restrictions, and lack of project funds. Second, delayed submission of third-party monitoring (TPM) reports hindered its oversight function. The ICR also highlighted that limited opportunities for project supervision due to conflict and violence restricted World Bank staff to conduct field supervision visits outside of Juba during the lifetime of the project. It also caused delayed third-party monitoring (TPM) verification visits and its report submission to the World Bank and subsequently, limited the scope of real-time monitoring of service delivery progress. However, the above issues, largely related to FCV, were not directly attributable to Task Team performance.

Environmental safeguards were satisfactory in both UNICEF and ICRC components throughout PEHSP's implementation. ICRC-operated health facilities followed ICRC's 'infection prevention and control' (IPC), 'water, sanitation and hygiene' (WASH), and 'medical waste management' (MWM) service standards that commensurate with World Bank safeguards policies. UNICEF implementation through INGO and NGO implementing partners using governmental health facilities however, needed to be brought up to World Bank standards for IPC, WASH, and MWM.

Social safeguards were also satisfactory in both UNICEF and ICRC components throughout PEHSP's implementation. Both ICRC and UNICEF prepared social assessment and related social development plans and conducted community consultations to identify related risks. Outreach activities were also conducted with the integration of local Government for sustainability. Both ICRC and UNICEF's grievance redress mechanism (GRM) was confirmed to be functional by the task team during the October 2019 mission, albeit UNICEF needed to further strengthen its GRM system.

Similar to social and environmental safeguard supervision, **financial Management (FM) was also satisfactory** in both UNICEF and ICRC components throughout PEHSP's implementation. PEHSP's third-party implementation modality was a direct response to fiduciary weaknesses during Health Rapid Results Project's implementation.

In alignment with the lessons learnt from HRRP, the regular presence of PESHP TTLs in a neighboring country strengthened communications with the CMU, implementing partners, and the Government. Given South Sudan's high-risk environment, the proximity of the TTLs to the ground allowed fluidity to follow-up and resolve day-to-day implementation issues even during COVID-19.

Quality of Supervision Rating
Satisfactory

Overall Bank Performance Rating
Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design
The M&E design was sound. Given the stated objectives, it was designed to collect comprehensive, information on availability of health services at health facilities in the targeted geographic areas in South Sudan. The objective indicators were clear and measurable and encompassed all outcomes of the PDO statement. The result framework (RF) indicators were well-selected to reflect progress towards PDO achievements and were able to accurately capture the challenges with pharmaceutical stockouts and supply chain management (captured through PDO1.3). These PDO indicators were also able to capture the improvements in health facility M&E capacity. The intermediate results indicators were adequate to capture the contribution of the project's components and outputs toward achieving PDO-level outcomes.

The monitoring system aimed to track reported service availability and additional data elements on health service performance from each health facility being monitored to enable the system to compute the essential set of indicators. The performance monitoring methodology also aimed to include citizen engagement mechanisms, customized to capture key domains on satisfaction and perceived quality of care, to capture community feedback on service delivery. The National 'Lot Quality Assurance Sampling' surveys were expected to produce information that could be rapidly interpreted and used to identify relative achievements in coverage rates for key health services.

In terms of sources of regular data, all health interventions supported by the project aimed to use the 'health management information system' (HMIS/DHIS2) in conjunction with data and information provided by implementing partners. Data from health facilities in the project's targeted areas were proposed to be closely monitored by partner organizations, along with corrective actions identified and undertaken. The data for monitoring were expected to come from: (i) 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 and implementing partners, sub-contracted by UNICEF.

The result framework, however, had few minor design weaknesses. The PAD noted the mixed feelings on reliability for some indicators at the time of project appraisal. No formal baseline was conducted for this project which is quite common for projects in FCV prone areas. Periodic conflict and lack of updated census data on population had impacted the validity of PEHSP baseline values and set targets. In the absence of baseline, some of the targets were rolled over from the previous 'Health Rapid Results Project' which were too low in context of the anticipated 3.5 million beneficiaries. The interview conducted with the Task Team informed that due to lack of reliable baseline values, benchmark target values of some of the indicators were adopted from WHO and other organizations' target values as well. Another design weakness was the set target values of some indicators in absolute terms. For example, targets for indicators like "Number of health facilities with essential medicines available" and "Number of health facilities providing at least 75 percent of the essential package of health services", were set in absolute numbers, and didn't factor in changes in the number of health facilities supported. Consequently, non-reporting or suspended health facilities were counted as non-achievement.

b. M&E Implementation

Both UNICEF and ICRC were attentive to the quality of data to ensure effective M&E implementation. UNICEF and ICRC data collection contributed to biannual 'Implementation Status and Results Report' (ISR), reporting on the RF indicators throughout project implementation. These indicators were presented in a consistent and clear manner in each reporting cycle. The ability to further disaggregate the data and the consistently frequent reporting facilitated project supervision, especially given the delays in the submission of TPM reports and allowed UNICEF to identify capacity gaps and design targeted responses to address them. In addition, the ICR mentioned that UNICEF field staff conducted data quality audits and verified data submitted in source documents, IP reports submitted to UNICEF, and DHIS2 data as part of its supervision visits to 20 percent of health facilities each quarter. ICRC conducted monthly supportive supervision visits. To ensure independence and credibility of data generated, PEHSP also engaged 'Liverpool School of Tropical Medicine' (LSTM) as the third-party monitoring agency for all UNICEF-supported counties in Jonglei and Upper Nile, and WHO for the coordination of the Health Service Functionality dashboard. LSTM was responsible for conducting quarterly field verification visits as well as leading the national Lot Quality Assurance Sampling Survey to assess national coverage of key health services.

The ICR reported some challenges as well which were faced during M&E implementation. For example, submissions of data and reports were reported to be a challenge by limited network connectivity, long travel distances, and the remoteness of some health facilities. Similarly, data from health facilities were completely lost sometimes due to seasonal floods. During implementation, the LSTM also faced implementation challenges like delayed data verification, sampling methodology and health facility replacement protocol that were skewed towards more easily accessible health facilities, and lack of data

on ethnic groups of beneficiaries (ICR, Annex 7). The challenges were however mitigated by using innovative remote and georeferenced monitoring technologies.

c. M&E Utilization

The project's monitoring arrangements produced a rich array of data and were used in various ways to guide implementation progress. The ICR reported that the RF data collected were used for planning of pharmaceutical procurement and quantity adjustments for health facilities orders, with UNICEF/ IPs providing supportive supervision and improvement plans to address identified gaps. The RF data also fed into routine reporting of PEHSP's implementation progress.

PEHSP's clear and overlapping monitoring arrangements were aligned to the 'Health Pool Fund' (HPF3) monitoring arrangements and have potential to help future projects in South Sudan. It, however, requires appropriate efforts to improve knowledge management and M&E capacity within the MoH and that are needed to complement monitoring arrangements developed under PEHSP, as data are currently not in an organized and usable manner within the MoH.

A rating of Substantial is assigned because there were moderate shortcomings in the M&E system's design, implementation, or utilization. The M&E system as designed and implemented was, adequately sufficient to assess the achievement of the objectives.

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

The project triggered Environmental Assessment OP 4.01 Category B in view of risks related to medical waste, workers and community safety, and minor rehabilitation works in health facilities. Two Environmental and Social Management Frameworks (ESMF) were prepared, each with medical waste management details. In the context of social impacts from proposed project activities, the project aimed to scale up attention and efforts to improve access to services for sexual and gender-based violence victims. 'Clinical Management of Rape' (CMR) and basic psycho-social support services were included in the essential package of health services offered at health facilities supported by the project. Since no land acquisition was expected, OP4.12 on Involuntary Resettlement was not triggered.

The ICR (p33) mentioned that both ICRC and UNICEF prepared social assessment (SA) and related social development plans. They also conducted community consultations to identify related risks and mitigation measures. Both SAs, as the ICR pointed out, were disclosed in-country on December 11, 2018, and December 13, 2018, respectively. The Environmental and Social Management Framework (ESMF) and SA for the UNICEF component was revised to include the Security and Significant Event Management Framework (SSEMF) and was redisclosed on September 25, 2020. The overall safeguards rating was recoded as satisfactory in the Operations Portal.

b. Fiduciary Compliance

The **fiduciary compliance** was adequate. The ICR (p34) informed that audits conducted on UNICEF and ICRC project accounting and financial reporting documents expressed an unqualified (clean) opinion. It also informed that UNICEF's FM arrangements were well-aligned with requirements under the World Bank Policy and Bank Directive (formerly OP/BP 10.0) on investment project financing. Financial Management arrangements were based on the FM Framework Agreement with UNICEF which allowed UNICEF to use its own rules and procedures. Fiduciary oversight of IPs followed the Harmonized Approach to Cash Transfers, or HACT framework with programmatic visits, spot checks, and audits. Following Agreements during negotiation, additional staff were deployed by UNICEF to support project accounting and financial reporting. The United Nations Board of Auditors found UNICEF's financial performance and cash flows for the audited years 2019 and 2020 fairly represented all material respects. The audits expressed an unqualified opinion on consolidated ICRC financial statements and that they represent a true and fair view of the financial performance and cashflows of ICRC. The Agreement Upon Procedures (AUP) report confirmed compliance in project expenditures incurred with specific expenditure line items agreed with the World Bank, accuracy in the forex rates applied, and consistency of the quarterly interim financial reports (IFRs) with the underlying records and supporting documentation.

Procurement: The implementation of procurement activities under UNICEF and performance of Alternative Procurement Arrangements (APA) were rated Satisfactory throughout PEHSP's implementation (ICR, p34). UNICEF followed the original design and used their own procurement arrangements under World Bank's Alternative Procurement Arrangements (APA) guidelines. For ICRC, World Bank procurement procedure and policy was not applicable as PEHSP only financed ICRC staff, utilities and operational costs associated with project activities in South Sudan. UNICEF's APA had a satisfactory procurement performance during implementation, with timely contracting of key procurement activities including all IPs, a third-party monitoring firm and procurement and distributions of all three tranches of essential commodities and drugs to health facilities**.** Two procurement risks identified during project preparation— delays in delivery and distribution of basic medicines and pharmaceutical items, and delayed submission of TPM reports however, occurred during implementation.

c. Unintended impacts (Positive or Negative)

Not reported.

d. Other

None.

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	
Bank Performance	Satisfactory	Satisfactory	
Quality of M&E	Substantial	Substantial	
Quality of ICR	---	Substantial	

12. Lessons

The ICR identified the following lessons learnt at project completion.

- Collaboration across the humanitarian-development partners based on their respective comparative advantage can lead to greater success. PEHSP benefitted by operating through two large-scale institutional partnerships established with UNICEF and ICRC.
- Emergency response measures built-in the initial project design are useful to address future emergencies. The project benefitted from flexibility to scale project resource allocations based on the size of the emergency.
- Short project duration may not be sufficient for sustaining long-term impact. PEHSP was designed specifically to provide interim support to Jonglei and Upper Nile after the closure of HRRP. The short period of two years was not sufficient for expecting a long-term impact.
- Close implementation support through intensified field supervision and capacity building efforts helps when operating in conflict affected FCV environments.
- An Implementing Partner selection process conducted with transparency, objective selection criteria, and active participation of all stakeholders helped maximize project buy-in.
- Proactive communication and engagement with communities are crucial for creating local ownership and buy-in for health services.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The report adequately highlights how activities were linked to intended results. There is adequate internal consistency. The logical linking and integration of the various parts of the report and results are mutually reinforcing. **Quality of analysis is high**. There has been sufficient evidence to support the TOC, summarizing of salient points and clear linking of evidence to PDOs. **Quality of evidence is sufficient**. The ICR presents a set of proximal results that is sufficient to support the achievements reported in a short period of time in an FCV situation. However, additional qualitative information to supplement quantitative achievements (or lack thereof) could have enriched the report more. **Lessons learnt are adequately based on implementation experience**

and analysis. They appropriately respond to the specific experiences and findings for the project. **The ICR is clear, and candid**. The ICR is aligned well to project development objectives. The narrative and evidence supported the ICR's conclusions on the project's overall outcome. **The ICR is however, lengthy**, with a main text reaching 43 pages.

a. Quality of ICR Rating
Substantial