Report Number: ICRR0022116

1. Project Data

Project ID	Project Name
P127187	SS-Health Rapid Results Project (FY12)
Country	**Practice Area(Lead)**
South Sudan	Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-54010,IDA-D1250,IDA-H9210,TF-12272	31-Oct-2014	99,196,309.39
Bank Approval Date	**Closing Date (Actual)**	
13-Apr-2012	30-Sep-2017	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	28,000,000.00	28,000,000.00
Revised Commitment	27,944,338.71	27,944,338.71
Actual	27,944,338.71	27,944,338.71

Prepared by	Reviewed by	ICR Review Coordinator	Group
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Project ID	Project Name
P156917	S. Sudan Health Rapid Results Project AF (P156917)

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
		0
Bank Approval Date	**Closing Date (Actual)**	

27-Jun-2016

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	0.00	0.00
Revised Commitment	0.00	0.00
Actual	0.00	0.00

Project ID	Project Name
P146413	South Sudan Health Rapid Results AF (P146413)

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
		0

Bank Approval Date	Closing Date (Actual)
13-Mar-2014	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	0.00	0.00
Revised Commitment	0.00	0.00
Actual	0.00	0.00

2. Project Objectives and Components

a. Objectives

According to the Emergency Response Paper (p. 8) and the Grant Agreement of April 20, 2012 (p. 5) the objective of the project was “i) to improve the delivery of high impact primary health care services in Recipient‘s states of Jonglei and Upper Nile; and ii) to strengthen coordination and monitoring and evaluation capacities of the Ministry of Health.”

Outcome targets were revised at 2014 and 2016 Additional Financings (AF). With one exception that is not material to the efficacy rating, both the original and revised outcome targets were exceeded, and therefore a split rating is not performed here.

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

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

Date of Board Approval
14-Mar-2014

c. Will a split evaluation be undertaken?
No

d. Components
Originally, the project consisted of two components:

Component 1: Delivery of high impact primary health care (PHC) services (appraisal estimate US$23.0 million, actual US$80.0 million): The financing of this component was increased twice through AF in March 2014 (US$31.2 million) and in June 2016 (US$21.0 million).

The government was to enter into a performance-based contract with a Coordination and Service Delivery Organization (CSDO) in each state. However, during project preparation the Ministry of Health (MOH) suggested use of direct contracting to recruit a single CSDO for the entire project. The CSDO was to be responsible for improving the delivery of selected high impact PHC services, including maternal and child health services such as vaccination, prenatal care, skilled birth attendance, etc. throughout their assigned state. The terms of reference of the CSDO involved: (i) direct service provision by the CSDO using its own staff and government civil servants in existing health facilities and other facilities that it was to take over from departing non-governmental organizations (NGOs); (ii) coordination of the work of existing NGOs and other development partners (e.g. mobilizing vaccines from the United Nations Children's Fund (UNICEF) and contraceptives from the United Nations Population Fund); (iii) strengthening of the management capacity of the County Health Departments (CHDs) and the state ministries of health (SMOH); and (iv) introduction of innovations that address some of the challenges facing the health care system.

The CSDO was to be held accountable for improving the quantity and quality of PHC services based on a specific set of measurable indicators that were also to reflect the project's Results Framework. Performance-based financing (PBF) was to pay the CSDO based on five indicators: diphtheria-tetanus-pertussis (DTP-3) immunization, facilities receiving supervision, essential drug availability, antenatal care (ANC) visits, and timely health management information system (HMIS) reporting. 90 percent of payments were to be based on inputs, and 10 percent was to be paid based on performance.

Delivery of PHC services through health facilities and extensive health outreach activities were to include:

- Child health services including immunization, supplements, nutrition, and provision of long-lasting insecticide treated nets (LLINs).
- Maternal health services including ANC, skilled delivery, postnatal care, and family planning.
- Basic curative services including treatment for malaria, acute respiratory infections, diarrhea, and HIV.
- PHC infrastructure including ensuring an adequate and timely supply of drugs, equipping health facilities, maintaining and upgrading health facility conditions, managing health care waste, staffing health care facilities, strengthening referral systems, building capacity, and piloting certain implementation initiatives such as the use of mobile phones for data collection.

The CSDO was to be responsible for capacity development of the SMOH, CHDs, health facility staff, and national NGOs. In order to ensure a focused approach to capacity building, the contract with the CSDO stipulated that it was to concentrate on the following critical stewardship functions: (i) systematic supervision (including the use of a quantitative supervisory checklist); (ii) coordination of the various service providers in the states; and (iii) improved monitoring of health service delivery, particularly the implementation and use of the HMIS. Also, the CSDO was to design and develop a pilot PBF scheme between the CSDO and health facilities/CHDs in selected counties in Jonglei and Upper Nile through the provision of grants ("Performance Based Sub-Grants") to eligible health service providers for the implementation of specific development projects, including pre-defined packages of high-impact PHC services.

The project's first AF was to fill a financing gap resulting from austerity measures adopted in the country following a shutdown in oil production in 2012. The AF provided additional support for the performance-based contract with the CSDO. The CSDO was to extend the existing design of the PBF model to more counties and cover wider geographical areas within Jonglei and Upper Nile states.

The project's second AF added citizen engagement activities to improve health service delivery and accountability at the local level.

Component 2: Capacity development of MOH at the national level (appraisal estimate US$5.0 million, actual 10.9 million): The financing of this component was increased twice through AF in March 2014 (US$3.3 million) and in June 2016 (US$4.0 million).

This component was to finance two sub-components:

1: Strengthening Grant and Contract Management: This sub-component was to strengthen MOH's capacity to plan, manage, and monitor grants and contracts through providing goods, technical assistance, and workshops and trainings.

2: Bolstering the Monitoring and Evaluation Function: This sub-component was to finance yearly health facility surveys (HFS) and household surveys using Lot Quality Assurance Sampling (LQAS). These surveys were to be nation-wide in scope but were to provide robust estimates at the state level. The MOH was to recruit an M&E firm to conduct the HFS and the LQAS surveys.

The first AF in March 2014 was to continue to support the strengthening of grant and contract management. The project was also to continue to support verification of activities of the CSDO in the extended period of implementation and support an additional household survey to capture data at that level following 18-24 months of implementation.

At the second AF, a new third component was added, as funding from the United States Agency for International Development, the United Kingdom Department for International Development, and the Norwegian Ministry of Foreign Affairs through the Emergency Medicines Fund was discontinued.

Component 3: Pharmaceutical Commodities (appraisal estimate US$15.0 million, actual US$9.67 million): This component was to finance support for the procurement, storage, and distribution of pharmaceutical commodities and essential medicines.

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

Project Cost: The project's total planned cost, with AF, was estimated to be US$103.0 million. Actual cost was US$99.2 million. According to the Bank team (June 1, 2020) the difference was due to exchange rate fluctuations.

Financing: The project was financed by a Bank Trust Fund in the amount of US$28.0 million (US$27.9 million disbursed), an IDA grant in the amount of US$25.0 million (US$23.7 million disbursed), an IDA credit in the amount of US$10.0 million (US$9.23 million), and an IDA grant in the amount of US$40.0 million (US$38.3 million disbursed).

Borrower Contribution: It was not planned for the Borrower to make any contributions.

Dates:

- The project received a first AF in the amount of US$35.0 million in March 2014, and a second AF in the amount of US$40.0 million in June 2016. Under the first AF, the end-of-project targets for all indicators in the results framework were revised to reflect the extension (from January 1, 2014 to October 31, 2015). Under the second AF, three new indicators were introduced under component 2 (two additional indicators on citizen engagement and an additional indicator on involvement of vulnerable and marginalized people in community-based decision making). Also, the end-of-project targets for all indicators were revised to reflect the project closing extension (from June 30, 2016 to September 30, 2017).
- The project was restructured six times:

1. On June 17, 2015 the project was restructured to: i) extend the closing date from October 31, 2015 to June 30, 2016 to provide more time for the implementation of activities, which had been delayed due to the ongoing conflict; and ii) reallocate funds among components.
2. On December 6, 2016 the project was restructured to link two dated covenants to the effectiveness date of the AF rather than a specific date due to internal fighting within South Sudan.
3. On January 30, 2017 the project was restructured to: i) revise withdrawal conditions; ii) introduce a new category of expenditures; and iii) revise two dated covenants.

4. On April 7, 2017 the project was restructured to extend the closing date from September 30, 2017 to March 30, 2018, as project implementation had paused due to the ongoing internal conflict.
5. On March 28, 2018 the project was restructured to: i) extend the closing date from March 30, 2018 to September 30, 2018 due to ongoing implementation delays; ii) extend the contract with the CSDO to ensure the ongoing delivery of project inputs; iii) use uncommitted funds in the amount of US$5.2 million to extend the contract with the CSDO; and iv) revise dated covenants to align them with the effectiveness date of the second AF instead of the stated date.
6. On July 20, 2018 the project was restructured to: i) extend the project's closing date from September 30, 2018 to April 30, 2019 due to cumulative and ongoing implementation delays; ii) transfer funds from component 3 to component 1 to allow for the continuation of basic health care services; iii) contract UNICEF to take over the role of CSDO from the current CSDO.

3. Relevance of Objectives

Rationale

According to the Emergency Project Paper (EPP, p. 2), when the Comprehensive Peace Agreement (CPA) was reached in 2005, South Sudan had gone through decades of conflict, massive displacement of the population, and widespread insecurity. The health care system lacked consistent funding, and the health status of the population was very poor. Little changed after the CPA was reached, and health indicators remained grim. In 2011, the under five-mortality rate (U5MR) was estimated to be 135/1,000 live births due to easily prevented or treated conditions such as malaria, pneumonia, diarrhea, and vaccine-preventable diseases. The EPP stated that it was possible that this figure significantly under-estimated the U5MR. In 2006, the maternal mortality ratio was estimated to be 2054/100,000 live births. Also, data from 2011 suggested that HIV/AIDS prevalence was approximately 3 percent nationwide. Furthermore, the annual incidence of tuberculosis was among the highest in the world, estimated at 325 per 100,000 people.

According to the EPP (p. 3), the health sector faced significant challenges. The MOH lacked capacity. In 2007, it was estimated that 85 percent of provided health services were delivered by NGOs. However, NGOs were generally not held accountable for specific outcomes, and grants to NGOs either did not contain indicators of success or did not include any consequences for good or poor performance. Also, the country suffered from barriers to health services. For example, at the time of project preparation, only 44 percent of households lived within a five-kilometer radius of a health care facility. The EPP (p. 3) stated that progress in improving health services was considerably slower in South Sudan than in other low-income post-conflict countries such as Liberia, Afghanistan, Timor Leste, and Cambodia.

The project was in line with the government's Health Sector Development Plan for the period 2012-2016, which aimed to: i) increase the utilization and quality of health services with emphasis on maternal and child health; and ii) strengthen institutional functioning including governance and health system effectiveness, efficiency, and equity. The objective of the project was also in line with the Bank's most recent Country Engagement Note (FY18-19), which aimed to support basic service provision for vulnerable populations and support livelihoods, food security, and basic economic recovery. The MOH specifically asked the Bank

to work in Upper Nile and Jonglei states, as no other development partner was willing to work in those states due ecological and transportation challenges as well as frequent inter-ethnic conflicts and repeated outbreaks of violence. The project was also in line with the Bank's Systematic Country Diagnostic of October 2015, and the new Country Engagement Note, which was prepared after the new Transitional Government of National Unity had been formed. The objectives of the project remained relevant during the first and second AF.

Rating
High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective
To improve the delivery of high impact primary health care services in Recipient's states of Jonglei and Upper Nile

Rationale
The project's theory of change envisioned that financing of the CSDO to enter into contracts with implementing partners such as NGOs and CHDs would enable them to deliver primary health care services (including vaccinations, prenatal and antenatal care, outpatient visits, skilled birth attendance, etc.) and to procure, store, and distribute pharmaceutical commodities. Together, these activities were envisioned to result in improved delivery of primary health services. The project was to deliver high-impact primary health care services that are the most cost-effective as defined in the Bank's Disease Control Priorities in Countries (www.dcp2.org).

The ICR identified the following assumptions underlying the theory of change: i) no escalation in conflict would happen; ii) service delivery would require minimal adjustment to accommodate seasonal flooding; iii) the CSDO would have sufficient management capacity; iv) NGOs and facilities would have sufficient service delivery capacity; v) the PBF verification methodology would be valid and would correspond with PDO achievement; vi) the CSDO's design of PBF would be conducive to improved service delivery; vi) funds would flow on time; and vii) pharmaceutical contractors would have sufficient capacity.

Outputs

The project planned to support 132 facilities in 13 counties in Upper Nile State and 150 facilities in 11 counties in Jonglei (282 facilities in total). However, according to the Bank team (April 28, 2020,) the project was only able to support between five and 10 hospitals across the two states during the project's duration due

to insecurity and resulting challenges in accessing facilities. The CSDO contracted implementing partners in each state, including national NGOs (four in Upper Nile and Jonglei), international NGOs (one in Jonglei and three in Upper Nile), and CHDs (two in Jonglei and six in Upper Nile), all of which operated facilities and delivered services. The CSDO was responsible for providing supervision, supply chain, and facility rehabilitation support for contracted NGOs and CHDs. The aim was to strengthen county health capacities and ensure the sustainability of the health system after project closure.

- The number of people who have received essential health, nutrition, and population (HNP) services increased from 129,758 people in 2011 to 729,431 people in 2018, surpassing the target of 677,000 people.
- The percentage of direct beneficiaries who were female increased from 51 percent in 2011 to 53 percent in 2019, not achieving the original target of 56.05 percent but achieving the revised target of 50 percent.
- The number of women who have received essential HNP services increased from 35,007 in 2011 to 278,734 in 2018, surpassing the target of 162,000 women.

Outcomes

- Outpatient care utilization: The number of outpatient visits per capita per year increased from 0.10 outpatient visits per year in 2012 to 0.62 outpatient visits per year in 2019, surpassing the original target of 0.40 and revised target of 0.50 outpatient visits per year.
- Maternal health services: The number of pregnant women receiving ANC during a visit to a healthcare provider increased from 21,180 women in 2011 to 204,016 women in 2019, surpassing the original target of 28,455 women. The number of births attended by skilled health personnel increased from 13,827 births in 2011 to 21,439 births in 2019, surpassing the original target of 16,345 births and the revised target of 12,000 births.
- Malaria prevention: The number of LLINs purchased and/or distributed increased from 126,452 nets in 2012 to 2,542,796 nets in 2016 (the last time this indicator was measured), surpassing the original target of 150,960 nets. The number of children below five years living under an LLIN the night before the survey decreased from 34.2 percent in 2013 to 27.65 percent 2019, not achieving the original target of 42.5 percent or the revised target of 40.0 percent.
- Immunization: The number of children who received measles vaccination by five years of age increased from 97,857 in 2011 to 171,640 in 2019, surpassing the original target of 106,560 children. The number of children under twelve months who received DPT3 increased from 16,986 children in 2011 to 126,177 children in 2019, surpassing the original target of 21,595 children. The number of children receiving any immunization increased from 97,857 in 2011 to 180,856 in 2019, surpassing the original target of 21,595 children.
- Nutrition: The number of women and children who have received basic nutrition services increased from 129,758 in 2011 to 743,610 in 2019, surpassing the original target of 677,000 women and children. The number of children under five years old receiving a dose of vitamin A increased from 18,074 children in 2011 to 552,975 children in 2019, surpassing the original target of 22,400 children.
- Health facilities: The percentage of health centers with at least two skilled health workers to provide care increased from 50 percent in 2013 to 80 percent in 2018, surpassing the original target of 65

percent. The percentage of health facilities having essential drugs at the time of a supervisory visit increased from 50 percent in 2012 to 65 percent in 2019, not achieving the target of 80 percent.

According to service quality and availability spot checks in 2018, an average quality score of 52 percent (49 percent in Jonglei and 56 percent in Upper Nile) was achieved. The score was assessed on several criteria: i) health facility environment and sanitation; ii) availability of functional equipment; iii) management; iv) pharmacy practice and availability of medicines; v) availability of guidelines for essential clinical care; vi) adherence to treatment guidelines; and vii) level of knowledge and skills of health workers. Also, a Health Facility Assessment conducted in 2019 found that: i) approximately 70 percent of health facilities in Jonglei and Upper Nile were functional at the time of survey; ii) approximately half of the functional health facilities had access to a doctor, a clinical officer, nurse, or a midwife; iii) approximately 18 percent of the health facilities did not report stock outs of medicine during the twelve months prior to the survey; iv) outpatient care was offered at all functional health facilities, but postnatal care (the lowest rated service) was offered at just 36 percent of functional facilities. Furthermore, UNICEF conducted supportive supervision in a total of 69 health facilities (35 facilities in Jonglei and 34 facilities in Upper Nile). The average percentage score for the seven evaluated areas was 49 percent (the lowest score (25 percent) was for utilization of services, and the highest score (67 percent) was for HMIS). The supervision identified several issues: (i) overall poor infrastructure; (ii) lack of basic equipment in many facilities; (iii) lack of qualified staff; (iv) errors and incomplete data recording and no written feedback provided to health facilities; (v) essential drugs critically low and stock outs occurred; (vi) lack of treatment guidelines and knowledge gaps; and (vii) very low utilization of all services in all health facilities.

Even though there were shortcomings in infrastructure, equipment, drug supply, and staffing at the time the project closed, it is clear that project interventions had a significant impact on health service delivery. Since the project was the only provider of health services during this period of time, the project did not encounter any attribution issues.

Rating
Substantial

OBJECTIVE 2
Objective
To strengthen coordination capacities of the Ministry of Health

Rationale
The project's theory of change envisioned that the provision of goods, technical assistance, and workshops/trainings would strengthen the MOH's capacity to plan, manage, and monitor grants, resulting in strengthening of its coordination capacity. It was assumed that the government's Project Management Unit (PMU) would be sufficiently staffed with capable people to manage contracts.

Outputs

- The CSDO and implementing partners conducted several trainings:
  - A total of 800 people received formal HMIS training (352 people in Jonglei and 448 people in Upper Nile).
  - A total of 6,767 people received formal service delivery training (2,423 people in Jonglei and 4,344 people in Upper Nile).
  - A total of 9,219 people received in-service training (5,275 people in Jonglei and 3,944 people in Upper Nile).
  - A total of 5,403 people participated in community awareness training events.

Outcomes

- The percentage of health facilities with structured supervision visits (using Quantitative Supervisory Checklists, which provided supervisors with a systematic means for carrying out supervision visits, recording their findings, and leaving a record of their findings in the facility) increased from 25 percent in 2012 to 65 percent in 2019, surpassing the original target of 37 percent and the revised target of 55 percent.
- 11.2 percent of health facilities with Boma/village health committees that were established met at least twice every quarter, not achieving the target of 40 percent. This indicator was added during the second AF in 2016.
- The target of 40 percent of established Boma/village health facilities that feel that their feedback was responded to by CHDs and other implementers was not achieved, as the indicator was never monitored. This indicator was added during the second AF in 2016.

Even though supervision of health facilities improved, there is insufficient information on engagement with village health committees. Community engagement/supervision is an important element for improving the quality and management of health service delivery. Also, the project's ability to strengthen the capacity of the nascent MOH was limited, resulting in contract management issues at the PMU.

Rating
Modest

OBJECTIVE 3
Objective
To strengthen monitoring and evaluation capacities of the Ministry of Health

Rationale
The project's theory of change envisioned that technical assistance and training would contribute to the production of yearly HFS and household surveys, which would strengthen MOH evaluation capacity.

Outputs

- The Liverpool School of Tropical Medicine acted as the third-party monitor (TPM). It provided training for approximately 1,200 people in conducting surveys and strengthening HMIS skills.

Outcomes

- The percentage of functional health facilities submitting standardized HMIS monthly reports within one month of the reporting month increased from 62 percent in 2012 to 89 percent in 2019, surpassing the original target of 80 percent and the revised target of 75 percent.
- UNICEF data showed that 88 percent of 203 facilities in Jonglei and Upper Nile reported in the HMIS between February and November 2019.

According to the ICR (p. 24), the MOH reported that the project's support to strengthening the HMIS resulted in a significant improvement in HMIS capacity.

Rating
Substantial

OVERALL EFFICACY
Rationale
The project experienced serious data quality challenges. The ICR (p. 36) stated that the quality of data used to assess project performance and used in Implementation Status Reports (ISRs) was weak, raising questions about the ability to assess project outcomes with confidence. However, the Bank team stated (June 1, 2020) that project data was the best available data within the context of South Sudan, and that there was no evidence for over- or under-reporting. Given these caveats on data quality, overall efficacy is rated Substantial, based on reported data indicating that the project achieved substantial improvement in the delivery of high-impact primary health services and improvement in the M&E capacity.

Overall Efficacy Rating

Substantial

5. Efficiency

Economic Efficiency

The EPP did not include a traditional economic analysis due to the emergency nature of the project and a lack of data. Instead, it provided a financial overview of South Sudan's health sector. The economic and financial analyses of the first and second AF were brief and included little new information.

The ICR (p. 26) also did not conduct a traditional economic analysis. Instead, it summarized evidence from the literature that supported the provision of an essential package of maternal and child health services. For example, research by Ozawa et al (2016) found that immunization investments resulted in a sixteen times greater return than the original investment. The ICR (p. 26) stated that the project aimed to benefit 2.22 million people at a total cost of US$28.0 million, which equals US$12.61 per capita to deliver the targeted benefits (as well as capacity building and project monitoring programs), or US$5.05 per capita per year. At the end of project implementation, the total project cost was US$99.19 million, which equals US$36.7 per capita covering 2.7 million beneficiaries (due to population growth in the two states). The ICR stated that even though the project was implemented in an expensive Fragility, Conflict and Violence (FCV) environment and experienced higher costs due to the fiscal crisis, the per capita costs to deliver the project remained in line with the costs calculated at project appraisal.

Operational Efficiency

The project experienced several implementation delays due to significant financial management and procurement bottlenecks as well as South Sudan’s ongoing civil war. The planned closing date for the second AF was September 30, 2017, which had to be extended three times (to a total of 19 months), with the project closing on April 30, 2019. Also, the project had two management levels, which channeled resources to overhead costs away from service delivery. In addition, verification for the PBF experienced issues that resulted in substantial payment delays for the CSDO. Furthermore, the ICR (p. 34) stated that the project experienced gaps in Bank supervision such as lack of missions and documentation, inconsistent in-country presence, high task team turnover, lack of details in ISRs, and incomplete follow up on the project’s mid-term review, all of which likely impacted implementation efficiency.

The project’s external audits encountered a total of US$11.4 million of expenditure that lacked documentation, and the auditors could not access records for expenditures in the amount of US$3.9 million (a total of US$15.3 million, or 15.4 percent of the total project cost). These findings could indicate inefficient use of the project’s financial resources.

Taking everything together, the project’s overall efficiency rating is Modest.

Efficiency Rating

Modest

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

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

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

6. Outcome

Relevance of the objective was rated High given the PDO's alignment with the Bank's most recent Country Engagement Note (FY18-19), which aimed to support basic service provision for vulnerable populations and support livelihoods, food security, and basic economic recovery. Achievement of the first objective was Substantial, achievement of the second objective was Modest, and achievement of the third objective was Substantial, resulting in an overall efficacy rating of Substantial, with caveats around reportedly poor data quality. Efficiency was Modest due to the lack of an economic analysis and shortcomings in operational efficiency. Taking everything together, the project's overall outcome rating was Moderately Satisfactory, indicating moderate shortcomings.

a. Outcome Rating

Moderately Satisfactory

7. Risk to Development Outcome

The project's risks can be summarized in the following broad categories:

Conflict: South Sudan continues to experience conflict, which is a significant risk to any project outcomes achieved and the continuity of basic health service provision. Also, the ongoing situation is likely to have a negative impact on project assets due to damage and theft.

Financing: According to the ICR (p. 43), the project's outcomes face the risk of lack of government funds for the health sectors in the two supported states. Without new financing by Bank or other development partners, there would be limited to no funding for providing basic health services. Also, financing for the maintenance of project assets will be needed. The Bank continues to support the health sector in South Sudan through the Essential Health Services Project (US$105.4 million; 2019-2021) in which the Bank is providing financing in cooperation with UNICEF and the International Committee of the Red Cross to mitigate fiduciary, safeguards, and other management challenges across the country's portfolio.

Capacity: The government continues to face limited capacity to deliver basic health services. The ICR (p. 43) stated that development partners might withdraw once all the project financing is used resulting in the deterioration of local capacity especially due to a lack of pharmaceuticals, human resources, and other essential inputs needed to provide basic health services.

8. Assessment of Bank Performance

a. Quality-at-Entry

The project was prepared under OP 8.0 (Rapid Response to Crises and Emergencies) in just over four months. In the context of this short preparation period, project design had several shortcomings that negatively impacted project implementation:

Technical analysis: According to the ICR (p. 31), project design was based on lessons learned from phase 1 and 2 of the MOH's Umbrella Health Program (supported by a Multi-Donor Trust Fund) that aimed to i) to strengthen key stewardship functions of the MOH, and ii) improve the delivery of basic health services in four states (Central Equatoria, Eastern Equatoria, Jonglei and Upper Nile). These lessons included the need to: i) focus on results instead of implementing agreed work plans through results-based financing; ii) influence NGOs and government facilities not under the control of the CSDO through government capacity development; iii) conduct dry season campaigns to reach out to isolated communities; and iv) provide incentives to health workers through performance-based contracting. Additional lessons from other FCV areas were summarized in a "four M" analysis that emphasized the importance of mapping (as in ensuring full geographic coverage), monitoring, motivation, and management.

Implementation structure: A CSDO was contracted to be responsible for activities such as ensuring adequate drug supplies, staffing, outreach activities, implementation of the HMIS system, capacity development, supervision, coordination of service delivery, and ensuring quality of care. According to the ICR (p. 29), while the contract stated that the CSDO was allowed to deliver services, sub-contract NGOs, or support government facilities, the contract did not define fiduciary and supervision arrangements with the sub-contractors. Also, the contract gave the CSDO a wide range of flexibility and did not specify sequencing of activities or specifications of activities, making the supervision of project implementation for the MOH, given its weak capacity, challenging. Furthermore, the project relied on direct contracting for

hiring a single CSDO (the EPP had planned for two CSDOs, one in each state), which resulted in several implementation challenges (see section 10b for more details).

Also, the ICR (p. 29) stated that the project had a complex management structure between the PMU, the CSDO, and sub-contracted service providers/implementing partners (IPs). The PMU within the MOH was responsible for supervising the CSDO, which held the funds and was responsible for supervising the IPs. This complex structure made it challenging to maintain clear oversight.

Furthermore, the performance-based payments to the CSDO required verification by the TPM. However, the ICR (p. 31) stated that challenges with the TPM resulted in substantial payment delays for the CSDO. Also, as noted above, the CSDO was on a lump-sum contract, with 90 percent being paid based on inputs and 10 percent being paid on a performance basis. However, due to a lack of clarity, the CSDO planned for the 10 percent as part of its core budget, which meant that if the performance-based indicators were not achieved, the CSDO's core budget decreased. According to the ICR the CSDO was "too removed" from actual service provision (which was the responsibility of NGOs and CHDs) to effectively impact service delivery. Finally, there were several procurement weaknesses, such as the direct contracting for hiring a single CSDO, which resulted in implementation challenges (see section 10b for more details).

Risk Assessment: The EPP identified several risks, such as implementing agency risk (capacity and governance) and "delivery, monitoring, and sustainability" risk, as High. Mitigation measures for weak capacity at the central and state levels were to include strengthening of institutional capacity at the MOH by filling key positions and providing technical assistance, especially in the areas of planning, management, and M&E. At the state level, the core management team of the implementing agencies was to work within the SMOH to reduce human resource gaps. In addition, the project was to support recruitment of qualified South Sudanese staff to support the SMOH in the areas of management, coordination, and monitoring and evaluation. The governance risk was rated High, but no mitigation measures were identified in the EPP. The risk of weak financial management systems was also identified. Mitigation measures in that area were to include provision of technical assistance through an international financial management expert. Mitigation measures related to data collection and analysis were to include establishing a baseline and hiring an independent monitoring firm to verify results.

Mitigation measures were inadequate for all risks and resulted in significant implementation challenges such as ineligible expenditures, audit qualifications, implementation delays, and weak monitoring data. Also, risks related to security, conflict, and political turmoil were not identified; ultimately, these risks resulted in the project having to be paused.

Costing analysis: The EPP estimated that providing basic health care services in Jonglei and Upper Nile was to cost approximately US$5 per capita per year. However, according to the ICR (p. 32), this was not a realistic cost estimate for an FCV context and was significantly less than international NGOs were being paid in South Sudan. Therefore, the amount of financing was likely insufficient given the challenging circumstances.

Implementation readiness: According to the ICR (p. 33), the project was not ready when it became effective because: i) critical PMU staff were not trained and positioned; ii) the CSDO was not contracted

until January 2013 (five months after effectiveness); iii) the TPM had not been appointed; iv) major procurement activities had not been completed; and v) the project's implementation manual was not updated until November 2013 and included little information on technical specifications, the responsibilities of each actor, and the role of the PMU in regards to the CSDO.

Quality-at-Entry Rating
Unsatisfactory

b. Quality of supervision

The project's supervision was affected by a highly challenging context and implementation environment. There was conflict and civil unrest throughout most of the project implementation period. The Bank team could not conduct site visits after late 2013. The project covered a large, mostly rural geographical area, with low population density, affected by conflict, totaling 25 percent of South Sudan's population. South Sudan experienced widespread population displacement within the country and to neighboring countries, a critical humanitarian situation, development partners leaving the two project sites, and institutional capacity continuously weakening. In addition, in 2014 the MOH underwent leadership changes, which resulted in further weakening of the ministry's capacity.

Despite these significant management and security challenges, the project achieved Substantial outcomes. The Bank team stated (June 1, 2020) that the Bank and client learned by doing throughout implementation. Also, the Bank team's capacity to address challenges evolved and strengthened over time as the Bank learned through experience how to implement operations in the specific context of South Sudan, for which there was limited precedent.

However, the ICR described significant shortcomings with project supervision. According to the ICR (p. 41), the Bank team provided ISRs in a timely manner and reported on the project's legal covenants on a regular basis, but the ISRs had several shortcomings: i) limited information on data sources was included, and the use of the same data for several reporting periods was not pointed out; ii) changes in ratings were not explained and general information on project implementation was not provided; iii) PDO and implementation progress ratings were not supported by indicator data; iv) implementation challenges were not identified; and v) little guidance by Bank managers was provided. The ICR stated that the ISRs improved from June 2016 onwards.

The project experienced a high turnover of Task Team Leaders (TTLs), with four TTLs and three Co-TTLs over a seven-year implementation period resulting in many supervision and oversight issues. Documentation of implementation was limited, making transitions between TTLs even more challenging. According to the ICR (p. 42), the Bank team did not record any aides-memoire between September 2012 and March 2017, as Bank team members were based in Juba and no field travel was allowed. Instead, the Bank team reviewed the project with the government. However, the ICR stated that these reviews were not stored in the Bank's system. The ICR stated that documentation improved after 2018.

According to the ICR (p. 42) the mid-term review (MTR) was conducted in a timely manner but did not address critical shortcomings such as issues related to building capacity within the MOH and SMOH, revising the results framework, and addressing financial management and audit issues.

The ICR (p. 42) stated that the Bank conducted financial management (FM) supervision on an annual basis. Identified shortcomings were addressed through capacity development within the PMU, regular reviews of the project's FM arrangements, and direct payments to the CSDO. However, there were still several significant FM-related shortcomings (see section 10b). Also, the project did not record any safeguard ratings in the Bank's operations portal, and the project did not comply with the Bank's safeguards policies (see section 10a).

Acknowledging the challenging FCV context and the project's achieved outcomes, but also the significant shortcomings reported in the ICR, quality of supervision is rated Moderately Unsatisfactory.

Quality of Supervision Rating
Moderately Unsatisfactory

Overall Bank Performance Rating
Unsatisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design
The project's objective was clearly specified, and the theory of change connecting key activities to planned outcomes was logical. The selected indicators were specific and included baselines and targets. However, the results framework lacked indicators to measure results of several project activities such as community empowerment, pilot programs, and quality of care.

The Directorate of Research, Planning and Health System Development in the MOH was to be responsible for program monitoring and reporting on performance. Technical support was to be provided through an internationally recruited M&E firm. However, the ICR (p. 35) stated that the CSDO and the MOH lacked capacity to adequately conduct M&E activities.

According to the ICR (p. 35), the M&E design included a TPM that was responsible for: i) conducting quarterly verification visits to Jonglei and Upper Nile to assess the CSDO's implementation of performance-based payments; ii) assessing outcomes of health care interventions; iii) conducting periodic HFS; iv) supporting the MOH to conduct LQAS surveys; v) supporting the implementation of the HMIS; vi) building capacity within the national and state MOH in the use of HMIS and LQAS; and vii) pilot testing the feasibility of cell phone surveys for rapid and easily-collected data on key indicators.

b. M&E Implementation

According to the ICR (p. 36) the TPM conducted verifications on a quarterly basis, and the LQAS surveys were conducted in 2011, 2015, and 2018. However, there were issues in collecting Quarterly Verification Visits (QVV) data for the evaluation of the CSDO due to: i) accessibility issues to facilities because of heavy rains and insecurity, resulting in a not random sample of facilities; and ii) lack of reliable denominators for the calculation of coverage due to large-scale population movement. The ICR (p. 36) stated that there were no indications that the QVV adjusted for population shifts. Therefore, the units of measurement in the LQAS and the results framework were different and could not verify each other.

The ICR (p. 36) stated that the quality of data used to assess project performance and used in ICRs was weak. Data from the CSDO was tabulated from different IPs and lacked consistency and clarity, which made an accurate tabulation challenging. Also, data from the HMIS was weak. The ICR stated that CSDO data and HMIS data showed substantial discrepancies, with differences in the range of 12 percent to 355 percent. Furthermore, the ISRs did not always include up-to-date data, which might have been an indication of issues with data collection.

M&E weaknesses were not sufficiently addressed even though they were flagged in the MTR. The ICR (p. 36) stated that the AF 2 paper identified modifications to the results framework, but these modifications were never reflected in the ISRs and did not seem to have been implemented. Furthermore, the 2014-2016 audit identified shortcomings in the CSDO's monitoring capacity due to lack of M&E staff and dependency on IPs to submit data.

c. M&E Utilization

According to the ICR (p. 37), data was used to assess progress towards achieving the PDO. Also, it appeared that M&E was used to calculate results-based payments to the CSDO. However, given the significant shortcomings of M&E data, it is not clear to what extent it was possible to base project management decisions on the available data.

M&E Quality Rating

Modest

10. Other Issues

a. Safeguards

The project was classified as category B and triggered the Environmental Assessment (OP/BP 4.01) safeguard policy. According to the ICR (p. 37), since it was prepared under OP/BP 8.0 (Rapid Response to Crises and Emergencies), the project was allowed to conduct an Environmental and Social Screening Assessment Framework to fulfill all safeguard requirements prior to appraisal. Even though the project hired two full-time local safeguards consultants, the final ISR noted significant delays in the finalization of several safeguard documents, such as the revision of the National Medical Waste Management Plan. Also, the Environmental and Social Impact Assessment was disclosed at the beginning of 2018, six years into project implementation.

According to the ICR (p. 38), the Social Assessment (due to the applicability of OP/BP 4.10 (Indigenous Peoples)) was first deferred and then delayed, and by the time of project closure not cleared and disclosed. According to the ICR (p. 37), the government had limited interest in assigning counterparts to complete the safeguard documents for the Bank's revision and clearance. According to the Bank team (June 1, 2020), the project did not comply with the Bank's safeguard policies. Environmental safeguards documents were not finalized until 2018, resulting in difficulties to evaluate adherence to safeguards standards and monitor and ensure compliance. In addition, the project did not have a fully functional grievance redress mechanism. Finally, the project did not record any safeguard ratings in the Bank's operations portal.

b. Fiduciary Compliance

Financial Management

According to the ICR (p. 38), the Bank conducted FM supervision missions on an annual basis between 2013 and 2019 and twice in 2017. The project conducted two types of audits: project audits of the PMU, and audits of the CSDO. However, the project encountered several significant FM issues, such as lack of FM capacity within the PMU, weak internal controls, and limited ability to manage financial aspects of the contract with the CSDO. An additional FM weakness was that the PMU used Excel for accounting throughout project implementation rather than a more robust accounting system.

The ICR (p. 38) stated that until June 2016, audits reported ongoing outstanding advances to PMU staff and gaps in fiduciary systems. Audits conducted between July 2017 and April 2019, could not receive adequate evidence for providing the basis for an audit opinion since the auditors did not have access to sub-contractors of the CSDO to verify payments. The project prepared audit management letters that highlighted the lack of a fixed asset register and weak asset handover procedures, longstanding project staff advances, non-competitive procurement procedures, and shortcomings in pharmaceutical monitoring. The project's final audit in April 2019 found US$160,000 in ineligible expenditure from the MOH.

The contract with the CSDO stated that the CSDO was to be audited on an annual basis by an audit firm accepted by the MOH. In total, four audits of the CSDO were conducted. A firm contracted by the CSDO conducted the first audit for the period January 1, 2013 to December 31, 2013. However, in order to increase the impartiality of the audits, a firm contracted by the MOH through the PMU conducted the second and third audits for the periods August 1, 2014 to September 30, 2016 and October 1, 2016 to June 30, 2018. The South Sudan National Audit Chamber conducted the last audit. Some of the audits were delayed due to conflict and issues with the procurement of an audit firm.

According to the ICR (p. 39), the 2013 CSDO audit did not find any major issues. The 2014-2016 audit issued a qualified opinion due to the auditor's inability to access financial records related to US$3.9 million in funds paid by the CSDO to IPs. The management letter also stated that there was an issue of project funds co-mingling with funds for other CSDO activities in a single account even though the CSDO's contract especially stated that the CSDO was to have a separate account for project funds. The 2016-2018 audit had two versions. The first version issued an unqualified opinion. However, the Bank identified discrepancies, and the opinion was revised to a qualified opinion. The basis for the qualified opinion was related to differences in balances between the CSDO's bank accounts and records, and internal and in-country expenses without documentation, in the amount of approximately US$ 3 million.

The ICR (p. 39) stated that the final audit report was conducted because the CSDO disputed the results of the independent audit. The audit received a qualified opinion due to co-mingling of project accounts, lack of documentation for US$8.4 million in expenses, US$3.1 million in ineligible expenditures, and discrepancies between bank balances and records. After the audits were conducted, the CSDO gave the Bank access to the financial records of the IPs. The Bank found another US$3.06 million in ineligible expenses, resulting in a total of US$6.16 million ineligible expenditures by the CSDO.

The ICR (p. 38) stated that after 2016, FM supervision identified more issues; these findings might have resulted from the Bank team including a new FM specialist and the hiring of an FM consultant and FM staff for the PMU. According to the ICR (p. 39), the contract with the CSDO was not sufficiently clear in terms of FM guidelines and the CSDO's and IPs' requirements to document expenses. Also, there was lack of clarity in the contractually outlined procedures for the PMU overseeing the CSDO's FM, CSDO management of its finances, and the CSDO's accountability for FM.

From the end of 2017 until project closure, FM was rated Moderately Unsatisfactory.

Procurement

According to the ICR (p. 40), the project's procurement performance was rated Moderately Satisfactory until the end of 2012. Performance was downgraded to Unsatisfactory until the end of 2013 due to lengthy delays in procurement of the TPM. Between the end of 2013 and the beginning of 2017, procurement was rated Satisfactory. From January 2017 until project closure, the rating continued to fluctuate between Moderately Satisfactory and Unsatisfactory. These ratings might indicate that the project's procurement performance was unstable or that the initial ratings were not sufficiently candid. The project faced several challenges due to weak procurement capacity at the PMU, challenges in administering the CSDO's contract and the pharmaceutical supplier's contract, and delays in sub-contracting and managing payments. Also, the ICR (p. 40) stated that the 2018 audit management letter identified a lack of competitive bidding procedures for some procurement by the PMU. Furthermore, the 2014-2016 CSDO audit management letter pointed out a lack of procurement compliance when recruiting sub-contractors. Finally, the 2016-2018 audit identified procurement issues for implementing partners (IPs) such as a lack of adequate procurement documentation and competitive bidding processes.

According to the ICR (p. 30), the direct contracting of a single CSDO (the EPP had planned for two CSDOs, one in each state) was a design shortcoming that resulted in several implementation challenges. The CSDO had several weaknesses: i) even though the CSDO was familiar with the country, it did not implement any measures to mitigate the issues resulting from yearly flooding and significant population movement; and ii) the CSDO lacked a reliable FM system and controls, which had a negative impact on the project's financial integrity.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Satisfactory	Moderately Satisfactory	
Bank Performance	Moderately Satisfactory	Unsatisfactory	Acknowledging the project's highly challenging context, there were nonetheless major shortcomings in Quality at Entry,

			and significant shortcomings in Quality of Supervision.
Quality of M&E	Modest	Modest	
Quality of ICR	---	Substantial	

12. Lessons

The ICR (p. 44-46) provided useful lessons learned, adapted here by IEG:

- **Project implementation readiness is critical for ensuring successful project implementation, even though it is especially challenging in an FCV environment.** This project was not ready for implementation for several reasons: the CSDO was not hired until five months after project effectiveness, the PMU staff had not been trained; the TPM had not been appointed; and major procurement activities had not been completed. The ICR (p. 45) listed critical components of readiness that would have benefited project implementation, including: i) training of PMU, implementing agencies' staff, and the project steering committee; ii) agreement on the results framework and on robust data collection and verification systems; iii) development of detailed project, financial management, procurement, and social safeguards implementation manuals; and iv) drafting of bidding documents for the initial implementation period.
- **Conducting a competitive procurement process for key implementing entities such as the CSDO is critical for ensuring that the most capable entity is awarded the contract to implement the project.** In this project, the MOH suggested a direct contract with a single CSDO, an NGO that was already operating in Jonglei and Upper Nile. However, this resulted in significant implementation challenges for several reasons: i) the CSDO lacked a robust financial management and control system, which had a negative impact on the project's financial integrity. By the time the project closed, the project had US$11.4 million of undocumented spending; and ii) even though the CSDO was already operating in the two states, it failed to circumvent the problems related to annual flooding and significant migration.
- **Complex project management structures are particularly challenging in an FCV environment with weak capacity.** In this project, the PMU within the MOH was responsible for overseeing the large contract with the CSDO, which enjoyed a great level of flexibility in spending project funds. However, the PMU did not have the needed capacity to oversee all these activities, in addition to the procurement of pharmaceuticals and the TPM contract.
- **The performance-based contract for a service delivery contract needs to include indicators that the contractor has control over**. In this project, the CSDO was removed from direct service delivery, since the service was provided by NGOs, CHDs, and other entities. Therefore, paying the CSDO on service delivery indicators that the CSDO had no control over and for which data verification was challenging might not have had the intended impact. Instead, the CSDO could have been paid for outputs it was directly responsible for such as timely, complete, and accurate pharmaceutical supply.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR provided a good overview of project preparation and implementation. It was internally consistent and sufficiently candid and provided useful lessons learned. Furthermore, the ICR provided additional data from various surveys beyond the project's results framework, critically assessed data quality, and contained strong discussions of attribution. However, the ICR did not include a traditional economic analysis and would have benefitted from providing information on the project's impact on DPT3 and measles cases, maternal mortality etc. Also, the ICR stated different procurement ratings than recorded in the operations portal.

a. Quality of ICR Rating
Substantial