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Report No: PADHI00390

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT

IN THE AMOUNT OF SDR 47.6 MILLION
(US$62.5 MILLION EQUIVALENT)

TO THE

UNITED NATIONS CHILDREN'S FUND

AND A

PROPOSED GRANT

IN THE AMOUNT OF SDR 14.9 MILLION
(US$19.5 MILLION EQUIVALENT)

TO THE

WORLD HEALTH ORGANIZATION

FOR A

SUDAN HEALTH ASSISTANCE AND RESPONSE TO EMERGENCIES PROJECT

DECEMBER 2, 2024

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

CURRENCY EQUIVALENTS

(Exchange Rate Effective June 30, 2024)

Currency Unit =	Sudanese Pound (SDG)
SDG 600.42 =	US$1
US$1 =	SDR 0.7602597

FISCAL YEAR
January 1–December 31

Regional Vice President:	Victoria Kwakwa
Regional Director:	Daniel Dulitzky
Country Director:	Maryam Salim
Practice Manager:	Ernest E. Massiah
Task Team Leaders:	Amr Elshalakani, Abeyah A. Al-Omair, Moustafa Mohammed ElSayed Mohamed Abdalla

ABBREVIATIONS AND ACRONYMS

AI	Artificial Intelligence
AM	Accountability Mechanism
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CEN	Country Engagement Note
CHW	Community Health Worker
COVID-19	Coronavirus Disease 2019
CSO	Civil Society Organization
DHIS2	District Health Information Software 2
E&S	Environmental and Social
EHS	Environmental, Health, and Safety
EOC	Emergency Operations Center
ESF	Environmental and Social Framework
ESHS	Environmental, Social, Health, and Safety
ESMF	Environmental and Social Management Framework
ESS	Environmental and Social Standards
EWARS	Early Warning, Alert, and Response System
FAO	Food and Agriculture Organization
FCV	Fragility, Conflict, and Violence
FM	Financial Management
FMFA	Financial Management Framework Agreement
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GEMS	Geo-Enabling initiative for Monitoring and Supervision
GHG	Greenhouse Gas
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
IDA	International Development Association
IDP	Internally Displaced Person
IDSR	Integrated Disease Surveillance and Response
IFR	Interim Financial Report
INGO	International Non-governmental Organization
IP	Implementing Partner
IPC	Infection Prevention and Control
IRR	Internal Rate of Return
LHMT	Locality Health Management Team
M&E	Monitoring and Evaluation
NCD	Noncommunicable Disease
NDC	Nationally Determined Contribution
NGO	Non-governmental Organization
PCC	Project Coordination Committee
PDO	Project Development Objective
PHC	Primary Health Care

PIM	Project Implementation Manual
PMU	Project Management Unit
PPSD	Project Procurement Strategy for Development
SAM	Severe Acute Malnutrition
SANAD	Emergency Crisis Response Safety Net Project
SEA/SH	Sexual Exploitation and Abuse/Sexual Harassment
SEP	Stakeholder Engagement Plan
SHARE	Sudan Health Assistance and Response to Emergencies
SHNRP	Sudan Humanitarian Needs and Response Plan
SMF	Security Management Framework
Somoud	Enhancing Community Resilience Project
TPM	Third-party Monitoring
UN	United Nations
UNFCCC	United Nations Framework Convention on Climate Change
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Project Beneficiary(ies)	Operation Name		
Sudan	Sudan Health Assistance and Response to Emergencies		
Operation ID	Financing Instrument	Environmental and Social Risk Classification	Process
P504629	Investment Project Financing (IPF)	High	Urgent Need or Capacity Constraints(FCC)

Financing & Implementation Modalities

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

Expected Approval Date	Expected Closing Date
13-Dec-2024	31-Jan-2027
Bank/IFC Collaboration	
No	

Proposed Development Objective(s)

To restore access to a basic package of health and nutrition services and preserve the main elements of essential public health functions.

Components

Component Name	Cost (US$)
Improving Access to Basic Health and Nutrition Services	65,352,999.00
Preserving the Main Elements of the Health System	2,778,664.00
Monitoring and Evaluation and Project Management	13,868,337.00

Organizations

Borrower:	United Nations Children's Fund, World Health Organization		
Contact	Title	Telephone No.	Email
Implementing Agency:	World Health Organization, United Nations Children's Fund		
Contact	Title	Telephone No.	Email
Naseeb Qirbi	Senior Programme Management Officer	201010229833	qirbin@who.int
Tedbabe Degefie Hailegebriel	Chief of Health and Nutrition	249 912309412	thailegebriel@unicef.org

PROJECT FINANCING DATA (US$, Millions)

Maximizing Finance for Development

Is this an MFD-Enabling Project (MFD-EP)? No

Is this project Private Capital Enabling (PCE)? No

SUMMARY

Total Operation Cost	**82.00**
Total Financing	**82.00**
of which IBRD/IDA	**82.00**
Financing Gap	**0.00**

DETAILS

World Bank Group Financing

International Development Association (IDA)	82.00
of which IDA Recommitted	82.00
IDA Grant	82.00

IDA Resources (US$, Millions)

	Credit Amount	Grant Amount	SML Amount	Guarantee Amount	Total Amount
National Performance-Based Allocations (PBA)	0.00	82.00	0.00	0.00	82.00
Total	**0.00**	**82.00**	**0.00**	**0.00**	**82.00**

Expected Disbursements (US$, Millions)

WB Fiscal Year	2025	2026	2027
Annual	32.80	43.20	6.00
Cumulative	32.80	76.00	82.00

PRACTICE AREA(S)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

CLIMATE

Climate Change and Disaster Screening

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

SYSTEMATIC OPERATIONS RISK- RATING TOOL (SORT)

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

POLICY COMPLIANCE

Policy

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

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[✓] Yes [ ] No

Have these been approved by Bank management?

[✓] Yes [ ] No

Is approval for any policy waiver sought from the Board?

[✓] Yes [ ] No

ENVIRONMENTAL AND SOCIAL

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

E & S Standards	Relevance
ESS 1: Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10: Stakeholder Engagement and Information Disclosure	Relevant

ESS 2: Labor and Working Conditions	Relevant
ESS 3: Resource Efficiency and Pollution Prevention and Management	Relevant
ESS 4: Community Health and Safety	Relevant
ESS 5: Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
ESS 6: Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
ESS 7: Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Relevant
ESS 8: Cultural Heritage	Relevant
ESS 9: Financial Intermediaries	Not Currently Relevant

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

LEGAL

Legal Covenants

Sections and Description
Schedule 2 Section I.A.2 to the WHO Financing Agreement: In order to ensure proper implementation of its Respective Parts of the Project, not later than thirty (30) days after the Effective Date, the Recipient shall establish and thereafter maintain, throughout the Project implementation period, an adequately staffed Project Management Unit ("PMU"), based in the Recipient's offices in the Republic of the Sudan which shall be responsible for the day-to-day management, implementation, and monitoring and evaluation of the Project, with composition, mandate and resources as described in the PIM and in accordance with the ESCP.
Schedule 2 Section I.A.3 to the WHO Financing Agreement: In coordination with UNICEF, not later than thirty (30) days after the Effective Date, the Recipient shall establish and thereafter maintain throughout the implementation of the Project a coordination committee (the "Project Coordination Committee") with a composition and terms of reference agreed by the Recipient, UNICEF and the Association, to, inter alia, provide overall guidance and coordination of the Project implementation, identify and mitigate Project risks, review monitoring results, and make recommendations on implementation adjustments, as further set out in the PIM. The Project Coordination Committee shall be composed of representatives of the Recipient, and UNICEF and any other members as further described in the PIM.
Schedule 2 Section I.B.1 to the WHO Financing Agreement: Not later than thirty (30) days after the Effective Date, the Recipient shall prepare, and thereafter maintain a PIM for its Respective Parts of the Project, in form and substance acceptable to the Association.
Schedule 2 Section I.C.1 to the WHO Financing Agreement: The Recipient shall, not later than thirty (30) days after the Effective Date for the calendar year in which this Agreement shall become effective and not later than February 28 of each subsequent calendar year, or such later date as the Association may agree in writing, prepare and furnish to the Association for agreement, the annual work plan and budget containing the proposed activities to be carried out under

its Respective Parts of the Project during the following calendar year, together with the financing plan for such activities and a timetable for their implementation.
Schedule 2 Section III.2 to the WHO Financing Agreement: Prior to any procurement and not later than thirty (30) days after the Effective Date, the Recipient shall prepare and furnish to the Association for review the Procurement Plan, prepared in accordance with terms of reference satisfactory to the Association, and thereafter, implement the Project in accordance with such Procurement Plan as shall have been agreed with the Association.
Schedule 2 Section I.A.2 to the UNICEF Financing Agreement: In order to ensure proper implementation of its Respective Parts of the Project, not later than thirty (30) days after the Effective Date, the Recipient shall establish and thereafter maintain, throughout the Project implementation period, an adequately staffed Project Management Unit ("PMU"), based in the Recipient's offices in the Republic of the Sudan which shall be responsible for the day-to-day management, implementation, and monitoring and evaluation of the Project, with composition, mandate and resources as described in the PIM and in accordance with the ESCP. The PIU personnel shall have the appropriate skillsets, experience and expertise including, inter alia with regards to financial management, procurement, environmental and social, gender-based violence (GBV), Project management coordination, and the relevant expertise as required under the ESCP. For the first sixty (60) days after the Effective Date, UNICEF shall draw on existing personnel capacity from other UNICEF offices to fill in capacity gaps as an interim measure pending the recruitment of the relevant PMU staff as further described in the PIM and ESCP.
Schedule 2 Section I.A.3 to the UNICEF Financing Agreement: In coordination with WHO, not later than thirty (30) days after the Effective Date, the Recipient shall establish and thereafter maintain throughout the implementation of the Project a coordination committee (the "Project Coordination Committee") with a composition and terms of reference agreed by the Recipient, WHO and the Association, to, inter alia, provide overall guidance and coordination of the Project implementation, identify and mitigate Project risks, review monitoring results, and make recommendations on implementation adjustments, as further set out in the PIM.
Schedule 2 Section I.B.1 to the UNICEF Financing Agreement: Not later than thirty (30) days after the Effective Date, the Recipient shall prepare, and thereafter maintain a PIM for its Respective Parts of the Project, in form and substance acceptable to the Association.
Schedule 2 Section I.C.1 to the UNICEF Financing Agreement: The Recipient shall, not later than thirty (30) days after the Effective Date for the calendar year in which this Agreement shall become effective and not later than February 28 of each subsequent calendar year, or such later date as the Association may agree in writing, prepare and furnish to the Association for agreement, the annual work plan and budget containing the proposed activities to be carried out under its Respective Parts of the Project during the following calendar year, together with the financing plan for such activities and a timetable for their implementation.
Schedule 2 Section I.E.1 to the UNICEF Financing Agreement: The Recipient shall, no later than a hundred and twenty (120) days after the Signature Date, hire and thereafter, maintain throughout Project implementation, a Third-Party Monitoring Agent, with qualifications, experience and terms of reference satisfactory to the Association and WHO, to be financed out of the proceeds of the Financing, to carry out the Recipient's Third-Party Monitoring of the Project implementation.
Schedule 2 Section III.2 to the UNICEF Financing Agreement: Prior to any procurement and not later than thirty (30) days after the Effective Date, the Recipient shall prepare and furnish to the Association for review the Procurement Plan, prepared in accordance with terms of reference satisfactory to the Association, and thereafter, implement the Project in accordance with such Procurement Plan as shall have been agreed with the Association.

Conditions

Type	Citation	Description	Financing Source
Disbursement	Schedule 2 Section IV.B.1 (a) to the WHO Financing Agreement	Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made for payments made prior to the Signature Date, except that withdrawals up to an aggregate amount not to exceed SDR 5,960,000 may be made for payments made prior to this date but on or after March 1, 2024, for Eligible Expenditures under Category (1).	IBRD/IDA
Disbursement	Schedule 2 Section IV.B.1(b) to the WHO Financing Agreement	Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made for payments under Category 1 unless and until the Recipient has prepared, consulted on, disclosed and adopted the Environmental and Social Management Framework in accordance with the ESCP and in terms and substance satisfactory to the Association	IBRD/IDA
Disbursement	Schedule 2 Section IV.B.1 (a) to the UNICEF Financing Agreement	Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made for payments made prior to the Signature Date, except that withdrawals up to an aggregate amount not to exceed 19,040,000 SDR may be made for payments made prior to this date but on or after March 1, 2024, for Eligible Expenditures to	IBRD/IDA

		be applied on a pro-rata basis under Categories 2 and 3.	
Disbursement	Schedule 2 Section IV.B.1(b) to the UNICEF Financing Agreement	Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made for payments under Category 1 unless and until the Recipient has prepared, consulted on, disclosed and adopted the Environmental and Social Management Framework in accordance with the ESCP and in terms and substance satisfactory to the Association	IBRD/IDA

I. STRATEGIC CONTEXT

A. Country Context

1. **Since the removal of the authoritarian regime in 2019, Sudan has been enmeshed in a rocky transition toward civilian government that turned into a military takeover in October 2021 and armed conflict in April 2023.** The military takeover on October 25, 2021, triggered the application of the World Bank's Operational Policy 7.30 pausing disbursements under existing operations and new operations with the Government. The recent conflict that erupted in mid-April 2023 further exacerbated the country's economic and social instability.

2. **The deepening conflict is causing widespread loss of life and property, substantial infrastructure damage, massive disruption of basic services and economic activities, vast displacement, and rising humanitarian needs.** Since April 2023, an estimated 10,900 people have been killed,[1] and 11.16 million people are now displaced as a result of the country's conflict.[2] Half of the population—24.8 million people—needs humanitarian aid and protection.[3] Millions of people lack access to basic services, such as health, education, water, and food. The destruction of health facilities has interrupted access to medical services, and about 43 percent of children are missing out on basic vaccines.[4] This situation is compounded by the recent outbreaks of dengue fever, cholera, and measles, further exacerbating the dire humanitarian needs across the country.

3. **Sudan's Gross Domestic Product (GDP) is estimated to have contracted by 20 percent and 15 percent in 2023 and 2024, respectively, due to the ongoing conflict, which has disrupted economic activity and exacerbated pre-existing challenges**. The decline in economic activity partly reflects a significant reduction in private and government consumption and investment, which is also affected by the large displacement of the population. On the supply side, a major driver of the contractions is the damage to the services sector (medical, educational, telecommunications, retail and wholesale services), which is mostly concentrated in Khartoum. At the same time, the agriculture sector, a key employer and driver of the Sudanese economy, has been disrupted, resulting in a significant decline in production and soaring food prices. As violence spread, farmers were forced to abandon their lands, while widespread looting of food stocks and agriculture equipment in production areas such as Al Jazira and Kordofan have further crippled the sector. Inflation remained high at 66 percent in 2023 and surged to an alarming 211 percent in October 2024,[5] primarily driven by sharp currency depreciation, disrupted supply chains and food shortages, and rent hikes. On the fiscal front, the collapse of government institutions has disrupted public spending, and the exodus of people has reduced the tax base causing a sharp decline in revenues due to decreased economic activity and demand.

4. **Sudan is a highly climate-vulnerable country, with high exposure to droughts, floods, and extreme heat, which are becoming more frequent and more extreme because of climate change.** Its capacity to adapt to these climate shocks is among the lowest globally, ranking 179 on the Notre Dame Global Adaptation Index.[6] The country comprises extremely dry, hot, and drought-prone regions in the north, along with wet, flood-prone regions in its central and southern regions of the country. Both droughts and floods significantly affect Sudan's food security and livelihoods, critically affecting over 80 percent of its population, which depends on rain-fed agriculture. This sector makes up over 30 percent of the GDP.[7]

[1] United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA). 2024. *Sudan Situation Report*. February 23, 2024.
[2] UNOCHA. 2024. Sudan Situation Report. November 3, 2024.
[3] Ibid.
[4] https://www.gavi.org/vaccineswork/crossing-frontlines-deliver-life-saving-vaccines-sudan
[5] Central Bureau of Statistics, Inflation Report, November 2024.
[6] Notre Dame Global Adaptation Index, 2024, https://gain.nd.edu/our-work/country-index/rankings/.
[7] Food and Agriculture Organization (FAO). 2020. *Special Report: 2019 FAO Crop and Food Supply Assessment Mission to Sudan.*

Marginalized communities—including the poor, rural inhabitants, women, and girls—are the most vulnerable to the impacts of climate change in Sudan.[8]

5. **Over the last decade, poverty has been steadily on the rise in Sudan,[9] with extreme poverty nearly quadrupling from 15.2 percent in 2014 to 56.7 percent in 2024.**[10] Since the split and independence of South Sudan in 2011, Sudan's economy has continuously declined, with an average per capita GDP growth of -3 percent over 2012-2022. The situation has deteriorated significantly in recent years, with the extreme poverty rate almost tripling from 20.4 percent in 2018 to its current level. The 2019 revolution, which ended the 30-year Bashir regime and marked the beginning of a fragile economic recovery, was slowed down by the Coronavirus Disease 2019 (COVID-19) pandemic and halted by a military coup in 2021. The power struggle between military elites led to large-scale conflict in April 2023, devastating the Sudanese social fabric and economy, and worsening household living standards.

6. **Despite the conflict, the World Bank remains engaged in Sudan, including through interventions to improve and sustain service delivery.** More recently, the World Bank approved the Sudan Somoud—Enhancing Community Resilience Project (P181490), which was designed to complement the current humanitarian aid to Sudan by laying a foundation for medium- and longer-term development support in areas with high concentration of IDPs. Moreover, the Sudan SANAD—Emergency Crisis Response Safety Net Project (P505963) is sequenced to first provide fast-tracked support to the target communities informed by UN-led local rapid needs assessments of urgent service needs in education, health, water, sanitation, and hygiene (WASH), and gender-based violence (GBV) response.

B. Sectoral and Institutional Context

7. **For a long time, Sudan's health system has been described as on the brink of collapse because of its consistently unsatisfactory health outcomes.** Primary health care (PHC) coverage is very low, resulting in a high maternal mortality ratio of 270 per 100,000 live births.[11] The under-five mortality rate is 55 per 1,000 live births,[12] the neonatal mortality rate 27 per 1,000 live births,[13] and the prevalence of stunting 36.4 percent.[14] Additionally, only a little over half of pregnant women attend at least four antenatal care (ANC) visits.[15] A Joint External Evaluation of the core capacities for pandemic preparedness conducted in 2016 showed weak to no capacity in 37 of the 48 areas evaluated, including critical components of the real-time surveillance system, national laboratory system, and health workforces.

8. **Following the 2019 revolution, Sudan started laying the foundations for a longer-term health system reform program.** At that time, the country's health system had multiple challenges, including limited resources, high turnover of health workers, weak infrastructure, and poor service delivery. To address these issues, the National Health Sector Recovery and Reform Policy (2021–2024) and the Health Sector Strategic Plan (2022–2024) were developed. These plans provide a framework that reorients available resources and capacities toward improving health services through

[8] Norwegian Institute of International Affairs. 2022. *Climate, Peace and Security Fact Sheet - Sudan*. Stockholm International Peace Research Institute.
[9] There is currently no recent and credible poverty estimate for Sudan. The most recent official poverty estimates are based on the 2014-15 National Household Budget and Poverty Survey. Projections based on GDP per capita growth, indicate that, extreme poverty rate, the percentage of the population living on less than US$2.15 per day (2017 Purchasing Power Parity) is estimated to have increased from 15.2 percent in 2014 to 56.7 percent in 2024.
[10] World Bank. 2024. Macro Poverty Outlook. Washington, DC: World Bank.
[11] World Bank Data. Maternal Mortality Ratio—Sudan. 2024. https://data.worldbank.org/indicator/SH.STA.MMRT.NE?locations=SD.
[12] World Bank Data. Under-5 Mortality Rate—Sudan. 2024. https://data.worldbank.org/indicator/SH.DYN.MORT?locations=SD.
[13] World Bank Data. Neonatal mortality rate—Sudan. 2024. https://data.worldbank.org/indicator/SH.DYN.NMRT?locations=SD.
[14] UNICEF (United Nations Children's Fund). 2021. *Nutrition Annual Report*.
[15] UNICEF. Sudan Health. https://www.unicef.org/sudan/health.

enhancing the coverage of the PHC service package, strengthening emergency care and emergency preparedness and response, and mobilizing additional resources for health.

9. **The conflict that erupted in April 2023 has profoundly worsened the state of Sudan's health sector, significantly hampering access to health services.** Currently, about two-thirds of the population lack access to health services. In conflict-affected areas, nearly 75 percent of health facilities are not functioning,[16] while the remaining ones are inundated by the influx of people seeking care. Disrupted service delivery has resulted in the interruption of essential health services, including obstetric care and emergency services. The situation is further exacerbated by attacks on health facilities, the dire shortage of medical supplies and equipment and health and nutrition workers as well as insufficient funding for health services and salaries, especially for frontline workers. Financial losses to the health system are estimated at US$900 million, including life-saving drugs and vaccines and federal social support for free health care services, severely affecting an already underfunded sector.[17]

10. **The conflict has significantly increased the vulnerability of women and children in Sudan.** Gender gaps, GBV, and detrimental social norms that disadvantage women and girls have long persisted, and the ongoing conflict is depleting human capital. In 2024, about 1.7 million children under the age of one are at risk of missing lifesaving vaccinations to protect them from preventable diseases, while 700,000 children with severe wasting are at an increased risk of dying without timely treatment, jeopardizing the future of a generation of children.[18] Furthermore, out of 2.64 million women and girls of reproductive age, 105,000 are estimated to be currently pregnant.[19] Lack of access to appropriate care for safe and clean deliveries for those women and their newborns is a major concern, especially for those with pregnancy complications, as more deliveries will have to take place at home.

11. **Disease outbreaks such as cholera, malaria, measles, and dengue have escalated** because of disruption to basic public health services, coupled with the start of the rainy season and the lack of access to water and sanitation systems. More than 10,700 suspected cholera cases, including 275 that resulted in death, were reported as of January 20, 2024, from 60 localities in 11 states.[20] Moreover, the WASH sector reported that about 19 million people were in urgent need of assistance at the end of 2023—an increase of almost nine million people compared to the precrisis period.[21]

12. **Climate change is further exacerbating the health situation in the country.** Transmission of malaria, dengue, and diarrheal diseases, including cholera, are worsened by climatic changes in the country, particularly flooding and high heat.[22,23,24] Between June and September 2024, about half a million people were affected by heavy rains and flooding across 15 states in Sudan, and 2,900 cases of cholera were reported.[25] Climate change-driven flooding and droughts

[16] USA for United Nations High Commissioner for Refugees. *Sudan Crisis Explained*. November 14, 2024.
[17] UNICEF. 2023. *The Impact of Sudan's Armed Conflict on the Fiscal Situation and Service Delivery*.
[18] UNICEF. 2023. *Humanitarian Action for Children 2024*.
[19] United Nations Population Fund. Sudan. 2024. http://www.unfpa.org/sudan.
[20] WHO. Sudan Outbreaks Dashboard. https://worldhealthorg.shinyapps.io/OutbreaksDashboard/.
[21] UNOCHA. *Sudan Humanitarian Needs and Response Plan 2024*. December 2023.
[22] Sudan's First National Communication under the UNFCCC. (2003).
[23] Republic of the Sudan. National Adaptation Plan (n1).
[24] Aal R, Elshayeb A. 2012. "The Effects of Climate Changes on The Distribution and Spread of Malaria in Sudan." *American Journal of Environmental Engineering.*
[25] Sudan: Humanitarian Impact of Heavy Rains and Flooding Flash Update (September 2024). OCHA https://www.unocha.org/publications/report/sudan/sudan-humanitarian-impact-heavy-rains-and-flooding-flash-update-no-04-5-september-2024.

further affect undernutrition by compromising food security.[26] Flooding and high heat also affect health service delivery by making it difficult to access health facilities and compromising health infrastructure.

C. Relevance to Higher Level Objectives

13. **The Sudan Health Assistance and Response to Emergencies (SHARE) Project is aligned with the World Bank's goals and regional and global strategies and contributes to the twentieth replenishment of the International Development Association (IDA20) policy commitments.** Specifically, SHARE contributes to the World Bank's mission to end extreme poverty and boost shared prosperity on a livable planet and the Eastern and Southern African regional priorities by investing in improved water and sanitation. The project is in line with IDA20 commitments that place special priority on improving overall human capital for pandemic prevention and preparedness through building resilient health systems that have the capacity to prevent, detect, and respond to disease outbreaks and other health emergencies. The project's measures to adapt to the impacts of climate-induced events as well as mitigate greenhouse gas (GHG) emission contribute to the health emergencies agenda. The project is also fully aligned with the 2023 Dar es Salaam Declaration on human capital.

14. **The project is aligned with the World Bank's Country Engagement Note (CEN) for Sudan for FY2021–2022.**[27] The project will contribute to Focus Area 2, Objective 2.3 of the CEN: "Strengthening service delivery and resilience." Additionally, the project is well aligned with the World Bank Strategy for Fragility, Conflict, and Violence (FCV) 2020–2025[28] Pillar 2 on remaining engaged during conflict and crisis situations, with a direct link to its first high-priority area of investing in human capital, as well as Pillar 4, which centers on mitigating the spillovers of FCV, given that the project will facilitate provision of services to internally displaced persons (IDPs) in Sudan.

15. **The project complements both World Bank and development partner investments strengthening health systems strengthening, disease control and surveillance, interventions for individual and institutional behavior change, and citizen engagement.** The project supports the attainment of universal health coverage and of the Sustainable Development Goals. Moreover, the project is aligned with the planned World Bank Global Challenge Program by investing in strengthening capacity for climate and health emergency preparedness and response and critical nutrition interventions for children and pregnant women. The project is also supporting improved water and sanitation and energy efficiency in health facilities and integrates digital solutions for service delivery. Furthermore, the project contributes to the Sudan Humanitarian Needs and Response Plan (SHNRP) 2024 by: (i) supporting the provision of safe, equitable, dignified, and unhindered access to PHC services; (ii) strengthening emergency preparedness and response; and (iii) addressing the needs of vulnerable groups disproportionately affected by health emergencies**.**

16. **The project is consistent with the country's Nationally Determined Contribution (NDC) submitted to the United Nations Framework Convention on Climate Change (UNFCCC).** Sudan ratified the Paris Agreement on climate change on August 2, 2017, and submitted the updated first NDC (third version) on September 22, 2022, in accordance with Article 4, paragraph 12 of the Paris Agreement. Sudan is committed to the climate adaptation activities related to the health sector, including strengthening surveillance and early outbreak warning systems for climate-sensitive diseases and climate and health emergencies, building community capacity for climate emergency preparedness and response, and developing climate-resilient health systems.

[26] Integrated Food Security Phase Classifications, Sudan, Projections, October 2023-February 2024: https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_Sudan_Acute_Food_Insecurity_Oct2023_Feb2024_Report.pdf.
[27] World Bank. 2020. *Sudan: Country Engagement Note for the Period FY21–FY22.* Washington, DC: World Bank (Report No. 152835-SD). This was discussed by the World Bank's Board of Executive Directors on October 8, 2020.
[28] World Bank. 2020. *World Bank Group Strategy for Fragility, Conflict, and Violence 2020–2025*. Washington, DC: World Bank.

II. PROJECT DESCRIPTION

17. **The project is being processed under the World Bank Policy for Investment Project Financing, paragraph 12 of Section III:** Projects in Situations of Urgent Need of Assistance or Capacity Constraints due to conflict, impending natural disaster, and capacity constraints. The project will be implemented over a two-year period, through third-party implementation by the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO).

18. **The project is designed to complement the current humanitarian aid to Sudan by laying a foundation for medium- and longer-term development support in areas with high concentration of IDPs.** It builds for the future of Sudan by restoring access to basic health services, protecting human capital, and enhancing communities' resilience. The project will finance health and nutrition services as well as help maintain the capacity of the existing health system—that is, public health facilities and community-level engagement. The project will ensure complementarity and close coordination with the SANAD and Somoud projects on the areas of related interventions to maximize impact.

A. Project Development Objective

PDO Statement

19. The Project Development Objective (PDO) is to restore access to a basic package of health and nutrition services and preserve the main elements[29] of essential public health functions.

PDO Level Indicators

- Number of health, nutrition, and population services provided to project beneficiaries, of which IDPs and female.
- Number of functional laboratories with early outbreak detection capabilities as per WHO guidelines.

B. Project Components

20. The project financing is an IDA grant of US$82 million equivalent. The project will finance basic health and nutrition services as well as help maintain the capacity of the existing health system—that is, public health facilities and community-level engagement. The project will envisage retroactive financing up to 40 percent of total financing, made on or after March 1, 2024, before the signing date of the Financing Agreements for eligible expenditures. The project will include the following three components.

Component 1: Improving Access to Basic Health and Nutrition Services (US$65,352,999 equivalent)

21. This component aims to enhance access to basic health and nutrition services in Sudan through low-cost, high-impact interventions using a PHC approach. It targets both displaced and host communities. A minimum service package that includes the following services will be supported under this component at different levels of service delivery: Expanded Program on Immunization; integrated management of childhood illnesses; maternal, newborn and pediatric health; nutrition; and noncommunicable diseases (NCDs), including mental health, in addition to prevention and response to outbreaks and health emergencies. Accordingly, service packages will be categorized into the following three levels based on accessibility:

[29] The main elements of essential public health functions are the activities to prepare for and respond to health emergencies and control diseases by strengthening emergency preparedness, laboratory, and disease control systems.

- Level 1: Fully Accessible Areas. In states or localities with no interruptions, the full minimum package of services will be provided throughout the project areas. The service package will be provided through the various platforms including fixed health facilities, mobile units and outreach programs, campaigns, and community-based platforms.
- Level 2: Partially Accessible Areas. In states, localities, and health facilities that become partially accessible during project implementation, a selected list of services will be provided. The mode of delivery will depend on what is feasible and may include outreach programs, campaigns, and networks of community volunteers and workers.
- Level 3: Severely Restricted Access. In areas where health facilities face significant disruptions or are inaccessible, a limited selection of services may be provided. Fixed health facilities may be inaccessible to the population for security reasons. Deployment of mobile teams and campaigns may also be difficult under these challenging conditions. The project will also use high-level United Nations (UN) coordination and the UNOCHA's role to open up a humanitarian corridor for supply and services movement.

22. In addition to accessibility, this project will closely monitor and continuously assess the following factors that may influence the scaling up or scaling down of services: staff capacity, particularly during times of crisis; the population's demand for services; availability of critical supplies and commodities; and the overall functionality of health facilities throughout the project's life cycle. This comprehensive approach ensures a responsive and adaptive service delivery model that can effectively address the evolving needs and challenges in the targeted areas.

Subcomponent 1.1: Strengthening the Integration of Primary Health Care Model (US$41,410,233 equivalent, implemented by UNICEF)

23. This component aims to bridge the significant service gap through the delivery of prioritized packages of health and nutrition services at the PHC and community levels. To narrow the service gap, this subcomponent will complement the PHC facility-based services with an integrated outreach model and service delivery by community health workers (CHWs). This model will cater to the needs of the population in remote areas and IDPs through outreach rounds as well as mobile teams in climate-vulnerable areas without functioning PHC facilities. Climate-sensitive data use and planning will be embedded in this subcomponent to tailor service delivery in response to anticipated flooding, which, because of climate change, is becoming more intense and detrimental to health service delivery. Cross-cutting social behavior change interventions will be conducted for demand generation and health and hygiene promotion. UNICEF will work closely with WHO for the continuum of care between PHC and first referral care in hospitals. The package of services will mainstream mental health and psychosocial support where possible.

24. About 420 PHC facilities will be supported to maintain functionality in providing basic health and nutrition services. Activities include: (a) support to human resources through incentives (excluding the formal employment or payment of salaries of civil servants)], training, and capacity building; (b) procurement of essential medicines, health and nutrition supplies, and basic equipment; (c) monitoring and supportive supervision visits; and (d) operating cost,[30] including provision of fuel, electricity, water, cleaning materials, etc. UNICEF will be responsible for: (a) oversight and coordination of health services and information systems, including reactivation and rollout of District Health Information Software 2 (DHIS2) at project facilities; (b) supervision and quality assurance for PHC facilities in line with relevant plans and

[30] Operating cost refers to the reasonable incremental costs incurred on account of the implementation, management and monitoring of the project, including office supplies, office space rental, equipment maintenance and repair, vehicle operation and maintenance, utilities, communication charges, mass media and printing services, translation, and interpretation charges, bank charges, charges for transporting cash into the country, travel and lodging allowances, per diems, incremental salaries of contracted employees, but excluding salaries and allowances of the Member Country's civil service.

guidelines; (c) coordination and conducting of in-service training; (d) supporting WHO as needed in the provision of capacity development of Locality Health Management Teams (LHMTs) to plan, supervise, and oversee service delivery and the DHIS2 system; and (e) integrated pharmaceutical procurement, quantification, and forecasting.

25. The services provided at the PHC facilities will be complemented by a basic package of services delivered at the community and household levels through a network of CHWs, volunteers, and midwives. Core inputs for the community-based level will cover: (a) supporting the operations of mobile teams and a community health and nutrition cadre; (b) procurement of medical and non-medical supplies, medicine, nutrients, and routine vaccines; and (c) monitoring and supervision support. Mobile teams will be deployed to provide an integrated health and nutrition package of services to the IDPs, areas without functional health facilities or with access challenges, and unserved communities in the hard-to-reach areas. Under this subcomponent, an estimated 25 mobile teams are planned to be established, and more than 1,200 community health and nutrition cadre are planned to be supported to serve a catchment population of more than one million people.

Subcomponent 1.2. Supporting Health and Nutrition Services at the First Level Referral Centers and Hospitals (US$9,792,766 equivalent, implemented by WHO)

26. This subcomponent will complement the PHC model by ensuring the continuum of care at referral centers and hospitals through the provision of a basic package of health and nutrition services, including: (a) management of severe acute malnutrition (SAM) cases with complications and for patients who failed an Outpatient Therapeutic Program at Therapeutic Feeding Centers and/or Stabilization Centers; (b) support to human resources through incentives (excluding the formal employment or payment of salaries of civil servants), training, and capacity building; (c) provision of Basic Emergency Obstetric and Neonatal Care (BEmONC) and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) services in targeted referral centers; (d) provision of basic health diagnostic and pharmacy services in the areas of maternal and child health, communicable diseases, NCDs, including mental health and rehabilitation, public health, infection prevention and control (IPC), WASH, and improving quality of care; (e) procurement and maintenance of equipment, as well as, procurement of medical and non-medical supplies, essential medicines including oxygen supply, routine vaccines, training, and operating costs for the first level referral centers and hospitals; (f) support to vaccination campaigns to reach under-vaccinated populations and raise awareness about its benefits; and (g) implementation of telemedicine where possible.

27. The WHO will be responsible for: (a) oversight and coordination of health services and information systems including reactivation and rollout of DHIS2 at selected hospitals/first level referral centers; (b) supervision and quality assurance of hospitals/first level referral centers in line with relevant plans and guidelines; (c) coordination and provision of in-service training; (d) in coordination with UNICEF, capacity development of LHMTs to plan, supervise, and oversee service delivery and the DHIS2 system; (e) integrated pharmaceutical procurement, quantification, and forecasting; and (f) support for the implementation and rollout of digital health technology to address service delivery and human resources challenges at selected hospitals.

Subcomponent 1.3: Climate Change Adaptive Health Service Delivery (US$3.65 million equivalent, implemented by WHO)

28. Sudan is extremely climate vulnerable, particularly to floods and high heat, as well as to climate-sensitive diseases, primarily malaria and diarrheal diseases such as cholera with significant impacts on health and health service delivery. Climate change has exacerbated the impacts of the conflict on the population. This subcomponent aims to reduce the impacts of climate change on health and the health system and will finance: (a) technical assistance to support the development of contingency plans for climate change health service delivery at referral health facilities; (b) flood and high heat risk assessments at health facilities; (c) development of pre-positioning plans for vector control and water treatment

supplies to limit outbreaks of vector-borne and waterborne diseases; (d) training of CHWs on climate emergency preparedness and response; (e) basic interventions to make referral facilities more climate resilient including minor rehabilitation, solar power, IPC, and WASH; (f) climate change risk communication activities to highly climate vulnerable communities; and (g) integration of meteorologic data into the Early Warning, Alert, and Response System (EWARS) to better understand the relationship between outbreak prone infectious diseases and climate change.

Subcomponent 1.4: Climate Change Resilient Health Facilities (US$9 million equivalent, implemented by UNICEF)

29. Flooding in Sudan, which is becoming more frequent and severe with climate change, has had a detrimental impact on health facilities, damaging or destroying many of them. Extreme heat, which is also becoming more severe due to climate change poses a risk to patients at health facilities. To reduce the impacts of climate change on health and the health system, this subcomponent will finance: (a) rehabilitation of health facilities at risk of flooding and high heat to make them more resilient to these conditions, including WASH improvements, given that flooding is a primary driver of diarrheal diseases, including cholera; (b) installation of solar power systems for health facilities while minimizing GHG emissions to improve access to power, given the limitations caused by climate shocks and conflict; and (c) technical assistance to support the development of climate change health service delivery contingency plans at primary-level health facilities.

Subcomponent 1.5: Integrating Digital Solutions to Service Delivery (US$1.5 million equivalent, implemented by UNICEF)

30. This subcomponent will support the rollout, implementation, and integration of digital innovations that will facilitate service provision and enhance staff communication and training, allowing for improved quality of service delivery and improved access to communications and health services in light of the conflict and flooding exacerbated by climate change. Data analytics with geospatial mapping can help health organizations visualize and analyze the geographic distribution of health conditions, social determinants of health, and health care resources. This spatial analysis supports targeted interventions in areas with higher needs or fewer resources. This subcomponent will include support to the following: (a) a multi-directional digital platform to strengthen health system governance to facilitate seamless and instant communication, interaction, networking, and feedback between health workers and their respective senior levels; (b) a platform dedicated to digital health services, providing tele-consultations for patients and collecting valuable feedback from patients on the availability and quality of services; and (c) an artificial intelligence (AI)-driven platform specifically designed for capacity building and continuous e-learning for PHC workers.

Component 2: Preserving the Main Elements of the Health System (US$2,778,664 equivalent, implemented by WHO)

31. This component will focus on strengthening health systems and public health programs and improving the main elements of the health system to prepare for and respond to health emergencies and control diseases by strengthening emergency preparedness, laboratory, and disease control systems. It will build on the activities implemented through the COVID-19 Emergency Response Project (P174352). Specific activities will include essential preparedness functions such as: (a) training and operating cost for integrated disease surveillance and response (IDSR) including EWARS; (b) operating costs and rehabilitation for selected Emergency Operations Centers (EOCs) with a primary focus on response to climate shocks; (c) supporting health information systems and the Health Resources and Services Availability Monitoring System; (d) developing, disseminating, and training of trainers on subnational emergency preparedness and response plans, primarily focusing on climate shock emergency preparedness and response along with response to conflict; (e) updating and disseminating laboratory guidelines and providing laboratory operating costs; and (f) training and deploying Rapid Response Teams. The component will also support strengthening the country's blood bank and transfusion systems, which currently have limited reach, impairing access to CEmONC and safe surgical services. This includes: (a) developing guidelines for the proper collection, storage, transport, and use of blood for transfusions; (b) building or strengthening

existing blood banking services; and (c) developing systems and protocols for the transfer of blood products for transfusion.

Component 3: Monitoring and Evaluation and Project Management (US$13,868,337 equivalent)

32. This component will finance costs related to monitoring and evaluation (M&E) and management of project activities. The project will ensure that independent and credible data on health service delivery and coverage and commodities are generated, and that the data are usable and will enable the World Bank and development partners to verify that resources are reaching the intended beneficiaries. The third-party monitoring (TPM) agency's role will include working with UNICEF, WHO, the World Bank, and implementing partners (IPs) to explain results, providing guidance on improved methods, proposing context-appropriate solutions, and conducting ex post facto verification of results provided by project reporting mechanisms.

Subcomponent 3.1: Third Party Monitoring (competitively selected TPM agency—US$2.00 million equivalent, implemented by UNICEF)

33. Subcomponent 3.1 will finance TPM to ensure accountability and transparency of project-supported activities. Under the project, a TPM agency will monitor and verify the delivery of project-supported inputs (for example, medications, supplies, and fuel) to the end users (for example, health facilities and public health campaigns, if needed), as well as monitor the service delivery activities conducted at supported facilities (including, but not limited to, collecting data on monthly utilization of supported health services). UNICEF will receive the financing to contract a TPM agency, and both organizations will agree: (a) to a schedule for regular, periodic monitoring of all supported health facilities and (b) on procedures and protocols for data collection, data transmission, and raw data reporting by the TPM agency to the World Bank, WHO, and UNICEF.

Subcomponent 3.2: Data Analysis and Knowledge Management (Total US$0.5 million equivalent [US$0.25 million for WHO and US$0.25 million for UNICEF])

34. Subcomponent 3.2 will support the analysis and utilization of data to improve the documentation of project activities, analyze implementation effectiveness, and report findings to internal and external audiences. The project expects that the World Bank, UNICEF, and WHO will collaborate to produce high-value data analysis products, focusing on prioritized topics that contribute to knowledge sharing and global learning. Under this subcomponent, UNICEF and WHO will appoint knowledge management focal points and agree to share relevant data among the organizations to support the described activities. The three organizations will jointly develop knowledge management products (for example, journal articles, briefs, and dashboards) and will also work closely with the TPM agency to ensure high-quality data collection that will inform data analysis. Key focus areas will include service availability, outbreak response, routine vaccination coverage, maternal health, SAM, and others, aligned with project-supported activities. The organizations will collect and analyze data from relevant sources, including EWARS, DHIS2, Health Resources and Service Availability Monitoring System, TPM, and other data sets. Analyses will focus on understanding the impact of project activities and exploring the mechanisms by which impacts were achieved.

Subcomponent 3.3: Project Management (Total: US$11,368,337 equivalent [US$3,028,570 for WHO and US$8,339,767 for UNICEF])

35. This subcomponent will finance Project Management Units (PMUs) for both UNICEF and WHO. Both agencies will perform project core management and implementation support activities through their multidisciplinary teams. Specifically, the two organizations will: (a) monitor the project targets and results in coordination with the existing local

health workforce; (b) handle procurement, financial management (FM), and disbursement management, including the preparation of withdrawal applications under the project; (c) ensure that independent audits of IPs carrying out project activities are undertaken; and (d) ensure that all reporting requirements for IDA are met according to the Project Financing Agreements. This component will support the M&E activities undertaken by the two organizations under the project. The project M&E arrangements emphasize not only measuring the results but also extracting lessons and recommendations for future interventions.

C. Project Beneficiaries

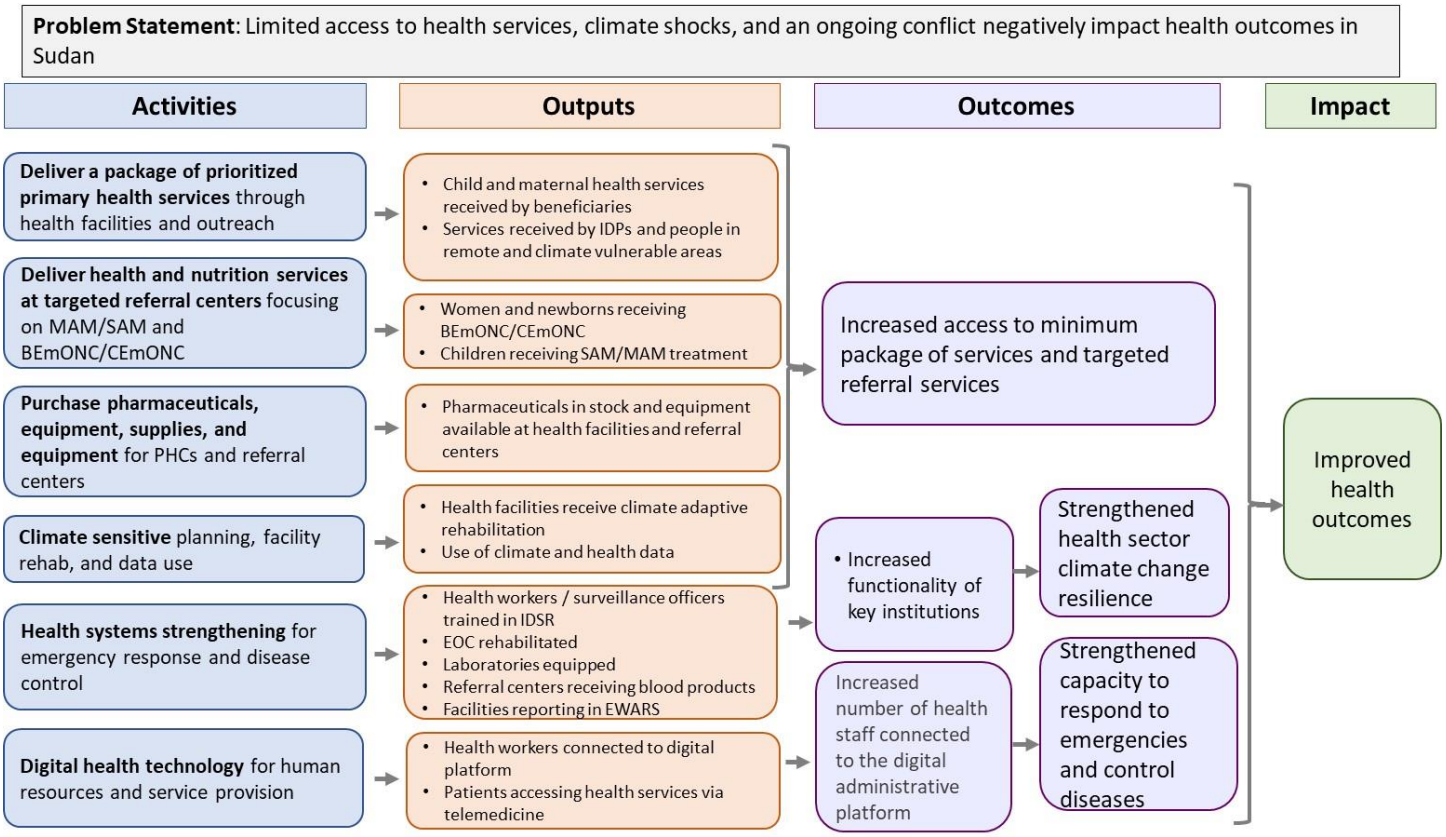
36. The population of Sudan, particularly women of reproductive age, children under five, and IDPs, will continue to benefit from the improved access to basic health services under the project. The project will support 420 PHC facilities and 10 hospitals and strengthen the health system through supporting essential system elements such as blood bank, laboratories, and surveillance systems. The project aims to provide health and nutrition services to nine million people[31] at supported health facilities and through community platforms.

D. Results Chain

37. Activities financed under the project will improve access to basic health and nutrition services to the population of Sudan, including IDPs and host communities, and strengthen health systems. These activities will contribute to outputs such as the number of beneficiaries receiving a basic package of health and nutrition services, an increased number of health facilities that receive pharmaceutical supplies, functional laboratories, and enhanced surveillance. In turn, these are expected to lead to the following outcomes: improved access to basic package of health services and strengthened health systems.

[31] About 14.7 million people are facing critical challenges in accessing essential lifesaving PHC as the health sector is collapsing because of the reduction of functioning health facilities along with an acute shortage of medical supplies, water, and fuel and the increase of attacks on health facilities according to the 2024 SHNRP.

Figure 1. Theory of Change



Note: MAM = moderate acute malnutrition.

E. Rationale for Bank Involvement and Role of Partners

38. **Rationale for World Bank involvement.** The World Bank has a strong comparative advantage in FCV settings, centering on its role as a development actor committed to sustained and long-term engagement that can support national and local systems and functions. In Sudan, the World Bank is in a unique position to leverage its experience from past and ongoing operations, primarily the Sudan Somoud—Enhancing Community Resilience Project (P181490) which supports community-led basic services and food security, Sudan Primary Education Emergency Support Project (P504621) which focuses on girls' education and prevention of school-related GBV, Sudan SANAD–Emergency Crisis Response Safety Net Project (P505963) which provides emergency safety nets support to vulnerable and food insecure populations, and Sudan COVID-19 Emergency Response Project (P174352) which invested in health system strengthening and response to health emergencies. The World Bank has carried out extensive analytical work in Sudan that informed the design of this project, including the 2021 diagnostic report on emergency preparedness and response capacities, and the 2023 Risk and Resilience Assessment.

39. **The value added by supporting the delivery of a basic package of health services through a World Bank-supported operation is high**, given the World Bank's ability to provide higher-level technical oversight and facilitate coordination and communication between the partner agencies. In this regard, the value of providing support through the proposed operation is greater than the sum of its parts. The proposed operation will result in ensuring continuity and expansion in the provision of basic health services in a coordinated manner to cover different population groups who often

shift their location in an environment where conflict and uncertainty remain underlying factors. It can bring together diverse actors from both the development and humanitarian service delivery segments and use their comparative advantages to ensure that those with the greatest need benefit equitably from the project's interventions. The project also invests significantly in building capacities of health service providers at the operational level to contribute to a stronger and more resilient health system in the country.

F. Lessons Learned and Reflected in the Project Design

40. **The project leverages over a decade of World Bank experience working in the health sector in FCV contexts.** There is recognition that, to ensure any significant impact on service delivery, there is need for flexibility at both the strategic and operational level. This helps to increase speed in the delivery of services, accountability and citizen engagement, and strategic partnerships given the vast needs, wide scope, and limited resources available.

41. **Fragile and complex environments require flexibility in project design and alignment to the political economy.** This flexibility allows for responsiveness to the volatile and ever-changing conditions of the country—whether economic or political. Fragile situations call for simpler project design with specific, yet achievable results, concentrating on immediate priorities that lay the groundwork for longer-term goals.

42. **Ensuring a quick disbursing mechanism and working through specialized existing partner agencies are critical for an effective emergency response.** Lessons learned from the Sudan COVID-19 Emergency Response Project (P174352) which aimed to provide a fast and flexible response to the COVID-19 pandemic in FCV settings, shows the importance of utilizing all World Bank Group operational and policy instruments and work in close coordination with the implementing organizations to make sure that the project is ready for implementation as soon as it is launched. The preparation of the Environmental and Social Management Framework is already underway, which is a condition of disbursement for both UNICEF and WHO.

43. **Coordination and complementarity with development partners focusing on the same objectives is key for delivering results**. Lessons learned from other countries (for example, the Republic of Yemen, Somalia, and South Sudan), as well as the Sudan COVID-19 Emergency Response Project (P174352) reflect the critical importance of the World Bank's partnerships with UN agencies and other partner organizations for ensuring basic service delivery during periods of conflict or urgent needs and maximizing results. UNICEF's and WHO's responsiveness and ability to mobilize IPs, critical inputs, and financing would help avoid gaps in service delivery and project implementation.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

44. **UNICEF and WHO will be the grant recipients as well as the managing and implementing agencies.** Each organization will be responsible for several activities based on the project design and their individual comparative advantage of each. UNICEF will focus on providing context-tailored health and nutrition packages at the community level and PHC facilities. WHO will provide selected services at selected hospitals, rural and state hospitals, and referral centers, in addition to implementing health system-strengthening activities. Details of the services and activities are provided in the project description section.

45. **Following the onset of the conflict, both organizations put mechanisms in place, through the existing local public system structures, to deliver tangible results on the ground**. UNICEF has so far managed to reach 6.4 million children and

families with emergency health supplies through 50 mobile teams, while 2.6 million children and women accessed 700 UNICEF-supported PHC facilities in 140 localities across all states. UNICEF has maintained a network of 76 nongovernmental organizations (NGOs) across the country (25 of which focused on health and nutrition and 16 focused on WASH). UNICEF also established a cash-transfer implementation unit for direct cash payments to individuals, frontline workers, and community-based facilities such as PHC facilities and schools. Currently, UNICEF has three field offices providing support in Kassala, Port Sudan, and River Nile and two additional regional teams in Blue Nile and Gedarif focusing on direct support to hotspots and safer and more accessible states covering Central Darfur, Sinnar, West Darfur, and White Nile. The remaining states, including Darfur, Gezira, Greater Kordofan, and Khartoum, are covered through partners. Further, UNICEF categorized Sudan as L3 which allows for all-of-agency mobilization as needed, including fast-tracking delivery of medicines, vaccines, and medical supplies.

46. **WHO is the Health Cluster Lead Agency and works to ensure coordinated responses to health needs across the country**. This includes strengthening the capacity of IPs and delivering technical assistance to national and international non-governmental organizations (INGOs) working in the states of Blue Nile, Darfur, Gezira, and Kordofan. In addition, WHO contracted 13 NGOs to provide life-saving interventions at 86 PHC facilities and 35 hospitals, alongside expanding and sustaining surveillance activities to bolster health service delivery, disease monitoring, and response. The organization is currently expanding its capacity for cross-border operations to deliver critical support to IPs working in inaccessible and hard-to-reach areas.

47. **UNICEF and WHO will engage qualified IPs (NGOs and civil society organizations [CSOs]) to implement the project activities** in coordination with the local authorities, and community-based organizations. Nonetheless, UNICEF and WHO will maintain monitoring and oversight responsibilities, including fiduciary and environmental and social (E&S) aspects of the respective components. No project funds will be channeled to or through federal, state, or local authorities or parastatal entities. The project will include provisions to mitigate security risks to project-financed activities. Direct implementation by WHO may also be considered where appropriate or applicable.

48. **The selection of targeted localities[32] will be based on eligibility criteria to ensure equity.** The project will cover all states (circumstances permitting) and select one targeted locality per state to ensure: (i) consistent service availability in all states; (ii) prevention, early detection and prompt response to any emerging outbreaks that might spread throughout the country, given population movements; and (iii) sustained health-workforce presence and operationality in the country to allow for rapid post-conflict revival of the sector. In the initial phase of the project, targeted localities will be selected based on a comprehensive set of health, accessibility, and vulnerability criteria. The delivery of services will build on the experiences of UNICEF and WHO, which have worked in over 780 PHC facilities and 35 hospitals in Sudan with support from various funding partners. Additionally, the selection process will aim to ensure alignment with WHO hospitals for continuum of care and referral pathways. The project also aims to complement and integrate with: (i) Sudan SANAD Project, where cash transfer support will be linked to critical health services to incentivize the update of MCH services provided through the SHARE project. It will also adapt and build on the existing interventions led by partners on the ground—mainly the Mother and Child Cash Transfer Plus (MCCT+) program, implemented by UNICEF, targeting pregnant and lactating women to support children during the first 1,000 days of life. Both projects will, through UNICEF, synergize (a) targeting of beneficiaries utilizing the health facilities, (b) using the same vendor for cash transfer, and (c) use cash transfer to increase traffic to facility and use facility utilization to register beneficiaries of cash transfer; and (ii) Sudan Somoud Project, where health services will be provided to four states (Northern, River Nile, Sennar and Gedarif) for a basic package of health and nutrition services in nearly 100 primary health facilities. The SHARE project will cover the remaining

[32] "Targeted localities" means the localities in the Republic of the Sudan in which the project will be carried out and selected in accordance with eligibility criteria agreed upon with the World Bank, which will be detailed in the PIM.

14 states with the same services, provide additional support in the four states under Somoud where needed, and provide secondary care services in all 18 states. To ensure flexibility and responsiveness to the dynamic in-country situation, services will be rolled out in a standardized tiered-packages across all supported health facilities, with regular assessments to allow for necessary adjustments.

49. **Both implementing agencies will establish PMUs that will be based in the implementing agencies' country offices in Sudan**. The PMUs will carry out day-to-day management and implementation of the respective components. The PMUs will be adequately staffed to ensure effective project management and coordination and compliance with fiduciary requirements. The PMUs' composition, roles and responsibilities, and resources will be described in the PIM. UNICEF will establish multiple PMUs for different World Bank-financed projects. To enhance efficiency and effectiveness, these PMUs will leverage collective expertise and coordinate to avoid duplication and share lessons learned.

50. **Coordination between UNICEF, WHO, and the IPs will be facilitated through the Project Coordination Committee (PCC).** The PCC will meet to jointly plan and coordinate activities while ensuring synergies. The PCC will support coordination of project implementation, identification and mitigation of project risks, review monitoring results, and make recommendations on implementation adjustments in response to the evolving situation. It will leverage existing coordination mechanisms such as the Health and WASH Clusters to engage with the Sudan health authorities at locality and state levels and use other coordination mechanisms in place for WHO, UNICEF, and the World Bank. The committee will be co-chaired by representatives from the two organizations and will meet periodically. Details of the coordination and governance mechanisms will be outlined in the terms of reference included in the PIM and finalized in agreement with the World Bank.

51. **The project will be funded by an IDA grant to WHO and UNICEF, who are co-signatories of the Financial Management Framework Agreement (FMFA).** The FM arrangements for the project will be governed by the FMFA between the World Bank and UN agencies, which provides for the use of the UN's financial regulations.[33]

52. **The procurement arrangements for the project are that UNICEF and WHO will follow their own procurement procedures as Alternative Procurement Arrangements** allowed by the World Bank Procurement Framework Policy Section III.F. This implementation arrangement is recommended by the Project Procurement Strategy for Development (PPSD) after assessments confirmed that procurement procedures of both agencies are acceptable to the World Bank under other agreements. This procurement arrangement is considered a fit-for-purpose arrangement, ensuring that the project's specific needs are met.

53. Given the critical health situation in Sudan, it is envisaged that the proposed US$82 million allocated under the project will be fully disbursed by July 2026. However, to ensure adequate time for financial closure, the project closing date is January 31, 2027.

B. Results Monitoring and Evaluation Arrangements

54. **Monitoring and tracking of project outputs will rely on different sources of information and monitoring mechanisms.** Through their team and network of partners, implementing agencies will track the planned and actual activities. Another level of tracking will be through a TPM arrangement. Additionally, to significantly enhance the transparency and accountability of TPM activities, the project will integrate support from the Geo-Enabling initiative for Monitoring and Supervision (GEMS) to enhance the monitoring and supervision capacity of the project. Working with

[33] UN Financial Regulations shall be understood as reference to the UNICEF Financial Regulations and Rules for UNICEF activities and WHO Financial Regulations and Rules for WHO activities.

GEMS will enable the World Bank to "monitor the monitors" and get access to direct field data in near real time rather than solely receiving aggregated periodic reports. Using GEMS, the project will seek to further build the local capacity to use technologies to collect and analyze data on the ground to improve accountability for TPM and enhance transparency and accuracy of M&E activities.

55. **The Results Framework for the project will build on the lessons from other FCV contexts and will aim at measuring actual service delivery outcomes.** UNICEF and WHO will provide detailed technical reports biannually with narrative updates on the overall project implementation and results including reporting on the achievement of the project's Results Framework indicators. In addition, quarterly matrices will be provided that will contain updated progress of Results Framework indicators.

C. Sustainability

56. **The project contributes to sustainability in three ways.** First, it aims to support and preserve the national implementation capacity by investing in the existing, local structure of health service delivery, which will help maintain the main foundations of the system for a speedy post conflict recovery of the health system. This also includes focusing on retaining available human resources and the core functions of the system. Second, the project will strengthen the health systems to be more responsive to emerging diseases and more resilient to public health threats. Third, the project will support the community-based approach through its community health services provided by CHWs. Evidence indicates that CHWs continue to provide some services such as health promotion and awareness even when funding stops. In addition, the project's primary focus on children and women of reproductive age will contribute to preserving the future of Sudan during the ongoing crisis.

IV. PROJECT APPRAISAL SUMMARY

A. Technical and Economic Analysis

Paris Alignment

57. **The project is fully aligned with the Paris Agreement on climate change.**

- **Adaptation goal.** Resilience measures are embedded throughout project activities. These measures are designed not only to limit the impact of climate change on project activities but also to strengthen the health system's ability to adapt to climate change. Health service delivery in Subcomponent 1.1 will use climate-sensitive planning and data use, along with CHW visits and outreach visits, to ensure continuity of services during climate shocks. Health emergency preparedness and response plans under Component 2 and plans for continuity of services during climate shocks under Subcomponents 1.3 and 1.4 will help minimize the impacts of climate shocks on health service delivery in Subcomponents 1.1 and 1.2. Rehabilitation of health facilities to make them more resilient to climate change under Subcomponents 1.3 and 1.4 is expected to further minimize the impacts of climate shocks on health service delivery. Activities in Subcomponent 1.5, Component 2, and Component 3 will include climate-sensitive planning and will be guided by climate emergency preparedness and response plans developed under Component 2 to further minimize the impacts of climate change on project activities.
- **Mitigation goal.** The project is not anticipated to involve any rehabilitation that involves electricity or electrical equipment beyond installation of solar power equipment. All project activities are universally aligned for mitigation.

Technical Analysis

58. **The health sector in Sudan is on the verge of collapse with many essential health services either ceasing to exist in some geographic locations or severely affected by the ongoing conflict.** This operation has been specifically designed to ensure that Sudan's population continues to have access to critical health care services. Furthermore, the design reflects the important lessons learned from World Bank experience in the region, notably from previous World Bank engagements in emergency health operations in countries with similar sociopolitical situations such as the Republic of Yemen and South Sudan. This relates to: (a) using the existing, on-the-ground technical capacity of health staff; (b) partnering with leading health organizations (UNICEF and WHO); and (c) providing the main elements of health system sustainability delivering the essential health services of the population, especially the disadvantaged groups.

59. **To guide the design of the operation, two major principles were used in formulating the project activities:**

(a) Achieve a balanced approach on two fronts: (i) providing a package of essential health services based on the principle of continuum of care throughout the life cycle (childhood, adolescence, adulthood, pregnancy, childbirth, and postnatal period) and among models of service delivery (including clinical care settings, outreach, and household and communities) and (ii) supporting the PHC facilities and first-level referral centers with the basic inputs for maintaining their operational capacity and 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 predefined guidelines and protocols for integrated service delivery and facility-based health planning that are suited to Sudan and are consistent with the current capacities in the country. These standards ensure that: (i) delivery through fixed facilities is based on the realistic distribution of services that ensure efficiency and optimal 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.

Economic Analysis

60. **The economic benefits derived from investing in health and nutrition services are substantial.** Sudan contends with significant public health challenges, marked by a maternal mortality ratio of 270 deaths per 100,000 live births and an under-five mortality rate of 55 per 1,000 live births. Sudan also has one of the highest rates of child malnutrition in the world. Children (more than 21 million) represent more than 50 percent of the population in Sudan, including 6.5 million under the age of five.[34] An estimated 3.5 million children suffer from acute malnutrition, including more than 700,000 facing severe acute wasting, which requires specialized, uninterrupted, lifesaving treatment.[35] The project will improve basic health services. For example, nutrition services under the project will employ a life cycle approach and will focus on children, women of reproductive age, and pregnant and lactating women. These evidence-based services have been proven to yield high benefit-cost ratios. Investing in specific child and maternal nutrition interventions has been estimated to yield between US$11 and US$35 for each US$1 invested. Investing in nutrition not only offers one of the highest returns on development funds but also establishes a solid foundation for successful initiatives in various other sectors.

61. **Economic analysis indicates the project is cost-effective.** Assuming the project will help improve the outcome of basic services for the targeted population, a conservative reduction of 10 percent in maternal mortality and under-five mortality rates starting in Year 2 will generate a significant economic value over four years from lives saved due to

[34] https://www.unicef.org/sudan/children-sudan. 2022 data.
[35] UNICEF. 2024. *Record Numbers of Children Seek Life-saving Care as Sudan War Drives World's Worst Displacement Crisis*. February 9, 2024.

improvements in access and quality of basic health services. Applying a conservative statistical value of life for low-income countries (US$45,000)[36] and a three percent discount rate, the project will yield an approximate net present value of US$45 million in economic return, with an internal rate of return (IRR) of 35 percent, and a benefit-cost ratio of 1.56. Under a scenario where the parallel exchange rate represents a 26.8 percent premium over the official exchange rate, the project is still cost-effective, with an IRR of 11 percent and a benefit-cost ratio of 1.14.

B. Fiduciary

(i) Financial Management

62. UNICEF and WHO have a proven ability to carry out project activities in hard-to-reach areas in Sudan and have adequate systems and mechanisms to ensure project implementation in situations of conflict and insecurity. The organizations' FM arrangements are well aligned with requirements under the World Bank Policy and World Bank Directive on Investment Project Financing. The FM arrangements will be based on the FMFA, to which UNICEF and WHO are co-signatories. UNICEF and WHO will ensure effective FM oversight of project activities through their accounting capacity and systems. They will prepare and submit quarterly unaudited interim financial reports (IFRs) to the World Bank within 45 days after the end of each quarter. Disbursement of funds will be based on the IFRs. For UNICEF, the external audit requirements will be satisfied through entity-level audits conducted by the UN Board of Auditors For WHO, entity-level audits are conducted by WHO's External Auditor pursuant to the application of WHO's financial rules and regulations. This includes the Single Audit Principle as adopted by the UN General Assembly and recognized by the World Bank.

(ii) Procurement

63. The World Bank will rely on and apply UNICEF's and WHO's rules and procedures as Alternative Procurement Arrangements. The World Bank has conducted a procurement capacity assessment of the organizations' Sudan country offices and found that they have good in-house procurement capacity with intensive capacity in managing projects in Sudan and similar contexts. Therefore, a staffing gap is unlikely even with the expected increase in workload under this project. If such a gap is identified, agreement will be reached with the World Bank on how to address it.

64. Procurement activities envisaged will be mainly consulting services, goods, non-consulting services, and small or medium-sized public works based on needs. UNICEF and WHO prepared a draft PPSD and a 6- to 18-month Procurement Plan. The draft Procurement Plan will be agreed upon with the World Bank before any procurement and not later than 30 days after the effectiveness date. UNICEF and WHO will provide updates on progress of procurement implementations as part of their semiannual progress reports. See further details in Annex 1.

C. Legal Operational Policies

[36] Viscusi, W. Kip, and Clayton J. Masterman. 2017. "Income Elasticities and Global Values of a Statistical Life." *Journal of Benefit-Cost Analysis* 8 (2): 226–250.

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

65. In accordance with the Bank Procedure on Operational Policy Waivers and Waivers of Operational Requirements, the following three waivers in connection with the project were concurred by Management: (a) a waiver of the application of the Anti-Corruption Guidelines to UNICEF and WHO in connection with the project; (b) a waiver of the application of the IDA Commitment Charge to UNICEF and WHO for the duration of the project; and (c) a waiver of the IDA national allocation eligibility criteria to allow UNICEF and WHO to receive the IDA grant out of the IDA allocation for Sudan. The Alternative Procurement Arrangements were approved on April 1, 2024, by the World Bank Chief Procurement Officer.

D. Environmental and Social

66. The project's overall E&S risk classification is rated High with substantial environmental risk and high social and sexual exploitation and abuse/sexual harassment (SEA/SH) risks. Seven of the ten Environmental and Social Standards (ESS) (except ESS 5, 7, and 9) of the World Bank's Environmental and Social Framework (ESF) are relevant to the project. The environmental, social, health, and safety (ESHS) risks and impacts related to the project and the proportionate mitigation measures are summarized as follows.

67. **Environmental risks.** The main potential environmental, health, and safety (EHS) risks and impacts are associated with Components 1 and 2. The potential EHS risks and impacts related with the rehabilitation or building and operation phases of health facilities (Component 1) and EOCs and blood banking services (Component 2) include noise and dust pollution, the generation of hazardous and non-hazardous waste and improper waste disposal, fire hazards, and inefficient use of natural resources. The procurement, use, and/or maintenance of medical and non-medical equipment and supplies, essential drugs, vaccines, consumables, reagents, and test kits (Components 1 and 2), along with the delivery of prioritized packages of health services (Component 1), could lead to waste generation. If not managed properly, this waste could cause environmental contamination and pollution. There are also e-waste issues associated with the financing of the (a) integration of digital innovations that will facilitate service provision and enhance staff communication and training allowing for improved quality of service delivery (Components 1 and 3) and (b) solar power for health facilities (Component 1). Project-related potentially hazardous wastes, resulting from Components 1 and 2, include infectious materials, sharps, pharmaceuticals, chemicals, and so on. Air pollution could arise from medical storage sites, medical waste incineration, and isolation wards, among others, if health facility wastes are not properly managed. The use of mobile health service teams and outreach rounds (Component 1) may also increase fuel consumption and vehicle emissions, further contributing to air pollution. Potential air pollution sources also include medical waste storage and incineration, isolation wards, and ventilation systems. Further, contaminated wastewater could be discharged from health facilities including medical wards, laboratories, pharmaceutical and chemical stores, and disposal of medical and lab equipment. All this poses occupational and community health risks. Project management (Component 3) activities, such as monitoring, evaluation, and knowledge management, can be resource-intensive, leading to increased carbon emissions and electronic waste. Overall, these potential EHS risks are generally site-specific, temporary, and reversible and can be managed by applying World Bank ESF standards, World Bank Group General EHS Guidelines, and Good International Industry Practice.

68. **Social risks.** The potential social risks and impacts of the project are also associated with Component 1: Improving Access to Basic Health and Nutrition Services and Component 2: Preserving the Main Elements of the Health System. The project will have the following social benefits: improved access to the health system; reduced maternal and child mortality; improved WASH facilities; better nutrition services for the vulnerable groups, IDPs, and children; and so on. Despite these positive contributions of the project, the following potential social risks and impacts are anticipated: (a) exclusion of vulnerable groups; (b) security risks and illegal activities, such as violence, extortion, theft, armed assault, looting, and vandalism of project materials and properties; (c) risks associated with SEA/SH; (d) weak community participation and engagement during implementation; (e) social tensions between the IDPs and host communities over project benefits and rejection of targeting criteria; and (f) a possible increase in IDP mobility to the project areas to benefit from the project. Overall, the E&S risks and impacts will be managed by applying the World Bank's ESF, including preparing and implementing the required E&S risks, management instruments such as the Environmental and Social Management Framework (ESMF), including as annexes, the Labor Management Procedures, Security Management Framework (SMF), SEA/SH Action Plan, General Waste Management Plan, and Stakeholder Engagement Plan (SEP).

69. **Gender.** Women and girls in Sudan face significant barriers in access to health services due to conflict and fragility as well as socioeconomic and cultural challenges that reinforce gender inequality in the country. This has contributed to especially poor health outcomes for women, particularly in relation to sexual, reproductive, and maternal health. Maternal mortality in Sudan is at 270 deaths per 100,000 births, and the lifetime risk of maternal deaths is 1 in 78.[37] The total fertility rate is high, at 4.5 births per woman, and a considerable proportion of these births take place among teenage girls with an adolescent fertility rate of 80 births per 1,000 girls ages 15–19 years.[38] Less than 50 percent of women participate in decisions related to their own health care, while 15 percent do not participate at all.

70. The project identifies lack of access to adequate health care, particularly for safe births, as a major barrier to maternal and child survival, especially for those with pregnancy complications. While 70 percent of the population lives within 30 minutes of a health facility, only 50 percent of people who visit one are attended by skilled health care providers, with coverage for maternal and childcare being one of the lowest in the region. Recent conflict has further weakened the health system, causing disruptions in essential health service delivery (including maternal and child health services), and has created cohorts of IDPs for whom accessing health care is especially a challenge.

71. Proposed actions to close gender gaps are presented under Component 1 of the project, which supports improving access to basic health and nutrition services. Within this, Subcomponent 1.1 focuses on strengthening PHC and reaching IDPs and remote populations through outreach and mobile teams. This includes delivery of maternal and child health and nutrition services, including skilled birth attendance, family planning, and antenatal and postnatal care, as well as referral for emergency obstetrics and neonatal care for pregnancy-related complications through outreach rounds and mobile teams. Furthermore, Subcomponent 1.2 which focuses on improving first-level referral centers, includes support for the provision of BEmONC and CEmONC services in the targeted referral center. Together, these two subcomponents support addressing the identified gender gap in access to adequate maternal health services, especially for pregnancy-related complications. The delivery of these services will help address the high maternal mortality.

72. **Measurement of progress against the identified gender gap** to address unsafe deliveries and reduce maternal mortality will be done using the following indicators:

- Number of deliveries attended by skilled health personnel.

[37] World Bank. 2024. World Development Indicators. Accessed 3-6-24.
[38] Ibid.

- Number of pregnant women receiving ANC visits.

73. **Citizen engagement.** The project will ensure proactive feedback processes including a feedback mechanism for all health services provided and training conducted by the project. Planned procurement activities will include hiring of a TPM entity to verify that resources are reaching the intended beneficiaries and potential harm is minimized, consultancy for health service quality assessment, and citizen engagement and beneficiary feedback surveys. There will be a grievance redress mechanism (GRM) specific to the project as per the requirements of ESS 10 and other relevant ESS. The proposed GRM is expected to provide an inclusive, accessible, and safe GRM process that receives and resolves grievances, closes the feedback loop with communities and builds trust, sensitively handles corruption and SEA/SH allegations, and provides the project with actionable data through which to adjust and improve its programming.

V. GRIEVANCE REDRESS SERVICES

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

VI. KEY RISKS

75. **The overall risk rating of the project is High.** This is informed by the following risks.

76. **Political and Governance (High).** Due to the conflict in past years, Sudan's federal institutions are currently non-functional and cannot be relied on for project implementation. However, state and locality-level institutions and local authorities are in place and operational. Federal-level security apparatus, such as the Humanitarian Aid Commission is functioning at the state level and will require coordination and consultation at the technical level to ensure smooth implementation and facilitation of project activities. UNICEF and WHO will work with other UN agencies as well as international and local partners to ensure coordination and complementarity of support.

77. **Macroeconomic (Substantial).** The economic impact of the revolution, other socioeconomic shocks, and the 2021 coup have aggravated the already weak pre-conflict economic performance. This has been further exacerbated by recent military destruction and a halt on domestic and international production and trade, lending to the freezing of donor aid, depreciation of the currency and rising inflation. These factors affect the availability of public funds to health facilities, impairing their functionality and service delivery. Although the project cannot fully mitigate these risks, it will contribute to maintaining urgently needed basic health and nutrition services to alleviate some of the adverse effects.

78. **Technical Design of Project (Substantial).** Provision of health services and their implementation by two implementing agencies add complexity to the project's technical design. To mitigate this risk, the project will focus on community interventions that have been proven effective. The security challenge and frequent mobility of the population fleeing areas heavily affected by conflict may compromise the ability of UNICEF and WHO and their implementing partners to adequately identify eligible potential beneficiaries. This will be mitigated by the strong field presence and knowledge of the agencies and their IPs.

79. **Institutional Capacity for Implementation and Sustainability (High).** Project implementation will be led by UNICEF and WHO, which have adequate capacity and local presence to implement the respective components. The project will finance the recruitment of a TPM agency that will complement their technical support at the local level and conduct verification of progress and compliance. Nonetheless, the operating environment of the project is complex and dynamic, which may challenge the implementing agencies' capacities. To mitigate this, UNICEF and WHO will collaborate with capable and experienced IPs early on in the project. The sustainability of the project is heavily dependent on the long-term availability of external financing, well into the post-conflict period. To mitigate some of this risk, options such as establishing a multi-donor trust fund will be explored to secure at least medium-term commitments from international donors.

80. **Fiduciary (High).** The fiduciary risks identified such as the country environment, could affect the FM arrangements for the project. These include challenges of volatility and the impact of the ongoing conflict in Sudan that could impede access to the intended beneficiaries, and the insecurity that could adversely affect the delivery of the project-supported inputs (for example, medication, supplies, and fuel) to the end users such as health facilities and raise the risk of safeguard of funds. Furthermore, project supervision will be challenging because of insecurity, and the verification of project outputs will be difficult and costly because of the inherent physical and logistical constraints of visiting multiple locations. In addition, there are inherent risks in the project design given its decentralized nature and the fact that it will be implemented in all states with priority given to safer and accessible localities with potential escalation of the conflicts to these states. These risks will be mitigated through the proposed implementation modality through UNICEF, WHO, and their IPs (INGOs, NGOs, and so on) and leveraging their experience and capacity of working in FCV contexts.

81. **Environmental and Social (High).** The project's overall E&S risk is classified as high with high social risk and substantial environmental risk to reflect the risks and impacts stated under Section IV.D. The social risk of the project is considered high mainly because of the FCV context of the country and along with security challenges, including the recent conflict that erupted in mid-April 2023, which could affect the implementation and achievement of project outcomes if not properly managed. The project will be implemented in conflict-affected areas and IDP hosting regions, which are volatile and highly prone to instability and conflict situation. The implementing agencies will monitor the implementation of the project's E&S risk management instruments at the project-site level with additional monitoring by the TPM agency. To avoid the elite capture, a clear and uniform approach to social mobilization and community engagement will be outlined in the PIM and communicated to the relevant communities. Support will also be informed by community consultations to better understand the potential risks for exclusion and social tension between IDPs and host communities. As the project is being processed under paragraph 12, Section III of the World Bank Policy for Investment Project Financing, the draft Environmental and Social Commitment Plans (ESCPs) and the SEP were prepared and disclosed before negotiations on the World Bank, UNICEF and WHO websites (on June 26, 2024, and the ESCPs again on November 29, 2024) while an ESMF will be prepared later, as a condition of disbursement for UNICEF and WHO, with an aim to properly manage ESHS risks and impacts of the project.

82. **Stakeholders (High).** Sudan's long history of conflict will likely affect any engagement with authorities and the communities, which could impede implementation and access. Therefore, there will be emphasis on sensitization of and

consultation with the communities during implementation, making sure that IDPs and host communities are an integral part of decision-making. Consultations will be carried out in a culturally appropriate manner to ensure that women and members of historically marginalized communities engage. The project will ensure that local authorities are aware of the project interventions, working with them to facilitate any access procedures, and engaging state and Mahalia-level authorities in planning and coordination activities at the technical level to the extent possible. The project will not move forward in a given location without the consensus and assurances of all stakeholders involved in the project.

83. **Other risks (High) have been identified.**

- **Security risk.** Several facilities were previously attacked and looted, leading to deaths of patients and health workers. These risks remain a reality for the World Bank and partner agencies providing support to health services across the country. Multiple efforts have been made, however, to mitigate potential risks through the development of a customized SMF along with its implementation arrangements. The PIM will also outline procedures as per UNICEF and WHO guidance on risks and modalities for determining the need to cease work in a particular area due to security concerns.
- **Data protection.** There is a substantial residual risk related to data collection, processing, and privacy during implementation of the project activities, which may arise from: (a) access to personally identifiable and sensitive information by unauthorized personnel; (b) gaps in data privacy and protection regulations; and (c) cybersecurity breaches. The project will follow specific guidelines and procedures for dealing with such data to be highlighted in the PIM and in accordance with each agency's policies and procedures. These measures may include data minimization (collecting only data that are necessary for the purpose), data accuracy (correct or erase data that are not necessary or is inaccurate), use limitations (data are only used for legitimate and related purposes), data retention (retain data only for as long as they are necessary), informing data subjects of the use and processing of their data, and allowing data subjects the opportunity to correct information about them (also see UNICEF Policy on Personal Data Protection). The project will provide support for software and hardware investments that further mitigate the risk of breaches to cybersecurity. Using digital platforms with AI features for capacity building and service delivery may be associated with risk in data privacy and cybersecurity. In addition to the measures mentioned above, periodic assessments combined with enhanced human oversight and regular training are the mitigation measures against this risk. Moreover, the project will work closely with Sudan SANAD project in ensuring data privacy is maintained at PHCs and other facilities that experienced looting and destruction in the recent past.

VII. RESULTS FRAMEWORK AND MONITORING

PDO Indicators by PDO Outcomes

Baseline	Period 1	Closing Period
Restore access to a basic package of health and nutrition services		
Number of health, nutrition, and population services provided to project beneficiaries (Number)		
Nov/2024	Jan/2026	Jan/2027
0.00	3,145,000	7,861,700
➢Female (Number)		
Nov/2024	Jan/2026	Jan/2027
0.00	1,573,000	3,931,000
➢IDP (Number)		
0.00	472,000	1,180,000
Preserve the main elements of essential public health functions		
Number of functional laboratories with early outbreak detection capabilities as described in the PIM (Number)		
Nov/2024	Jan/2026	Jan/2027
0.00	5	10

Intermediate Indicators by Components

Baseline	Period 1	Closing Period
Improving Access to Basic Health and Nutrition Services		
Number of pregnant women receiving ANC visits (Number)		
Nov/2024	Jan/2026	Jan/2027
0.00	30,850	74,700
Proportion of identified GBV survivors who received first-line support relative to the total number of GBV survivors who sought services at the facilities (percentage) (Percentage)		
Nov/2024	Jan/2026	Jan/2027
0.00	80	80

Proportion of HFs rehabilitated to be climate resilient (Percentage)		
Nov/2024	Jan/2026	Jan/2027
0.00	15	30
Number of children immunized (Number of people) CRI		
Nov/2024	Jan/2026	Jan/2027
0	2,400,000	6,000,000
Number of women receiving deliveries attended by skilled health personnel (Number of people) CRI		
Nov/2024	Jan/2026	Jan/2027
0	29,000	72,000
People receiving quality health, nutrition, and population services (Number)		
Nov/2024	Jan/2026	Jan/2027
0.00	3,200,000	8,000,000
Preserving the Main Elements of the Health System		
Percentage of supported health facilities with timely and complete reporting in EWARS (Text)		
Nov/2024	Jan/2026	Jan/2027
0.00	70% for completeness; 50% for timeliness	80% for completeness; 70% for timeliness
Number of Rapid Response Teams trained and deployed on investigation of alerts and immediate outbreak response (Number)		
Nov/2024	Jan/2026	Jan/2027
0.00	60	150
Number of health care workers trained in-service (Number)		
Nov/2024	Jan/2026	Jan/2027
0.00	1,350	3,350
➢Female (Number)		
Nov/2024	Jan/2026	Jan/2027
0.00	540	1,340
Number of health staff connected to the digital engagement platform (Number)		
Nov/2024	Jan/2026	Jan/2027
0.00	745	1,490
➢Female (Number)		
Nov/2024	Jan/2026	Jan/2027
0.00	372	745
Monitoring and Evaluation and Project Management		
Proportion of health facilities receiving monthly structured supervision visits (Percentage)		

Nov/2024	Jan/2026	Jan/2027
0.00	20	30
Number of monitoring reports submitted (Number)		
Nov/2024	Jan/2026	Jan/2027
0	4	8
Percentage of complaints to Grievance Redress Mechanisms satisfactorily addressed in a timely manner (Percentage)		
Nov/2024	Jan/2026	Jan/2027
0.00	40	80

Monitoring & Evaluation Plan: PDO Indicators by PDO Outcomes

Expand access to a basic package of health and nutrition services	
Number of health, nutrition, and population services provided to project beneficiaries	
Description	The indicator measures the actual utilization of health, nutrition, and population services, by capturing the number of services received by project beneficiaries. The data will be disaggregated for IDPs and female beneficiaries.
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Survey, TPM
Responsibility for Data Collection	UNICEF, WHO
Preserve the main elements of the health system	
Number of functional laboratories with early outbreak detection capabilities as per WHO guidelines	
Description	Laboratories equipped with RDTs for rapid detection of cholera, malaria, and dengue fever, staffed by a trained lab technician proficient in using RDTs, and capable of collecting, packaging, and transporting infectious disease samples to the National PHL for further testing and confirmation via PCR or cultures if needed.
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	WHO

Monitoring & Evaluation Plan: Intermediate Results Indicators by Components

Improving Access to Basic Health and Nutrition Services	
Number of deliveries attended by skilled health personnel	
Description	Number of deliveries attended by trained health personnel in targeted sites
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	UNICEF, WHO
Number of pregnant women receiving ANC visits	
Description	Number of women at child bearing age with a live birth in a given time period who received ANC, four times or more from any provider in project targeted areas.
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	WHO,UNICEF
Proportion of identified GBV survivors who received first-line support relative to the total number of GBV survivors who sought services at the facilities (percentage)	

Description	Percentage of identified GBV survivors who received first-line support as defined in the PIM. The denominator is the total number of GBV survivors who sought services at the facilities.
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	WHO, UNICEF
Number of children immunized with life-saving vaccines (Number)	
Description	Number of children immunized with life-saving vaccines as described in the PIM
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	UNICEF, WHO
Proportion of prioritized HFs rehabilitated to be climate resilient	
Description	Denominator is the number of HFs identified, after conducting an assessment, to be vulnerable to or at high risk of service delivery disruption due to climate shocks (floods, heatwaves, and droughts).
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	UNICEF, WHO
People receiving quality health, nutrition, and population health services (Number of people)	
Description	The number of people benefitting from the utilization and quality improvements of health prevention, promotion, diagnostic, curative, rehabilitative and palliative care due to WB activities during the intervention period. Data will be disaggregated for youth and female population
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	UNICEF, WHO
Preserving the Main Elements of the Health System	
Percentage of supported health facilities with timely and complete reporting in EWARS	
Description	The denominator is the number of supported health facilities whose staff are trained on the system and have minimum connectivitiy to report. The numerator is the number of health facilities submitting complete and timely reports as defined in the PIM.
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	UNICEF, WHO
Number of Rapid Response Teams trained and deployed on investigation of alerts and immediate outbreak response	
Description	The cumulative number Rapid Response Teams trained on investigation of alerts and immediate outbreak response training through the project and deployed in the field.
Frequency	Bi-annual

Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	WHO
Number of health care workers trained in-service	
Description	The cumulative number of health care workers trained in-service, disaggregated by gender, as defined in the PIM. The data will be disaggregated for female health workers.
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	WHO
Number of health staff connected to the communication engagement platform	
Description	Number of health staff connected to the communication engagement platform, disaggregated by gender, as described in the PIM. The data will be disaggregated for female health staff.
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	UNICEF, WHO
Monitoring and Evaluation and Project Management	
Proportion of health facilities with receiving monthly structured supervision visits (Percentage)	
Description	Proportion of health facilities receiving a structured supervision visits monthly by health authorities as described in the PIM.
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	UNICEF, WHO
Number of monitoring reports submitted (Number)	
Description	Number of monitoring reports submitted by implementing agencies to the World Bank as defined in the PIM.
Frequency	Quarterly
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	UNICEF, WHO
Percentage of complaints to Grievance Redress Mechanisms satisfactorily addressed in a timely manner	
Description	Percentage of complaints to Grievance Redress Mechanisms satisfactorily addressed in a timely manner as described in the PIM.
Frequency	Bi-annual
Data source	Progress reports
Methodology for Data Collection	Surveys, TPM
Responsibility for Data Collection	UNICEF, WHO

ANNEX 1: Implementation Arrangements and Support Plan

COUNTRY: Republic of the Sudan
Sudan Health Assistance and Response to Emergencies

Financial Management

1. **The project will be implemented by UNICEF and WHO as direct recipients of IDA grant financing, as well as the managing and implementing agencies. Each organization will be responsible for several activities based on the project design and their comparative advantage.** UNICEF will lead the implementation of Subcomponent 1.1: Strengthening the Integration of Primary Health Care Model; Subcomponent 1.4: Climate Change Resilient Health Facilities; Subcomponent 1.5: Integrating Digital Solutions to Service Delivery; and Subcomponent 3.1: Third Party Monitoring. The WHO will lead the implementation of Subcomponent 1.2: Supporting Health and Nutrition Services at the First-Level Referral Centers and Hospitals; Subcomponent 1.3: Climate Change Adaptive Health Service Delivery; and Component 2: Preserving the Main Elements of the Health System. UNICEF and WHO will jointly implement Subcomponent 3.2: Data Analysis and Knowledge Management and Subcomponent 3.3: Project Management. Both UNICEF and WHO have proven their ability to carry out project activities in often hard-to-reach areas in Sudan and have adequate systems and mechanisms to ensure project implementation in situations of conflict and insecurity. Both organizations' FM arrangements are well aligned with the World Bank's requirements under the World Bank Policy and World Bank Directive (formerly OP/BP 10.0) on Investment Project Financing. The FM arrangements will be based on the FMFA to which UNICEF and WHO are co-signatories. The 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 OP/BP 10.0 are waived in favor of the UN rules.

2. **UNICEF and WHO will also ensure effective FM oversight of project activities through their accounting capacity and systems.** UNICEF and WHO will prepare and submit quarterly IFRs to the World Bank within 45 days after the end of each quarter starting from the project effectiveness date. The IFR format will be agreed upon during the project appraisal. A mutually agreed upon IFR format will be generated from the UN agencies' FM system and will be reflected in the Disbursement and Financial Information Letter. In line with the FMFA, UNICEF and WHO will prepare and submit to the World Bank annual financial statements of account certified by the Chief Finance Officer or an authorized staff member. The annual financial statements should be submitted within six months of the end of the fiscal year. UNICEF and WHO will prepare and submit a detailed project budget and annual work plan based on planned activities to be executed over the life of the project and this will be agreed upon with and submitted to the World Bank. The World Bank will monitor budget execution as part of the quarterly IFRs. Any significant variances between actual and budgeted performance (that is, above 20 percent of the implementing agencies' respective budget cost categories) should be justified and discussed with the World Bank.

3. **The fiduciary risks identified under the project include the country environment, which could affect the FM arrangements of the project.** These include challenges of volatility, the impact of the ongoing conflict in Sudan that could impede access to the intended beneficiaries, and the insecurity, which could adversely affect the delivery of the project-supported inputs (for example, medication, supplies, and fuel) to the end users (for example, health facilities) and raise the risk of safeguard of funds. Furthermore, project supervision will be challenging because of insecurity, and the verification of project outputs will be difficult and costly because of 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 the safer states with potential escalation of the conflicts to these states. There are also broader macroeconomic risks in the portfolio, such as hyperinflation and significant local currency depreciation. These risks will be mitigated through the involvement of specialized third-party agencies that include UNICEF, WHO, and their IPs (INGOs, NGOs, and so on) and leveraging their experience and capacity of working in FCV contexts. To complement UNICEF and WHO monitoring, the project will finance the appointment of a TPM agent to sample, monitor, and validate the achievement of outputs and results in the various field locations. To enhance the transparency and accountability of the TPM agent, the project will integrate support from GEMS. GEMS will enhance the project supervision and monitoring, enabling the World Bank to monitor the TMP and get direct access to the field data in real time.

4. **External audit arrangements.** For UNICEF, the external audit requirements will be satisfied through an entity-level audit conducted by the UN Board of Auditors. For WHO through entity-level audits conducted by WHO's External Auditor pursuant to the application of WHO' financial rules and regulations, including the Single Audit Principle as adopted by the UN General Assembly and recognized by the World Bank. Although the World Bank recognizes the Single Audit Principle for the UN agencies' audit, given the high-risk circumstances of the project, the World Bank may request additional due diligence activities to be agreed upon with UNICEF and WHO during preparation. These may include (a) sharing the internal audit report of the country office (UNICEF's Office of Internal Audit and Investigation/WHO's Office of the Internal Oversight Services), which would be relevant to the project; (b) for WHO, sharing the country office's risk register (if any); and (c) IPs receiving project funds and subcontracted by UNICEF and WHO to be audited in accordance with their respective policies and procedures. The audit is to be carried out by an independent audit firm and in accordance with UNICEF and WHO monitoring procedures toward its IPs and internally sharing a summary of the audit findings with the World Bank.

5. **Disbursement, banking, and fund flow arrangements.** The disbursement methods will include reimbursement, advance, direct payment, and special commitment, as will be specified in the Disbursement and Financial Information Letter and in accordance with the World Bank Disbursement Guidelines for Projects, dated February 1, 2017. The Disbursement and Financial Information Letter will provide details of the disbursement methods, required documentation, and ceiling. Under this project, funds disbursed from the World Bank will be received by UNICEF and WHO in pooled Designated Accounts at their headquarters in New York and Geneva, used to receive contributions from all other partners. The initial advance will be disbursed based on a negotiated lump-sum amount based on a six-month cash forecast. Subsequent replenishment of funds will be made upon evidence of satisfactory utilization of the advance, including submission of IFRs. As per the FMFA, UNICEF and WHO are not required to open separate Designated Accounts for the project. To enhance accountability over the disbursements, UNICEF and WHO should maintain a separate ledger account for recording the funds channeled into the project.

Procurement

6. Given the ongoing violence and instability in Sudan, the project is prepared within the context of World Bank Policy on Development Cooperation and Fragility, Conflict and Violence and is also being processed under paragraph 12, Section III of the World Bank Policy on Investment Policy Financing (Projects in Situations of Urgent Need of Assistance and Capacity Constraints). The World Bank will directly sign the Financing Agreement with UNICEF and WHO as grant recipients and implementing agencies for the proposed project. UNICEF and WHO will perform project management and implementation support functions through their local offices in Sudan. The project will benefit from both organizations' vast presence and the experiences of their Sudan-based staff and teams, which allows the project to draw on-the-ground resources to inform preparation and will enable immediate deployment once the project is approved.

7. UNICEF and WHO will follow their own polices and procurement procedures as Alternative Procurement Arrangements allowed by the Procurement Policy under Section III.F of the World Bank Policy: Procurement in Investment Project Financing and Other Operational Procurement Matters (July 2016). The use of Alternative Procurement Arrangements was approved by the World Bank Chief Procurement Officer.

8. UNICEF and WHO policies, procurement rules, and procedures were assessed against the World Bank's core procurement principles and governance requirements, conducted as part of global World Bank engagement by the Operations Policy. The findings revealed that UNICEF and WHO procurement rules and procedures meet the World Bank's requirements and are acceptable under agreements with UN agencies.

9. UNICEF and WHO have rolled out a procurement system that allows debarring of the donors or World Bank-sanctioned vendors list, including (a) the UN ineligibility list, (b) the Consolidated UN Security Council Sanctions List, and (c) the World Bank Corporate Procurement listing of non-responsible vendors. UNICEF and WHO will further confirm that their systems already consider the World Bank listing of ineligible firms and individuals.

10. UNICEF and WHO will undertake project activities by using their staff. Procurement activities envisaged will be mainly consulting services: recruitment of individual consultants, firms, international and local NGOs and CSOs, goods, small and medium works, as might be needed, 'if any'.

11. The World Bank also conducted a supplementary procurement capacity assessment of the UNICEF and WHO Sudan offices to manage project procurement with focus on staffing and experience, procurement oversight arrangements, supply of requirements, and general country offices' procurement performance with considerations of the current context. The findings and recommendations were discussed and found acceptable. UNICEF and WHO will ensure that policies for sanctioned and ineligible individuals and firms are observed through a proper due diligence process conducted before contract award.

12. UNICEF and WHO have prepared PPSDs for the project, and in accordance with Paragraph A.3 in section III of the World Bank Guidance: 'Procurement in Situations of Urgent Need of Assistance or Capacity Constraints', the finalization of the PPSDs will be deferred to the project implementation phase. UNICEF and WHO will both prepare a 6 to 18-month Procurement Plan for the project, including cost estimates, selection methods, market approach options, and time schedules. The initial Procurement Plan will be agreed upon with the World Bank before any procurement and not later than 30 days after the effectiveness date. UNICEF and WHO, as part of their progress reports during implementation, will submit procurement monitoring and contract implementation information to the World Bank.

13. During all procurement processes, the suppliers will be required to complete a disclosure form for any actual or potential conflict of interest during the tendering process, to be signed and included in their solicitation submissions. Similarly, all contractual agreements will include conflict-of-interest clauses prohibiting such activity. UNICEF's and WHO's procurement focal points and members from different procurement-related committees must also complete a form declaring they are free from conflict of interest and have no financial or personal interest in the cases to be reviewed. If it is determined that a conflict of interest does exist, that person will be fully removed from any involvement in the procurement process.

14. **The overall project procurement risk is assessed to be High**, **and the residual risk is assessed as Substantial based on the country's situation.** The mitigation measures agreed upon similarly with UNICEF and WHO are summarized in Table 1.1.

Table 1.1. Procurement Risks Mitigations Matrix

Risk description	Mitigation measures	Time frame	Responsibility
Adverse price increases and exchange rate fluctuations caused by hyperinflation and political instability leading to government restrictions on US dollars, material increase of program cost, exchange rate losses, and potential funding gaps.	• Source selected goods and services internationally to limit the effects of local shortages and dire inflation. • Monitor daily exchange rates and alert all stakeholders to possible changes in the distribution plan. • The UN exchange rate is now determined every two weeks to ensure more flexibility and limit significant variance due to the volatile exchange rate. • Review the Procurement Plan for strategic purchases and long-term agreements for supply and provision of critical services.	During implementation	UNICEF, WHO
Fraud and corruption in the procurement process due to inadequate internal controls, insufficient prioritization of fraud prevention, and lack of accountability resulting in loss or diversion of resources and reputational risk.	• Maintain adequate segregation of duties and clear delegation of authority levels. • Implement procurement committees, vendor due diligence, and vetting protocols, anti-fraud and corruption contractual clauses, and electronic tendering system. • Watch for conflict of interest.	During implementation	UNICEF, WHO
Critical goods and services are unavailable due to international procurement lead times, lengthy customs delays, and supply chain blockages, impeding UNICEF's and WHO's ability to perform operational business processes.	• Source and improve local procurement and increase the capacity and orientation of local suppliers. • Maintain adequate rotational stocks of critical equipment available on standby. • Intensify lobbying efforts with government counterparts to expedite approvals and release of equipment from customs.	During implementation	UNICEF, WHO
The quality of some equipment, goods, or services available in the local market currently may not meet needed technical specifications.	• Provide detailed scope of work and technical specifications during tendering processes. • Build capacities of local suppliers with proper awareness of needed standards and gradually increase the number of local vendors to diversify the sourcing.	During implementation	UNICEF, WHO
Delays in payment based on invoices or services, as well as approval of evaluation bids reports, signing off, and approval of contracts.	• A dedicated staff will reinforce an invoice tracking system to ensure invoices are processed on time. • Procurement staff for close follow-up and reinforcement of committee and evaluation panel members.	During implementation	UNICEF, WHO
Poor or inconsistent quality and timeliness of partners' deliverables	• Conduct partner training on implementation, transfer modalities,	During implementation	UNICEF, WHO

Risk description	Mitigation measures	Time frame	Responsibility
not meeting contracted standards due to inadequate capacity or quality of partners to meet UNICEF's and/or WHO's procedures and standards, lack of training on the organizations' procedures and standards, low local standards of performance, inadequate monitoring of partner performance by UNICEF or WHO, lack of financial resources to ensure quality standard leading to unfulfilled commitments under project documents, unmet beneficiary needs, underachievement of objectives, and reputational risk.	reporting, accounting practices, and other relevant topics based on needs. • Have a robust complaints and feedback mechanism. • Implement Harmonized Approach to Cash Transfer Framework, including regular project visits, spot checks, and audits.		

15. The status of procurement for UNICEF and WHO will be reviewed as part of the World Bank's semiannual implementation support missions.

16. UNICEF's and WHO's operations are governed by the Charter of the UN, WHO Constitution in the context of WHO activities and the Convention on the Privileges and Immunities of the UN, or that of the Specialized Agencies of the UN as applicable, which has full juridical personality and enjoys such privileges and immunities as are necessary for the independent fulfillment of its purposes.

ANNEX 2: Climate Change

1. **The project has been screened for short- and long-term climate disasters and risks and has been found to be highly exposed, with moderate risk to project activities.** Sudan is extremely vulnerable to annual flooding, severe droughts, and increasing temperatures. The country is ranked 179th out of 185 countries in terms of climate adaptation, putting it near the bottom of the Notre Dame Global Adaptation Index.[39] Climate impacts are highly detrimental as agriculture and livestock are key sectors to Sudan's overall economy. Most of the land is vast arid plains, separated by hills and mountains. With over 35 percent of the total area of Sudan consisting of pasture and rangelands, arable land constitutes about 33 percent of the total area of the country, and about 21 percent of this land is under cultivation.[40] Outside of the Nile basin, water resources are limited, with low soil fertility. Rainfall in Sudan is unreliable and erratic, with great variation experienced between the northern, central, and southern regions. Northern regions typically experience virtually no rainfall, with less than 50 mm of precipitation annually; central regions receive between 200 mm and 700 mm per year; and some southern regions experience more than 1,500 mm annually.[41] Most rainfall is concentrated between June and September, with high seasonal variability. The mean average temperature is between 26°C and 32°C, with highs exceeding 43°C in the arid north.[42] This translates to variable climate vulnerability, particularly the agricultural and health sectors across the country, and drought is common.[43] The annual mean temperature is projected to increase by 1.5°C–2.6 °C by 2060.[44] Rainfall is projected to increase from maximum of 267.1 mm during 2020–2039 to 283.3 mm in 2040–2059, in line with the trend toward heavier and more debilitating rainy seasons.

2. **Sudan's climate vulnerabilities have had a severe impact on vulnerable populations including displaced persons, increased poverty, widened gender disparities, and augmented food insecurity.** Floods, erratic and seasonally variable rainfall, overgrazing and cultivation, and frequent droughts have undermined livelihoods and increased poverty. Agriculture is critical to Sudan's economy with over 80 percent of the population depending on agricultural production — contributing to over 30 percent of the GDP.[45] If the current rainfall trends continue, the Sahara Desert will continue to advance southward– estimated to be at the rate of 1.5 km per year—and has threatened 25 percent of agricultural land, resulting in over a 20 percent drop in food production.[46] Furthermore, locust infestations driven by the current extreme climatic conditions have further exacerbated land degradation, contributing to the food crisis and overall socio-ecological vulnerabilities.[47] Livelihoods and productivity of smallholder farmers, who rely primarily on rain-fed and traditional farming, are particularly affected by climate conditions. With diverse ecological zones in each of the Darfur states, across the northern and western areas of the region, on average, approximately 40 percent of harvests have failed due to climatic patterns, and this is projected to increase to 70 percent by 2050.[48] Further, the Integrated Food Security Phase

[39] Notre Dame Global Adaptation Index. 2024. https://gain.nd.edu/our-work/country-index/rankings/.
[40] Ministry of Environment, Natural Resources and Physical Development. 2016. Republic of the Sudan. *National Adaptation Plan*.
[41] World Bank. 2021. Climate Change Knowledge Portal.
[42] World Bank. 2021. Climate Change Knowledge Portal (n2).
[43] Republic of the Sudan. National Adaptation Plan (n1).
[44] World Bank. 2021. Climate Change Knowledge Portal (n2).
[45] FAO. 2020. *Special Report: 2019 FAO Crop and Food Supply Assessment Mission to Sudan.*
[46] USAID (US Agency for International Development). 2016. *Climate Change Risk in Sudan: Country Fact Sheet.*
Saad, S.A.M., et al. 2018. "Combating Desertification in Sudan: Experiences and Lessons Learned." *Outlook* 10: 141–155.
[47] Eltoum Masaad, M. A., and S. M. Dafalla Mohamed. 2014. "Eco-Geographical Analysis of Desertification and Desert Locust Infestation Problems in Sudan." *Sudan Journal of Desertification Research* 6 (1): 28–45
Iizumi, T., IE. A. Ali-Babiker, M. Tsubo, et al. 2021. "Rising Temperatures and Increasing Demand Challenge Wheat Supply in Sudan." *Nature Food* 2: 19–27.
[48] Republic of the Sudan. 2016. National Adaptation Plan (n1).

Classification projects increased food insecurity in Sudan in 2024, due in part to lower crop yields caused by drought. Decreasing crop yields and the ensuing increase in food insecurity has contributed to malnutrition and stunting, with declining human capital.[49] Adverse effects of climate change have also produced marginalization of rural communities and gender-based disparities (for example, in the local and national natural resource governance systems), greater risks for women and girls, thus contributing to the community risks associated with climate change.[50]

3. **The impact of climatic patterns on waterborne and vector-borne diseases and the impact of climate shocks on the already strained health system with limited adaptation capacity has greatly affected health in Sudan.** Sudan experiences flooding every year. Given the country's limited infrastructure, this flooding has debilitating results every year, disrupting health service delivery capacity as supplies, vaccines, medicines, and health workers cannot easily reach facilities by road or air as roads become impassable and airstrips are flooded. Foot travel is further complicated by large flowing rivers and swamps. Simultaneously, due to these climatic patterns, poor water quality, and limited health and human resources, the pathogenicity and transmission of waterborne and vector-borne diseases have increased annually during this period. Malaria accounts for 1.35 percent, and diarrhea for 4.85 percent of Sudan's burden of disease spike during the rainy season.[51] Malaria transmission from endemic to pan-endemic areas in Sudan has been correlated with meteorological variables during different times of the year. Malaria cases related to increasing temperatures have been documented in northern Sudan, and cases related to rainfall are well recognized in central and southeast Sudan, with western Sudan being the least endemic area.[52] Increasing temperatures threaten to accelerate and extend the spread of dengue fever and malaria, which are already highly prevalent in the state of Kassala in eastern Sudan.[53] Other common waterborne and parasitic diseases in Sudan include giardiasis, cholera, typhoid, dysentery, and schistosomiasis (or *bilharziasis*). A high prevalence of tuberculosis has also been reported in rural areas in the north and lower Atbara, in the River Nile State in northeastern Sudan.[54] Also of note is the impact on the Kordofan States, located in central and western Sudan, that are thought to be particularly vulnerable to an increased risk of waterborne and vector-borne diseases due to climatic changes. It is projected that the risk of transmission potential will increase substantially by 2060.[55]

4. **Current climate trends in Sudan continue to overburden a health care system that is already experiencing extreme stress and resource limitations**. Increased prevalence of waterborne and vector-borne diseases in particular is taking a heavy toll on local communities and proving to be detrimental to human capital. Access to health services is estimated at 70 percent in urban areas and only 20 percent in rural settings with 55 percent of urban areas having access to potable water, and only 10 percent for the rural population. Similarly, access to sanitation is 89 percent for urban populations and 60 percent for those in rural areas.[56] Sudan is highly vulnerable to fragmented access to health care and disruption in health services delivery that result from climatic catastrophes such as floods, storms, droughts, and high temperatures. Crop failure and high livestock mortality resulting from climatic trends increase migration from rural to urban areas, which further expands slums and exacerbates health and sanitation concerns.[57] High heat further complicates

[49] Integrated Food Security Phase Classifications, Sudan, Projections, October 2023–February 2024: https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_Sudan_Acute_Food_Insecurity_Oct2023_Feb2024_Report.pdf.
[50] Norwegian Institute of International Affairs. 2022. *Climate, Peace and Security Factsheet – Sudan* Stockholm International Peace Research Institute.
[51] Institute for Health Metrics and Evaluation. 2023. *Sudan*.
[52] Aal, R., and A. Elshayeb. 2012.. "The Effects of Climate Changes on The Distribution and Spread of Malaria in Sudan." *American Journal of Environmental Engineering*.
[53] Republic of the Sudan. National Adaptation Plan (n1).
[54] River Nile State NAP Committee. 2013. "River Nile State Committee NAP Report on Assessment of Climate Change Vulnerability and Adaptation Options and Strategies" in *National Adaptation Plan*.
[55] Sudan's First National Communication under the UNFCCC (2003).
[56] Sudan's First National Communication under the UNFCCC (n16).
[57] USAID. 2016. *Climate Change Risk Profile.*

quality health service delivery as travel to health facilities during the day is inhibited by the high temperatures in many arid parts of the country. While there has been an increase in irrigated areas in central parts of the country, this has not been accompanied by expansion with enough health programs to respond to the health impacts.[58] Strained community sanitation services have also affected health services delivery, and community awareness regarding preventative measures for waterborne and vector-borne diseases has been affected, particularly in inaccessible areas.[59] To develop climate-resilient health systems, there is a particular need for climate adaptation related to strengthening health surveillance systems, particularly early outbreak warning systems for climate-sensitive diseases, definitions of climate and health emergencies, and building of health workers' capacity in climate emergency preparedness and response.[60]

5. **This project intends to implement measures to adapt to the impacts of climate change— primarily floods and high-heat risks—while also implementing measures to mitigate GHG emissions in Sudan.** Specific measures are outlined in Table 2.1.

Table 2.1. Climate Change Adaptation and Mitigation Actions

Subcomponent	Climate activity
Component 1: Improving Access to Basic Health and Nutrition Services (US$65.35 million)	
Subcomponent 1.1: Strengthening the Integration of Primary Health Care Model (US$41.41 million, UNICEF)	**Given the substantive impact of flooding on health service delivery in Sudan, this subcomponent will embed multiple measures to ensure the system can maintain service delivery during seasonal floods.** • **Climate-sensitive planning and data use.** This subcomponent will use climate-sensitive planning and data to ensure continuity of health service delivery during seasonal floods, which are becoming more severe with climate change. This will include focused use of data to look at seasonal trends in health conditions, assessment of activities based on needs, and planning to maximize access to people during seasonal flooding and high heat. This activity will focus specifically on integrating climate-sensitive planning for anticipated impacts of climate shocks (that is, difficulty accessing facilities and populations, increase in climate-sensitive diseases, and disruptions in movement of staff and supplies), which are becoming more regular and severe with climate change, into routine service delivery plans. Climate-sensitive contingency plans in Subcomponent 1.4 will focus on plans for the extreme repercussions of climatic events (that is, population movements and destruction of health facilities). • **Climate-sensitive service delivery.** Service delivery will be adjusted to seasonal patterns to maximize delivery during flooding and high heat. Embedded approaches that will be utilized include, but are not limited to, use of community health care workers to deliver health services to flood-affected population, community-level outreach visits focused on foot travel during the rainy season and travel by vehicle during the dry season, dry season service delivery campaigns to maximize the reach of people during accessible periods (transport costs, accommodation costs, and logistics costs), air travel costs to transport staff and move supplies during the rainy season, and costs for porters to move supplies locally during the rainy season. • **Delivery of services for climate-sensitive conditions.** The package will finance delivery of services for waterborne and vector-borne diseases, as well as undernutrition, which are highly climate-sensitive in Sudan's context. Overlay of climatic data will be used to inform

[58] Sudan's First National Communication under the UNFCCC (ibid).
[59] Ministry of Environment and Physical Development. 2007. Republic of the Sudan. *National Adaptation Programme of Action.*
[60] Ministry of Environment and Physical Development. 2007. Republic of the Sudan. *National Adaptation Programme of Action.* Republic of the Sudan. National Adaptation Plan. 2016.

Subcomponent	Climate activity
	delivery of services for these conditions to support adaptation to the health impacts of climate change **(adaptation).**
Subcomponent 1.2. Supporting Health and Nutrition Services at the First Level Referral Centers and Hospitals (US$9.79 million, WHO)	• **Climate-sensitive health service delivery resilience measures.** The subcomponent will utilize the climate emergency preparedness plans developed in Component 2 and plans for continuity of health services in Subcomponent 1.3 to adjust services to prepare for and minimize disruptions due to climate shocks. These are anticipated to include outreach visits and plans to shift facility-based services to locations that are accessible and have minimal impacts of climate shocks, particularly flooding, as needed. • **Pharmaceutical procurement for climate-sensitive conditions.** This subcomponent will finance pharmaceuticals and supplies for climate-sensitive conditions in Sudan, particularly waterborne and vector-borne diseases and undernutrition. Seasonal data will be used to inform the procurement of these pharmaceuticals. This will help treat climate-sensitive diseases to reduce the health impacts of climate change. • **Climate-sensitive pharmaceutical planning and distribution.** To ensure continuity of services throughout the rainy season, pharmaceuticals need to be prepositioned ahead of time in most locations. This involves developing detailed seasonal plans and consolidated shipping during the dry season in flood-prone areas and cooler periods in dry, high heat-prone areas. This subcomponent will also finance as-needed air shipments of pharmaceuticals to fill gaps when these occur **(adaptation).**
Subcomponent 1.3: Climate Change Adaptive Health Service Delivery (US$3.65 million, WHO)	**This entire subcomponent focuses on climate change adaptation activities to increase the resilience of health service delivery to climate change in Sudan.** All activities intend to support climate change adaptation and are solely focused on climate change. • **Development of climate change health service delivery contingency plans at referral health facilities** will outline plans to ensure the continuity of health service delivery during climate shocks, which are becoming more severe because of climate change. This activity will focus specifically on contingency plans for extreme climatic events (that is, population movements and destruction of health facilities). The subcomponent will finance (a) technical assistance for developing the plans and (b) logistic costs for engaging with health facilities on plan development. • **Flood and high heat risk assessments of health facilities**. This activity will assess health facility risk for high heat and damage or access challenges due to flooding. This will both inform climate adaptive rehabilitation of health facilities and form the basis for later work planned on early warning systems for flooding and high heat. The subcomponent will finance (a) execution of the risk assessments and (b) operational costs of engaging with health facilities on using assessment results. • **Development of prepositioning plans for and prepositioning of vector control and water treatment supplies** to limit outbreaks of vector-borne and waterborne diseases. This subcomponent will ensure that supplies to prevent outbreaks of waterborne and vector-borne diseases are in place ahead of floods. The activity will finance (a) technical assistance for development of prepositioning plans, (b) logistics costs for prepositioning supplies, and (c) purchases of vector control and water treatment supplies. • **Training of CHWs on climate emergency preparedness and response and health service delivery during climate shocks** will help them support communities to prepare for and respond to climate shocks and will provide the competencies needed to support service delivery continuity during climate shocks (service delivery continuity activities for CHWs are financed under Subcomponent 1.1). This subcomponent will finance (a) development of the climate emergency preparedness and response curriculum and (b) execution of CHW climate emergency preparedness and response trainings.

Subcomponent	Climate activity
	• **Climate change risk communication activities to highly climate-vulnerable communities** will provide information on climate and health, focusing on climate shock emergency preparedness and response and the health impacts of climate change and how to reduce these to remote, highly climate-vulnerable populations. • **Integration of meteorologic data into EWARS** to better understand the relationship between outbreak-prone infectious diseases and climate change will expand EWARS to include meteorological data. This will allow for better understanding of the relationship between climate change and outbreak-prone diseases. The activity will finance (a) technical assistance for the expansion of EWARS to include meteorological data; (b) information technology costs for the integration of meteorologic data into EWARS; and (c) data use activities, supporting analysis, dissemination, and review of EWARS and meteorological data **(adaptation).**
Subcomponent 1.4: Climate Change Resilient Health Facilities (US$9.0 million, UNICEF)	**This entire subcomponent focuses on climate change adaptation and mitigation activities to increase the resilience of health facilities to climate change in Sudan while reducing GHG emissions.** All activities intend to support climate change adaptation and are solely focused on climate change. • **Rehabilitation of health facilities at risk of flooding and/or high heat** to make them resilient to flooding and extreme heat, which are increasing in severity, frequency, and scope in Sudan due to climate change. These include WASH improvements, given that flooding is a primary driver of diarrheal diseases such as cholera. This activity intends to make health facilities resilient to climate shocks. Climate is the main driver for the entire activity, including WASH improvements, which intend to ensure safe water supply and sanitation systems in flood-prone areas. WASH improvements will specifically cover measures to reduce the impact of climate change exacerbated flood and high heat on WASH facilities and waterborne and vector-borne diseases such as protecting water sources from flood-related contamination. WASH interventions and all interventions climate-resilient rehabilitation interventions will go beyond standard practice and are entirely related to climate change. Health facilities will be selected based on (a) flood and high heat exposure (based on climatic patterns in the geographic area) over the past two years; (b) proximity to known flood plains; and (c) vulnerability of infrastructure to floods. The activity will finance measures that go beyond standard practice, such as securing the outside and inside of buildings against rising water, construction of drainage systems to deal with extreme flooding, and use of reflective paint for passive cooling. The activity will finance (a) technical assistance for and the design of climate adaptive health facility rehabilitation measures, and (b) climate-adaptative health facility rehabilitation. **(adaptation)** • **Development of climate change health service delivery contingency plans at primary-level facilities** will ensure the continuity of health service delivery during climate shocks, which are becoming more severe because of climate change. This activity will focus specifically on contingency plans for extreme climatic events (that is, population movements and destruction of health facilities). The subcomponent will finance (a) technical assistance for the development of the plans and (b) logistic costs for engaging with health facilities on plan development **(adaptation).** • **Solar power for health facilities** to improve access to power, considering limitations caused by climate shocks and the conflict while minimizing GHG emissions **(mitigation).**
Subcomponent 1.5: Integrating Digital Solutions to Service	This subcomponent will finance digital activities to support improved communications between health facilities and senior leaders, patients and health facilities, and health workers and learning platforms. Climate change-induced flooding, which seriously impairs movement in

Subcomponent	Climate activity
Delivery (US$1.5 million, UNICEF)	Sudan is one of the three drivers of this activity: (a) improved quality of health care services, (b) limitations in transport and mobility due to the conflict, and (c) limitations in transport and mobility due to flooding which is becoming more frequent and extreme with climate change. This will embed concrete and structured mechanisms to respond to climate change-based needs as follows: • **The multi-directional platform to strengthen health system governance** will embed the following: (a) dedicated plans to ensure enhanced support for health care workers during the rainy season and climate shocks, with consideration of greater needs for communication via electronic platforms during periods when road transport is not possible and emergency response needs are higher due to climate shocks and flooding; (b) dedicated mechanisms for communications during emergencies; and (c) priority rollout to climate change-vulnerable areas, to be identified based on climate vulnerability maps. • **The digital health services platform for patient tele-consultations** will embed the following: (a) dedicated plans to ensure additional capacity for consultations during periods when road transport is not possible and the need for remote consultations is higher due to climate shocks and flooding; (b) dedicated mechanisms for health workers to respond to emergency needs to due to climate shocks or climate change (that is, flood based injuries and outbreaks of climate-sensitive diseases) during emergencies; and (c) priority rollout to areas vulnerable to climate change, to be identified based on climate vulnerability maps. • **The AI-driven platform for PHC worker capacity building and e-learnin**g will embed (a) training on climate change emergency response and the health impacts of climate change (based on the curriculum developed in Subcomponent 1.3) and (b) priority rollout to areas vulnerable to climate change, to be identified based on climate vulnerability maps.
Component 2: Preserving the Main Elements of the Health System (US$2.77 million, WHO)	
	This component includes activities that are climate change-focused and those that incorporate climate change within them, as well as for resilience measures, as follows: • IDSR training will have modules on the use of meteorological data against IDSR data to help facilitate an understanding of the impact of climate change on health. The training will also include modules on climate-sensitive diseases, which cover the impact of climate change on these conditions. • Subnational emergency preparedness and response plan development, dissemination, and trainings are being developed for emergency preparedness and response to climate shocks and conflict. Climate change is one of two impetuses and focal areas of the plans. • Laboratory guidelines will have specific sections on transport of materials during climate shocks and testing of laboratory specimens for outbreaks of climate-sensitive diseases, with attention to timely testing to allow for rapid response to the outbreaks. • Blood bank guidelines, systems, and protocols will include specific sections and protocols on storage and transport of blood specimens during climate shocks, with attention to the impacts extreme heat can have on safe storage of blood products and transport challenges from flooding. • EOCs are being supported to respond to climate shocks, outbreaks of diseases (including climate-sensitive diseases), and health emergencies resulting from the conflict. Climate change is one of three primary impetuses and focal areas for this activity, which will finance operational and rehabilitation costs for the EOC. • EOC rehabilitation will incorporate climate resilience measures to reduce the impacts of extreme heat and flooding on the EOC. The activity will finance measures that go beyond standard practice such as securing the outside and inside of buildings against rising water,

Subcomponent	Climate activity
	construction of drainage systems to deal with extreme flooding, and use of reflective paint for passive cooling* **(adaptation).**
Component 3: Monitoring and Evaluation and Project Management (US$13.86 million)	
Subcomponent 3.1: Third Party Monitoring (US$2.0 million, UNICEF)	This subcomponent will finance TPM for the project's climate change activities and so should be assessed at the same rate as the project's other climate change activities **(adaptation and mitigation).**
Subcomponent 3.2: Data Analysis and Knowledge Management (US$0.5 million [US$0.25 million for WHO and US$0.25 million for UNICEF])	This subcomponent will finance data analysis and knowledge management for the project's climate change activities and so should be assessed at the same rate as the project's other climate change activities **(adaptation and mitigation).**
Subcomponent 3.3: Project Management (US$11.37 million [US$3.03 million for WHO and US$8.34 million for UNICEF])	This subcomponent will finance project management for the project's climate change activities and so should be assessed at the same rate as the project's other climate change activities **(adaptation and mitigation).**

* Rehabilitation is not expected to involve any electrical equipment or wiring.