The Republic of South Sudan
Ministry of Health

South Sudan Health Sector Transformation Project (HSTP) (P181385)

Final

SOCIAL ASSESSMENT AND DEVELOPMENT PLAN

February 2025

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LIST OF ABBREVIATIONS

AAP	Accountability to Affected Populations
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
BHT	Boma Health Team
BPHNS	Basic Package of Health and Nutrition Services
CHD	County health department
CHW	Community health worker
CSOs	Civil Society Organisations
ENAP	Every Newborn Action Plan
FCV	Fragility Conflict & Violence
GAM	Global acute malnutrition
GBV	Gender-based violence
GoSS	Government of South Sudan
HDR	Human Development report
HSTP	Health Sector Transformation Project
HIV	Human immunodeficiency virus
HMIS	Healthcare management information system
IEC	Informational, educational and communications
IDP	Internally Displaced Person
IP	Implementing partner
IPC	Integrated food security phase classification
LQAS	Lot quality assurance sampling
M&E	Monitoring and evaluation
MOH	Ministry of Health
NBS	National Bureau of statistics
NGOs	Non-governmental organizations
NHP	National Health Policy
OCHA	Office for the Coordination of Humanitarian Affairs
OP	Operational Policy
OTP	Outpatient therapeutic programme
PHC	Primary health care
PHCC	Primary health care centre
PHCU	Primary health care unit
PoC	Protection of Civilians
PSEA	Protection from sexual exploitation and abuse
RMNCAH	Reproductive, Maternal, Newborn and Child Health
RRC	Relief and Rehabilitation Commission
RRHP	Rapid Results Health Project
SA	Social Assessment
SPLA	Sudan People's Liberation Army
SPLA-iO	Sudan People's Liberation Army in Opposition
SSDP	South Sudan Development Plan
SSEMF	Security and Significant Event Management Framework
TBA	Traditional birth attendant
UNICEF	United Nations Children's Fund
UNMISS	United Nations Mission in South Sudan
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

This document is the Social Assessment report for the provision of integrated Basic Package of Health and Nutrition Services (BPHNS) under the Health Transformation Project (HSTP) in the ten States (Upper Nile, Unity, Northern Bahr El Ghazal, Warrap, Western Bahr El Ghazal, Lakes, Western Equatoria, Central Equatoria and Eastern Equatoria) and three Administrative Areas (Abyei, Greater Pibor and Ruweng) of the Republic of South Sudan. The project is intended to complement existing activities carried out by the Government of South Sudan and other partners. Its primary objective is to deliver low-cost, high-impact integrated health services to the majority of the population, especially women and children, living in the country. This includes the provision of maternal, neonatal and child health services, including basic curative services at the primary level and provision of basic and comprehensive emergency obstetric and newborn care; procurement and distribution of essential medicines and supplies; strengthening systems for emergency preparedness and response and disease surveillance and outbreak response as well as for service quality improvement through training, supervision and coaching.

This Social Assessment provides an overview of the demographic, social, cultural and political characteristics of the beneficiaries in the country. It highlights the project's potential beneficial and adverse effects on vulnerable and disadvantaged groups such as the internally displaced population, flood affected communities and pastoral communities, refugees and persons with disability and hard to reach communities, how the positive impacts can be enhanced, and how social risks are managed. It focuses particular on the current health services and outcomes in the states and administrative areas, as well as the project's potential impact on public health in beneficiary areas. The Assessment was informed by a desk study review of relevant documents and prior and informed consultations with vulnerable and disadvantaged groups that assessed whether there is broad community support for such activities.

South Sudan, officially the Republic of South Sudan, is a landlocked country in eastern Central Africa. It is bordered by Ethiopia, Sudan, the Central African Republic, the Democratic Republic of the Congo, Uganda, and Kenya, and includes the vast swamp region of the Sudd, formed by the White Nile and known locally as the *Bahr al Jabal* meaning "Mountain Sea". The total population is estimated by the National Bureau of Statistics (15,254,269 people in 2024), and Juba is the capital and largest city. South Sudan gained independence from Sudan on 9 July 2011, making it the most recent sovereign state or country with widespread recognition as of 2024. Its rich biodiversity includes lush savannas, swamplands, and rainforests that are home to many species of wildlife.

Before 9th July 2011, South Sudan was part of Sudan, its neighbor to the north. South Sudan's population, predominantly African cultures who tend to adhere to Christian or animist beliefs, was long at odds with Sudan's largely Muslim and Arab northern government.

Widespread insecurity and the looting of health supplies and assets, including the closure of health facilities, reduced health service delivery in most of the states, and reporting rates of service delivery are also low. However, in recent surveys in parts of the country, almost 80 per cent of the population said they have access to health care: this is presumed to be linked to the high presence of humanitarian actors in the country. However, a range of indicators remains particularly poor in the area, including antenatal care (first and fourth visits), delivery with skilled birth attendants, immunisation coverage, and healthcare-seeking behaviour for a range of childhood illnesses. Poor hygiene and malnutrition also affect health. Meanwhile, gender-based violence, both intimate partner violence and conflict-related violence, is endemic across many communities in the country, with only limited access to even the most basic services for the clinical management of rape.

In this context, the Social Assessment finds that implementation of the project is likely to improve access to low-cost, high-impact health services by communities (including internally displaced persons) in the country and thereby reduce child and maternal mortality and the spread of vector diseases and generally improve the health of the population. The project's potential positive impacts outweigh the negative impacts, and it should significantly contribute to improving the health status and livelihoods in rural areas. Improvement of health care services should result in greater individual as well as community well-being. This may lead to greater

social cohesion and stabilisation during the project period. On the other hand, if inequitable service delivery is perceived, this could contribute to heightened conflict.

The desk review of previous reports/documents has highlighted multiple stakeholders that include, among others vulnerable groups, civil society organisations, donor agencies, and the Government. In such a situation, issues of equity are very pertinent concerning appropriate gender and intergenerationally inclusive framework that provides opportunities for consultation at each stage of project implementation among the borrower, the affected vulnerable and disadvantaged groups communities, their representative organisations, and other local civil society organisations.

The desk review also encompasses the communications channels that are important for passing on health messages to communities, especially regarding mobilisation. It found that village chiefs are considered the main channel for messages to be passed to communities, with other means including drumbeat and bell, peer-to-peer communication and social gatherings.

The study has analysed and concluded that the project activities will generate considerable social benefits to the communities in the country, though the project may not meet all the needs for health and nutrition. The study has also established several social consequences that the project activities are likely to induce albeit on a small and localised scale. These negative impacts can be mitigated as long as the recommendations given in the Social Development and Monitoring Plan are implemented through the planned activities and regular checks and monitoring. This is in line with the efforts of the Government to improve the health care of the rural population.

This study finds that the HSTP is expected to provide quality health and nutrition services with provision of standardized pharmaceuticals and increased access to health services including for women, internally displaced persons and other vulnerable groups, therefore expected to reduce morbidity and mortality of the people in South Sudan. The potential negative impacts if adequate mitigation measures are not put in place include elite capture and Gender based violence, Sexual exploitation and abuse as well as Child labor and Child marriage. It is, therefore, necessary that the actions set out in this report be integrated into the project and for monitoring to be carried out to ensure compliance.

Other risks resulting from the Fragility Conflict & Violence (FCV) context will also pose a challenge for project implementation. Such risks relate equally to communities as well as project workers. While largely not under the control of the project, it will ensure ongoing risk assessments and security risk management measures to enhance safety as much as possible under the given context. Security risks and mitigation measures have been assessed and developed and will be implemented proportionately and feasibly, including regular security risk assessments, resources for security measures, and cooperation with all stakeholders along the Saving Lives Together Framework (SLT). Constant coordination between GoSS, MOs, implementing partners (IPs), local communities, other UN agencies and partners and the World Bank is thereby essential.

To realize maximum benefits, community structures should be strengthened especially the women groups to address issues of gender-based violence and gender inequality. Mechanisms should also be put in place for rapid response mechanisms to address man made emergencies and natural disasters. Infrastructure and resources also require serious consideration, but this will have to be carefully assessed and efficiently managed given the limited budget within this project.

1. INTRODUCTION

This document is the Social Assessment report for the Health Sector Transformation Project (HSTP) which will operate nationwide in South Sudan. The HSTP is designed to expand access to basic packages of health and nutrition services for the people in South Sudan including refugees.

In South Sudan generally, malnutrition is widespread, along with a preponderance of infectious diseases, accounting for a considerable proportion of the total burden of disease. Infectious diseases, including malaria and typhoid, respiratory infections and acute watery diarrhea are among the major causes of death and morbidity. Internally displaced persons are among the most vulnerable populations living in this region, given the widespread inadequate access to basic services, limited economic opportunities, poor infrastructure, and food insecurity.

The project objective is to expand access to a basic package of health and nutrition service, improve health sector stewardship and strengthen the health system. The main strategy is to support an agile mix of static modalities of implementation, complemented by outreach interventions, through fixed health clinics and integrated outreach services delivered by mobile teams (especially during the dry season) to increase and expand equitable coverage and access, particularly for mobile or hard-to-reach populations with intermittent periods of stability and access. These front-line interventions will be supported in specific areas with the rollout of community-based health services, such as the Boma Health Initiative (including integrated community case management), to bolster community resilience and basic services provision, even while communities are exposed to shocks and cannot be accessed.

Specifically, to increase equitable access by vulnerable groups to essential healthcare services, the three main strategies will be

(a) *Directly supporting facility-based health service delivery*: In close collaboration with the Ministry of Health (MOH), State Ministry of Health and county health officials, MOs will provide implementing partners (IPs) with technical assistance, supplies and financial support, as part of overall capacity development to strengthen the delivery of basic health services to children and women, with priority given to the poorest and most marginalised communities. This will entail a mix of national and international NGOs identified through an open selection process.

(b) *Enhanced routine outreach*: Health teams attached to supported health facilities will be supported to expand coverage and access to health services in areas with intermittent periods of stability and access. This would provide a broader package of services more systematically to locations outside the catchment areas of the fixed/functional health facilities and within displaced populations, especially where there is a deficit of health and nutrition services. These outreach services will be provided monthly where possible (at minimum every 3 months).

(c) *Advancing community health*: Targeting communities far away from existing health facilities, through the Boma Health Initiative, a network of trained community health workers (BHWs) will be responsible for delivering a standard package of community health services building on integrated community case management (iCCM). Delivered at the household level, these services will also focus on health education and promotion of Child Health, Safe Motherhood, and basic Community Surveillance, along with community engagement and social mobilisation (e.g. during campaigns when outreach services are available).

The target population in the ten states and three administrative are as is estimated by the National Bureau of Statistics at 14.2 million (51.1% male, 48.9% female), an annual population growth rate of 3.57%, and total fertility rate of 4.5 (South Sudan Populations Project 2020-2040). This includes about 2.5 million women and children at risk of acute malnutrition (HPC 2024). Project beneficiaries will also include about 330,000 refugees, 440 returnees and their host communities. Furthermore, over 60 percent of public health facilities in country will benefit from this project, while the health system, health sector stewardship and capabilities of the MoH at different levels will be strengthened.

The areas of health care to be covered in the HSTP include the following:

a. Basic health and nutrition services;

b. Child health and nutrition services;
c. Maternal and neonatal health services;
d. Basic and comprehensive emergency obstetric and newborn care at primary health care centre and hospital level (BEmONC & CEmONC);
e. Family planning and sexual and reproductive services;
f. Basic curative services;
g. Infectious and non-communicable diseases;
h. Emergency and surgical services;
i. SGBV and mental health services;
j. Social and Behavioural Change Communication (SBCC), health promotion and education;
k. Strengthened referral systems
l. Procurement and distribution of essential medicines and supplies;
m. Emergency preparedness and response;
n. Disease surveillance and outbreak response; and,
o. Strengthen the health system, Quality of care improvement and supervision.

Partnerships will be established with implementing partners (IPs) to deliver the following essential primary health care services:

a. Child health services: immunization; vitamin A supplementation and deworming; promotion of adequate infant and young child feeding and caring behaviours; and use of long-lasting insecticide-treated nets;
b. Maternal health services: antenatal care (including home-based lifesaving skills and intermittent preventive treatment); skilled delivery; postnatal care; basic emergency obstetric care and family planning;
c. Basic curative services: treatment of malaria; treatment of acute respiratory infections; treatment of other illnesses; and treatment for survivors of gender-based violence.

1. Objective of the Social Assessment

The major objective of this social assessment is to identify potential social impacts and concerns related to the proposed project and assess the social characteristics of local communities, including determining the nature and characteristics of historically underserved people and vulnerable social groups in the HSTP intervention areas, with special emphasis on their unique identity, language, other cultural characteristics, geographical location, social institutions and organization and establish that the project will not negatively impact the way of life of these people. The social assessment will assess also the impact of the proposed interventions of HSTP on the more vulnerable groups and historically underserved people in line with World Bank's Environmental and Social Standard 1, 7, 8 & 10 (ESS-1,7, 8 &10) and to ensure that the project design reflects the needs of all beneficiaries in the most appropriate manner by identifying the key stakeholder groups in the program areas (including their livelihood and socio-cultural characteristics, etc.); recording their opinions and perceptions about the program; assessing the potential social impacts; determining how relationships between stakeholder groups will affect or be affected by the program; assessing implications for program design and implementation, and providing practical recommendations for dealing with the challenges and risks identified.

In line with the requirements outlined in Environmental and Social Management Framework (ESMF), this Social Assessment provides an overview of demographic, social, cultural and political characteristics of the historically underserved communities in the context of South Sudan, as well as different vulnerable and disadvantaged groups in the participating county of the country, the project's potential and adverse impacts on them, how the positive impacts can be enhanced, and social risks managed. In this regard, the assessment was based on a desk study review of relevant documents and prior consultations with most vulnerable and disadvantaged groups and assessed whether there is broad community support for the project. The Social Assessment is also intended to provide the affected vulnerable and disadvantaged communities with all relevant information about the project (including an assessment of potential adverse effects of the project on the affected vulnerable and disadvantaged populations).

1.2 Methodology

The Social Assessment was conducted by GoSS and MOs as a part of the development process for the HSTP. The assessment was mainly based on a social mapping exercise as well as a desk review of existing documents and reports.

Community-based social mapping was also conducted in 2023 with support from UNICEF to facilitate microplanning, partnership and monitoring of programme activities. Maps have been developed and regularly updated across the country. Community mobilizers were requested for the following information:

- Population: who are they and where are they located?
- What are the geographic features and infrastructure in the area?
- What is the administrative composition and basic information?
- Who can help us?
- How can they be reached?
- What are the key challenges?
- How many functional and non-functional facilities are there?
- How much risk is involved?
- How accessible is the area?

This was followed by micro-planning that entailed the

- Identification of possible missed areas
- Demarcation of deployment areas
- Logistics planning
- Division of areas - town/camp, villages and scattered settlements
- Planning activities and coverage areas
- Movement plans of frontline health workers and their supervisors
- Monitoring plan
- Proposed implementation plans in hard to reach and inaccessible areas, etc.

The data was reviewed and updated with new information and data drawing from reports that included key informant interviews and consultations with both rights-holders and duty-bearers, as well as analysis of the situation in the target area by the Government and international organisations.

2. OVERVIEW OF THE HEALTH SECTOR IN SOUTH SUDAN

South Sudan's healthcare system includes community, primary, secondary and tertiary levels. Community health care is based at the village level and is manned by community health teams. Health services are supposed to be free and accessible to the whole population at primary and secondary levels. In South Sudan's decentralised system, the national MOH provides policy guidance, leadership, funding, monitoring and evaluation, while state-level oversees health care delivery at other levels.

In 2022, there were 1,509 fully or partially operational health facilities in ten states and three administrative areas (HMIS, 2022). To prepare for HSTP project, a physical verification and mapping exercise has been conducting by MoH since March 2024 with technical support from WHO to assess status of the health facilities that not yet been completed as of June 2024.

The country has a partially functioning health management information system due to the varied challenges resulting from the conflict and flooding. For instance, completeness and timeliness of outpatient health consultation data collection is merely over 50 percent. For other indicators are much less complete.

Despite this lack of definitive data, South Sudan is believed to have some of the worst health outcome in the world. The maternal mortality ratio stands at 1,150 per 100,000 live births (Health Sector Performance Review Report, 2021), while the neonatal and under-five mortality rates are 98 and 63 respectively per 1,000 live births (Health Sector Performance Review Report, 2021). A significant disparity in health status across socio-demographic factors and geographical locations is well documented.

3. DESCRIPTION OF THE PROVISION OF HEALTH SECTOR TRANSFORMATION PROJECT (HSTP)

The areas of health care to be covered in the HSTP include the following: (i) Child health services; (ii) Maternal and neonatal health services; (iii) Basic and comprehensive emergency obstetric and newborn care at primary health care centre and hospital level; (iv) Basic curative services; (v) Procurement an distribution of essential medicines and supplies; (vi) Emergency preparedness and response; (vii) Disease surveillance and outbreak response; and (viii) Quality improvement and supervision.

The HSTP will support an agile mix of static primary health care services that are complemented by regular outreach to increase and expand equitable coverage and access, particularly for mobile/nomadic or hard-to-reach populations with intermittent periods of stability and access. These front-line interventions will be supported with the rollout of community-based health services, such as the Boma Health Initiative (including integrated community case management), to bolster community resilience and basic services provision even while communities are exposed to shocks and cannot be accessed. This, combined with emergency preparedness and response, will ensure service continuity. Additional efforts also will be made to address the plight of women and child survivors and extend life-saving services to improve accessibility. MoH to ensure an integrated approach between health, nutrition and social protection to improve the well-being and safety of vulnerable population including persons with disabilities, women and children through the administration of clinical management of rape services, and access to and provision of confidential and sensitive health services to survivors of all forms of gender-based violence (GBV).

In summary, the three main strategies will be applied in the project; (1) directly supporting facility-based service delivery; (2) routine outreach to areas that are intermittently stable and accessible; and (3) training for community health workers on the treatment of malaria, acute respiratory infections and diarrhoea among young children, disease surveillance and the reporting of service delivery data and vital statistics.

4. BASELINE SOCIO-ECONOMIC CONDITIONS OF THE PROJECT AREA

4.1 HSTP operation areas

The country administratively comprises ten states namely, Northern Bahr el Ghazal, Western Bahr el Ghazal, Warrap, Lakes, Upper Nile, Unity, Western Equatoria, Central Equatoria and Eastern Equatoria, and three administrative areas Greater Pibor, Ruweng and Abyei. These are further subdivided into Counties and Payams, with the lowest administrative level being the Boma.

According to the National bureau of statistics (NBS) for South Sudan, most of the population lives in rural areas, with only 17% living in urban areas. Access to safe water and improved sanitation is estimated at 40% and 10% respectively, whereas only 7.2% of the population has access to electricity. Public infrastructure, such as roads and bridges are lacking in most parts of the country, compromising access to over 60% of the population during rainy seasons (NBS 2021). Many communities continue to remain at risk of disease outbreaks including waterborne diseases, given the poor access to safe water and improved sanitation, and the perennial flooding the country experiences.

Literacy rates are among the lowest in the world, estimated at 34.5% for those 15 years and older with higher literacy rates among males (40.3%) than females (28.9%). From 2010 to 2020, the total net enrolment rate in primary, lower secondary, and upper secondary education was as low as 38%, 44% and 36% respectively. The country's human development index of 0.385 (2021), is the lowest in the world (with a life expectancy of 55.0 years at birth, 5.5 expected years of schooling, 5.7 mean years of schooling, and gross national income per capita of 768 (HDR[1] 2021-2022).

The 2018 Revitalised Agreement on the Resolution of Conflict in the Republic of South Sudan (R-ARCSS) continues to provide hope for peace. However, sub-national violence persists in some areas, leading to the displacement of people and loss of lives and livelihoods. Traditionally rooted in tribal and pastoralist disputes, inter-communal conflicts persist in many parts of the country. Limited access to remote locations where these incidents occur hampers access to services for affected people. Moreover, South Sudan still grapples with dire economic conditions marked by institutional fragility, economic policy distortions and limited diversification. The effects of conflicts deepen extreme poverty and hamper private-sector prospects and livelihood improvements. Despite hopes for an oil-led recovery after the 2018 truce and resumed oil production, COVID-19, sub-national violence, flooding and structural hurdles significantly impacted economic progress.

The people of South Sudan, especially women and children, experience a severe protection crisis. Levels of violence, exploitation and abuse are notably high, including conflict-related sexual violence, GBV and growing child protection concerns. The 2 million internally displaced persons (IDPs) represent the world's fourth most neglected displacement crisis, including over 37,000 IDPs in the Malakal Protection of Civilians (PoC) site (OCHA South Sudan Snapshot, January 2024). Concurrently, South Sudan grapples with Africa's largest refugee crisis, with over 2.27 million South Sudanese refugees hosted in neighboring countries (OCHA South Sudan Snapshot, January 2024). With the onset of the Sudan crisis in April 2023 and a combination of violence and the cessation of food distribution in parts of Ethiopia, thousands of people returned to South Sudan, many of whom are highly vulnerable and arriving in critically underdeveloped areas. According to UNHCR report, as of begging of 2024, 541,000 people have crossed the border to South Sudan from Sudan since the outbreak of the Sudan crisis. Moreover, many northern border areas that kept receiving Sudanese refugees were already under stress before the Sudan conflict broke out on April 15, 2023. The prospect of these refugees returning to their countries of origin in the near term is limited, and the trauma endured, assets lost, and livelihoods destroyed in fleeing conflict in the host country have created unique development challenges for refugees in reestablishing their lives in South Sudan.

South Sudan faces significant challenges that adversely impact its human capital with one of the lowest human capital index (HCI) scores at 0.31. In the country, 31 out of every 100 children are stunted, increasing the risk of physical and cognitive impairment which can ultimately affect the adult survival rate. South Sudan's adult survival rate is 0.68; once a child reaches the age of 15, under current conditions, they have a 68 percent

[1] HDR = Human development report

chance of surviving to the age of 60. Factors such as widespread violence, limited human resources for health, and inadequate health infrastructure further contribute to the low HCI.

Table 1: Types of health facilities selected for HSTP in South Sudan

	HEALTH FACILITY TYPE										
State /Administration Area	County Hospital	Hospital	Other	Mobile Clinics	PHCC	PHCU	Private Clinic	Specialized Hospital	State Hospital	Teach-ing Hospital	Total HSTP selected Health Facilities
Abyei						7			1		8
Central Equatoria	5				32	104				1	142
Eastern Equatoria	5				36	112			1		154
Jonglei	4				30	57			1		92
Lakes	3				20	73			1	1	98
Northern Bahr El Ghazal	1				24	74			1		100
GPAA	3					11					14
Ruweng AA	1				7	7					15
Unity	2				13	45			1		61
Upper Nile	6				27	95				1	129
Warrap	3				29	59			1		92
WBGS	3				19	50				1	73
Western Equatoria	5				34	140			1		180
National	**41**				**271**	**834**			**8**	**4**	**1,158**

The above number is likely to change according to the reporting and the changing contexts. Currently, the MoH is planning an assessment for more than 240 facilities which are either not reporting or having very low reporting i.e. reporting on only one indicator. Nevertheless, access to primary health care has been difficult for a large proportion of the vulnerable populations situated there, including internally displaced persons and host community populations.

4.2 Health Indicators

Health service delivery in the country continues to be extremely challenging due to the difficult operating environment, significant shortage of skilled health workers and the underdeveloped health infrastructure.

DHIS 2 data in 2023 shows that national coverage of Antenatal care (ANC 4) is at 22.4% and Skilled birth attendants is merely at 18.7%, while immunization coverage is showing over 85% - Penta 1 (107%), Penta 3 (96.8%) and Measles (89.3%). Boma health workers play a significant role for referral – constituting 44% coverage of total outpatient consultations. (See annex-2 for a summary of health indicators).

Figure 1. South Sudan Population Projections for 2024 (national bureau of statistics, 2023)

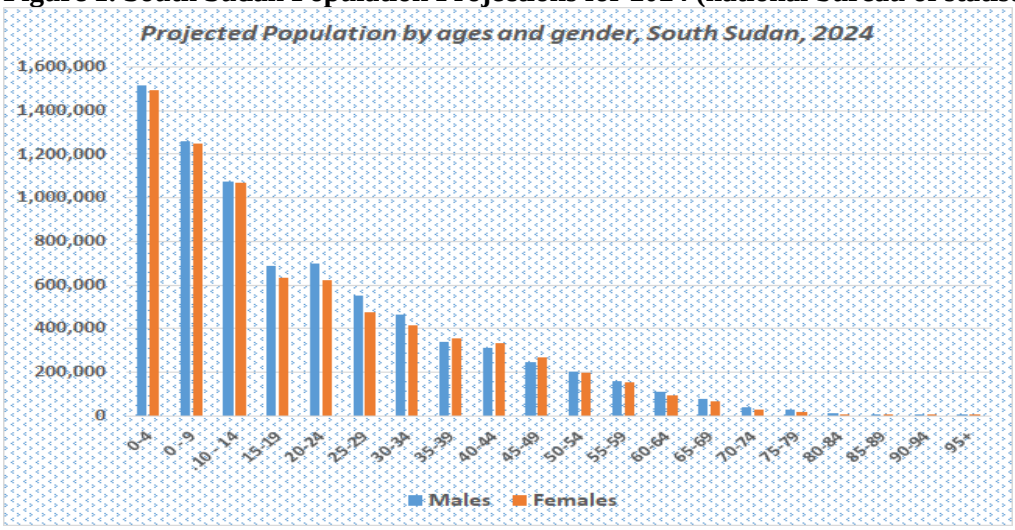


Table 2. Projected population by age and sex, 10 states

Age group	Males	Females	Total
0-4	1,516,455	1,495,043	3,011,498
5-9	1,259,966	1,249,757	2,509,723
10-14	1,075,698	1,067,268	2,142,966
15-19	687,087	635,065	1,322,152
20-24	696,043	621,510	1,317,553
25-29	553,531	474,251	1,027,782
30-34	461,378	414,566	875,944
35-39	340,204	355,822	696,026
40-44	310,759	331,614	642,373
45-49	247,768	268,816	516,584
50-54	201,583	197,336	398,919
55-59	160,730	153,538	314,268
60-64	111,273	91,679	202,952
65-69	77,165	64,710	141,875
70-74	38,889	28,328	67,217
75-79	26,495	18,570	45,065
80-84	9,630	5,761	15,391
85-89	3,499	1,850	5,350
90-94	439	175	614
95+	12	5	16

4.3 Health and Nutrition

The desk review of existing documents and reports consulted revealed that poor hygiene conditions also negatively impact the health situation in communities in the ten states and three administrative areas. In focus group discussions previously carried out, some community members reported that none of the population in their village used latrines. Open defecation directly contaminates drinking water sources, which is a health threat to communities especially during wet seasons. Malaria was the primary health concern among the communities consulted, followed by Pneumonia, Typhoid, Malnutrition, UTIs, STDs and Hepatitis B, Diarrhoea, Measles and Respiratory infections are the most common childhood diseases in the consulted communities. Childhood illnesses are highly correlated to acute malnutrition.

4.4 Gender-based violence

In South Sudan, the impact of persistent conflict, poverty, climatic shocks, and harmful social norms has led to alarming levels of gender-based violence (GBV) against women and girls. Recent events, such as the influx of refugees from Sudan, have exacerbated this crisis, with over 259,000 individuals fleeing to South Sudan, predominantly comprising women and children, highlighting the vulnerability of this demographic. Despite efforts to address these challenges, GBV remains widespread, with high rates of intimate partner violence (IPV) among married women aged 15-49, reaching 41% according to a World Health Organization. Moreover, a 2023 national prevalence survey conducted by the Ministry of Gender, Child and Social Welfare (MGCSW) and the United Nations Population Fund (UNFPA) revealed 75.8% of South Sudanese women aged 15-64 experience at least one form of violence over their lifetime. South Sudan has the world's fifth-highest prevalence of child marriage with over 52% of girls married under the age of 18, placing them at increased risk of early pregnancies and associated health complications. With overall reduced access to health services by the population, clinical management of rape services including even the most basic GBV services is also limited, ad hoc and severely compromised by the lack of the right and quantities of skill sets able to deliver an effective response.

The deep-rooted gender inequalities in education, economic opportunities, and decision-making processes further perpetuate vulnerability and marginalization, underscoring the urgent need for comprehensive multi-sectoral responses to address GBV effectively. Despite these challenges, South Sudan has made strides in establishing a legal framework and policy initiatives to address GBV, sexual exploitation, and harassment, signaling a commitment to enhancing protection and accountability. Key legislative measures such as the Penal Code Act of 2008 and the Child Act of 2008 provide avenues for legal recourse and protection yet incur limitations in reporting. Additionally, operational guidelines and policies, including the National Standard Procedures for GBV Prevention and Response and the National Gender Policy, support efforts against GBV/SEA and promote gender equality.

The effectiveness of these legal measures relies heavily on robust implementation and enforcement, alongside efforts to dismantle harmful social norms and improve access to support services for survivors. While progress has been made, sustained efforts and continued investment in addressing GBV are essential to ensure the safety and well-being of women and girls in South Sudan. GBV risk mitigation measures include training Government sectors, UNICEF's sectors and clusters on the Inter-Agency Standing Committee guidelines for GBV integrating GBV prevention and response in humanitarian action; conducting safety audits/safety assessments to identify safety needs for women and girls and engaging relevant actors to address them; supporting partners to develop and implement specific action plans to improve women and girls' safety; and leading advocacy efforts in collaboration with other actors to improve women and girls safety interest. GBV risk mitigation efforts also include the training of Government staff, MO's and partners' staff including contractors, consultants and volunteers on protection from sexual exploitation and abuse (PSEA).

4.5 Displacement in project areas

As of December 2023 (UN OCHA) it was reported that 2,063,315 individuals were internally displaced in the country, 1,259,765 were returnees and 441, 513 were refugees scattered in Renk, Pouloche, Northern Bahr el Gazal and Juba (UNHCR December 2023). Most of the returnees and some refugees are living within the host community in their respective locations.

PoC camps within the project areas are UNMISS-administered sites sheltering internally displaced persons in Bor, Malakal, Bentiu and Juba. In the four camps, UNMISS provides security while other United Nations organisations such as UNICEF, the World Food Programme and the Food and Agriculture Organization provide services in nutrition; health; water, sanitation and hygiene (WASH); and food security with supplementary support from civil society organisations. In all PoC sites, service provision is inadequate due to large numbers and inadequate funding.

Although most of the IDPs live outside the POC sites, no data is available on their access to health care and health status. Health indicators for internally displaced persons living outside POC sites are likely lower than the rest of the populations (see paragraph 2.2). Where POC sites are located (e.g., Bor, Malakal, Bentiu, and Malakal) every effort will be made to ensure host communities are served by the project, given that the population living in the POC sites are served by managing organisations (MO) and humanitarian agencies. Similar levels of services will be provided as resources permit to mitigate community perceptions of inequity.

4.6 Ethnicity of healthcare professionals

Another issue of concern raised in UNICEF's mapping exercise (2018) is that healthcare workers are perceived as 'imported' from other tribes. Partners therefore need to sensitize local communities about why they may need to bring skilled staff from elsewhere if qualified staff (such as clinical officers as midwives) are not available for local recruitment. Partners also need to make efforts to recruit unskilled local workers as much as possible (e.g. cleaning staff). This is particularly the case in areas where young people are unemployed and lack livelihood opportunities. If attention is not paid to this, this can trigger incidents, especially when compounded by rumours. Humanitarian organizations need to ensure regular community engagement to ensure that community issues, rumours and concerns are regularly aired and discussed, as early as possible, before they can mushroom into incidents. IPs will also be oriented on local social issues and will be accompanied on an advocacy trip to visit local authorities and communities about the new project. IPs will also be made aware of any sensitivity concerning the deployment of healthcare workers from ethnic groups coming from outside of the community to certain facilities, especially to those health facilities that serve a predominant tribe (UNICEF Mapping, 2018). These cultural characteristics and issues will be critically examined, identified and factored into local planning during the start of the project.

4.7 Violence against communities

As previously noted, many areas in South Sudan have extremely poor infrastructure exacerbated by sporadic armed conflicts. The level of conflict has reduced over recent years however there is still a high degree of inter-and intra-community violence, cattle raids and crime that has ravaged local and displaced populations. It is recognized that the Government of South Sudan has the primary responsibility of providing security to all communities however with limited resources and the current political environment, incidents against communities and those conducting humanitarian activities occur regularly. To mitigate the risk of violence, the project will support IPs to improve information sharing, training and security incident reporting protocols. Further details are outlined in *the HSTP Security Risk Assessment and Management Plan.*

4.8 Additional challenges

Additional barriers to access to healthcare among beneficiaries include lack of physical access, lack of good roads, lack of knowledge and information about the benefits of primary health, and lack of adequate community engagement when designing and implementing interventions. Several myths and misconceptions were noted. Some community members reported that vaccinations make women sterile, can lead to the early death of children, and are used by the United Nations and other agencies as a means of population control in South Sudan. Traditional Birth Attendants (TBAs) are seen as the "doctors" in the community, despite a lack of proper knowledge and skills. TBAs therefore need to be informed and empowered to refer patients, especially emergency cases, on time. They also need to be empowered to combat myths and misconceptions (such as children needing to stay inside for 30 days after birth, which can be a barrier to babies receiving postnatal care).

5. OVERVIEW OF POLICY AND REGULATORY FRAMEWORK

South Sudan Constitution 2011 - Article 9 of the constitution outline the Bills of Rights:

1. The Bill of Rights is a covenant among the people of South Sudan and between them and their government at every level and a commitment to respect and promote human rights and fundamental freedoms enshrined in this Constitution; it is the cornerstone of social justice, equality and democracy.
2. The rights and freedoms of individuals and groups enshrined in this Bill shall be respected, upheld and promoted by all organs and agencies of Government and by all persons.
3. All rights and freedoms enshrined in international human rights treaties, covenants and instruments ratified or acceded to by the Republic of South Sudan shall be an integral part of this Bill.
4. This Bill of Rights shall be upheld by the Supreme Court and other competent courts and monitored by the Human Rights Commission.

South Sudan National Gender Policy 2012 -The goal of achieving gender equality in South Sudan is anchored in the country's Transitional Constitution and guided by a vision of equality as an inalienable right for all women, men and children, and gender equality as a human right. The ultimate goal of this policy is to ensure that gender equality is an integral part of all laws, policies, programs and activities of all South Sudan's public institutions, the private sector and civil society so as to achieve equality in the cultural, social, political and economic spheres in South Sudan.

South Sudan Labour Act 2017 - The purpose of this Act is to establish a legal framework for the minimum conditions of employment, labour relations, labour institutions, dispute resolution and provision for health and safety at the workplace; in accordance with the Constitution of the Republic of South Sudan, 2011, and in conformity with international and regional obligations of South Sudan.

Child Act 2008 -The Act is to extend, promote and protect the rights of children in South Sudan, in accordance with provisions of Article 21 of the Interim constitution of South Sudan, 2005, and as defined in the 1989 United Nations Convention on the Rights of the Child and other international instruments, protocols, standards and rules on the protection and welfare of children to which South Sudan is signatory.

Social Insurance Act 2023 - The purpose of the act is to establish National social insurance for employees of the private sector and nongovernmental organisations. The HSTP will mainly support government employed workers that will be covered by public insurance. This Act will govern the insurance of for National workers directly employed by implementing partners and contractors and consultants

South Sudan Access to Information Act No. 65 2013 - The South Sudan Access to Information Act No. 65 of 2013 spells out that every citizen shall have the right of access to information. It focuses on the right to access information held by public bodies in South Sudan. The purpose of the Act is to give effect to the constitutional right of access to information, promote maximum disclosure of information in the public interest and establish effective mechanisms to secure that right.

Health Policy

The MOH in South Sudan developed the National Health Policy (NHP) 2016-2026 and Health Sector Strategic Plan 2023-2027 to provide the overall vision and strategic direction for development in the health sector. The NHP 2016-2026 which is to be implemented through two five-year strategic plans: 2016-2021 and 2021-2026, draws its mandate from the Transitional Constitution of the Republic of South Sudan (2005), Vision 2040, the South Sudan Development Plan (SSDP), and is cognizant of the Comprehensive Peace Agreement (August 2015) and the Sustainable Development Goals agenda. The overall goal of the NHP is a strengthened national health system and partnerships that overcome barriers to effective delivery of the Basic Package of Health and Nutrition Services (BPHNS); and that efficiently responds to quality and safety concerns of communities while protecting the people from impoverishment and social risk (WHO, 2018).

Under the overarching framework of the NHP, South Sudan has developed a National Health Sector Strategic Plan (2023-2027), which will serve as a framework for action for UNICEF and partners. The country is also updating its BPHNS and developing a costed multi-year plan for immunization (2018-2022) as well as a

Reproductive, Maternal, Newborn and Child Health (RMNCAH) Strategy (2018-2022) and an Every Newborn Action Plan (ENAP). The current lack of finalized plans and guidelines has implications for the prioritization of key interventions, including support for newborn care.

As a strategy for mobilizing action at the household and community level to reduce the high rates of ill health and preventable, premature deaths in South Sudan, the MOH intends to expand coverage of part of the BPHNS at the community level largely through the Boma Health Initiative. This initiative aims to deliver an integrated package that includes health promotion, integrated community case management, safe motherhood, and the control of common communicable diseases and epidemics. When the prior WB-supported project was first implemented in 2021, the Boma Health Initiative had not been fully rolled out at scale. Nevertheless, a review was undertaken of two pilots along with a cost analysis that is informing roll-out plans in 2019. In readiness for scale-up, training materials and resources have been partially revised with work ongoing and a community health management information system is being developed.

World Bank Environmental and Social Standard 7 (ESS7)

ESS7 recognizes that Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities (SSAHUTLCs) have identities and aspirations that are distinct from mainstream groups in national societies and often are disadvantaged by traditional models of development. According to ESS7 in many instances, they are among the most economically marginalized and vulnerable segments of the population. Their economic, social, and legal status frequently limits their capacity to defend their rights to, and interests in, land, territories, and natural and cultural resources, and may restrict their ability to participate in and benefit from development projects. In many cases, they do not receive equitable access to project benefits, or benefits are not devised or delivered in a form that is culturally appropriate, and they may not always be adequately consulted about the design or implementation of projects that would profoundly affect their lives or communities.

These groups are characterized by significantly identified features attributable to them and peculiarly define their group identity. Thus, in this ESS, as indicated in the WB (2018) the term "Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities" (or as they may be referred to in the national context using an alternative terminology) is used in a generic sense to refer exclusively to a distinct social and cultural group possessing the following characteristics in varying degrees: (a) Self-identification as members of a distinct indigenous social and cultural group and recognition of this identity by others; (b) Collective attachment to geographically distinct habitats, ancestral territories, or areas of seasonal use or occupation, as well as to the natural resources in these areas; (c) Customary cultural, economic, social, or political institutions that are distinct or separate from those of the mainstream society or culture; and (d) A distinct language or dialect, often different from the official language or languages of the country or region in which they reside.

Moreover, this ESS recognizes that the roles of men and women in indigenous cultures are often different from those in the mainstream groups, and that women and children have frequently been marginalized both within their own communities and as a result of external developments, and may have specific needs. Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities are inextricably linked to the land on which they live and the natural resources on which they depend. They are therefore particularly vulnerable if their land and resources are transformed, encroached upon, or significantly degraded. Projects may also undermine language use, cultural practices, institutional arrangements, and religious or spiritual beliefs that Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities view as essential to their identity or well-being.

Objectives:

To ensure that the development process fosters full respect for the human rights, dignity, aspirations, identity, culture, and natural resource-based livelihoods of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities.

- To avoid adverse impacts of projects on Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, or when avoidance is not possible, to minimize, mitigate, and/or compensate for such impacts.
- To promote sustainable development benefits and opportunities for Indigenous Peoples/ Sub-Saharan African Historically Underserved Traditional Local Communities in a manner that is accessible, culturally appropriate, and inclusive.
- To improve project design and promote local support by establishing and maintaining an ongoing relationship based on meaningful consultation with the Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities affected by a project throughout the project's life cycle.
- To obtain the Free, Prior, and Informed Consent (FPIC) of affected Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities in the three circumstances described in this ESS.
- To recognize, respect, and preserve the culture, knowledge, and practices of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, and to provide them with an opportunity to adapt to changing conditions in a manner and in a time frame acceptable to them.

ESS7 on Indigenous People is relevant to this Project. As a result, this Social Assessment has been prepared and broad community support has been assessed for project activities. As the policy applies to almost all citizens of the project area, no Indigenous Peoples' Plan is required, as results of the Social Assessment apply to all beneficiaries and the measures outlined in the Social Development and Monitoring Plan will be addressed by and mainstreamed into the overall project activities. In each states, most health facilities have been mapped to enable the selection of NGO partners. The selection process will take into account ethnic considerations. The Request for Expressions of Interest (EOI) stipulates that each NGO partner has to: (1) show an understanding of local context and conflict sensitivity risks which differ from County to County and within different groups and demonstrate the ability to translate contextual understanding into effective interventions, including community engagement; and (2) outline access constraints and security considerations and how the NGO will manage these, whilst integrating conflict sensitivity into the proposed interventions. The poor and underserved will remain central to the project in prioritization, with the restoration of services in the areas most affected by the conflict and consequently least provided for, and monitoring will assess the coverage and inclusiveness of the health service provision and thus provide information that will constitute a basis for corrective actions, if necessary. Benefits and the approach by which they will be provided will be culturally appropriate and adapted to the respective needs and structures of the vulnerable groups involved.

Accountability to Affected Populations (AAP)

MoH will in collaboration with partners continue the culture of engaging the community from the initiation of the project for the community to own it. Stakeholder meetings will be held in the location identified for implementation of the response. The community will be routinely consulted and provided with information regarding the project implementation. This will include engaging existing South Sudan's Relief and Rehabilitation Commission (RRC), State and County Health Department representatives, community elders, women, youth groups, religious leaders and representatives of beneficiaries. Aside from this, under the guidance of MOH, the management organization and IPs will be the medium through which communities will be encouraged to express their concerns, and views and provide regular feedback to the Management organization and IPs for the resolution of MoH using a regular structured modality. Other reasonable modalities for feedback that is useful to the communities/beneficiaries will also be considered. This feedback will form part of the project performance reporting to MoH and management organization and will help guide the fine-tuning of the project to enhance positive beneficiary experience.

6. POTENTIAL SOCIAL RISKS AND IMPACTS AND MITIGATION MEASURES

6.1 Social risks and impacts

Despite the promising positive social impacts, the project social and SEA/SH risks are classified as high. The project could face multiple potential social risks as it will be implemented nationwide where prevalence of poverty, drought, security challenges, and many more complex social issues under the Fragility Conflict & Violence (FCV) context of South Sudan are severe. Social risks are above all the result of the FCV context in

the project area. The table below summarizes some of the foreseeable social risk the project can induce or exacerbate.

Social risk	likelihood	Impact	Mitigation measures
GBV and Sexual Exploitation and Abuse (SEA) are two areas of concern resulting from high vulnerabilities of local communities. This may arise during recruitment of workers and vendors as well as employees of the project misusing their economic position to exploit vulnerable individual in the community	Moderate	High	Implement and monitor the GBV or SEA/SH Action Plan developed for the project including measures to training vendors and health workers on GBV/PSEA
Safety and security of workers, assets and staff becoming targets of violent groups	Moderate	High	Implement the security risk assessment and management plan (SRAMP)of the project including measures to provide security SOPs, security training and engagement of local authorities and law enforcement agents to protect project staff
Community health and safety, security and safety of services and beneficiaries. Exposure of beneficiaries to medical waste and poor quality of services may be a result of low skill cadre health workers being engaged in service provision	Low	Moderate	SOPs and standards of care will be provided to health workers including conduct of trainings and mentorship. Use MOH recommended staffing norms for all health facilities. Institute infection prevention and control measures including proper disposal of medical waste as per the requirements specified under the ESMF.
Land acquisition risks due to facility rehabilitation	Low	Low	Project does not support ,major rehabilitation and constructions work. However, whenever the project involves land acquisition, proper site-specific resettlement plan will be developed and implemented in accordance with the RF.
Grievances from people related to beneficiaries, especially pertaining to ethnicity of staff and medical procedures going wrong.	Moderate	High	Involve communities in the recruitment and deployment of qualified health workers. Provide training, job aids and mentors to sharpen skills of health workers to provide quality health services
Intra and inter-communal tensions (including between refugees and host communities) over implementation issues	Moderate	Moderate	Develop an effective project communication and involve communities throughout the project cycles
Equity issues such elite capture and social exclusion especially of the most vulnerable group	Moderate	Moderate	Create locally appropriate committees that will help oversee project implementation

Climate change-related social risks including increased exposure of women and children to disease.	Low	Low	Utilities climate sensitive power supply to health facilities through solarization and safer waste management

6.2 Social Development and Monitoring Plan

The Social Development and Monitoring Plan is designed to ensure that the management plan is implemented through participation and input of all the relevant stakeholders. The basic principles of the Social Development and Monitoring Plan are to ensure that the mitigation measures are followed up and implemented through the planned activities and regular checks and monitoring.

Table 6: Social Development and Monitoring Plan

Risk Area	Risk	Project activities	Potential impacts	Proposed mitigation measures	Responsible ORG	Monitoring indicator	Reference	Frequency of monitoring/ Timeframe
Safety, Security and Emergency Risks	Safety and security of workers, assets and staff becoming targets of violent groups. Intra and inter-communal tensions (including between refugees and host communities) over project implementation issues	Health service delivery via facilities or community outreach Targeting of health institutions by parties to the conflict / protection mechanisms/ looting. Security of Project Personnel embedded in the communities	•IPs are not prepared nor equipped to respond to emergencies, including disease outbreaks • Essential health services are disrupted • Injury or loss of life of Project Personnel due to targeted or non-targeted security incidents	Train IPs in emergency preparedness and response, including infectious disease surveillance and response (IDSR) Pre-position supplies (especially during the dry season), including emergency contingency supplies (e.g. cholera kits) Provide technical assistance to IPs to develop emergency contingency plans Collaborate with emergency responders/humanitarian actors Ensure distribution of health facility sites that will enable all populations to safely and securely access them, given their cultural background, specific vulnerabilities, the areas	MOH, MOs, IPs	•Number of health workers trained in emergency preparedness and response •Availability of pre-positioned supplies •Number of health facilities and	SMP, SEP	Prior to commencement of project and throughout the life cycle of the project

				of control of different parties to conflict, and trends in the conduct of hostilities. Strengthen dialogue with local stakeholders to effectively negotiate for people's access to services. MOs will continue to work closely with MoH and UNMISS and OCHA to utilize their channels for lobbying for access in conflict areas to allow programmatic assessments and interventions, monitoring and vital distribution of life-saving drugs and its partner access. Bolster security in hospitals, PHCCs, and PHCUs through manned guarding of facilities, and securing of points of entry. Strengthen regular and ongoing community engagement and dialogue to reduce targeting of health institutions when conflict occurs. Strengthen support to IPs via the SSEMF, including financial support to strengthen the security management capacity of the IPs. Improve security-related Significant Event reporting to enhance information sharing and ability to inform decisions around Project Personnel security and service provision. Strengthen community engagement and dialogue to reduce targeting of health institutions when conflict occurs. Coordination with UNMISS Force Protection in accessing conflict-prone areas, permitting project implementation and monitoring by MOs and its partners Utilize the goodwill of MOs with beneficiary communities to gain access and secure an enabling and secure environment.		communities supported • Number and type of incidents reported • Number and type of community engagement activities		

Community Health and Safety	Community health and safety, security and safety of services and beneficiaries. Exposure of beneficiaries to medical waste and poor quality of services may be a result of low cadre health workers being engaged in service provision. Grievances from people related to beneficiaries, especially pertaining to ethnicity of staff and medical procedures going wrong.	Health service delivery via facilities or community outreach. Procurement and distribution of pharmaceuticals and medical inputs.	• Community activities seen as not acceptable according to local traditions or not affordable, thereby generating hostility to the healthcare system and resulting in a lack of buy-in of community health services by community leadership and stakeholders • Shortage of suitably qualified staff or presence of lowly skilled medical staff resulting in poor-quality critical lifesaving services • Salaries meant for health workers not being remitted to staff resulting in absence of health personnel at facilities and disruption of services • Inequitable availability and access to service delivery in areas that are not highly vulnerable • Shortage of suitably qualified staff or presence of lowly skilled medical staff	Mapping of functional health facilities and selection of those to be supported, considering local administrative boundaries, government and non-government (IO) controlled areas, population size, cultural characteristics of the population, and conflict dynamics. Communicate with local leaders to inform communities about the health care services to come in the community. Coordination with other partners and local health actors to mitigate duplication and reduce gaps in service delivery Support the formation and strengthening of health local groups (e.g. Boma Health Committees) for self-monitoring. Programme monitoring and supervision that includes consultations with community members. Strict monitoring by MO and 3rd party audit institutions (programme visits, spot checks, audits) Physical verification and mapping of health facilities by community mobilizers as well as an auditing firm. Application of biometrics payment system for incentive payment. Regular monitoring of IPs and health facilities, including audits and spot checks. Transparent recruitment of qualified health care workers, with preference provided to residents (as less likely to have high turnover) and with attention to gender and conflict sensitivity. Support CHD and SMoH with in-service training, monitoring and supervision of facility and community-based health care workers for quality improvement of services	MoH, MO, IPs	•Mapping of areas and the health facilities to be supported within each lot • Status of mapping of health facilities • Number of programme monitoring visits, spot checks, audits •Number of healthcare workers trained (by type of training, by gender) •Standardised Package of Performance-based incentives available • Number of health facilities and communities supported • Number and type of community	SEP, GBVAP, SADP	Prior to commencement of project and throughout the project life cycle

				Provision of technical assistance to strengthen the capacity of CHDs, IPs and NGOs in delivering programme results . FSPs pay standardised performance incentives to eligible health workers. Strengthen community engagement and dialogue to reduce targeting of health institutions when conflict occurs Coordination with UNMISS Force Protection in accessing conflict-prone areas, permitting project implementation and monitoring by MOs and its partners.		engagement activities • Number and type of incidents reported		

Environmental and Facility risks	Land acquisition risks due to facility rehabilitation Climate change-related social risks including increased exposure of women and children to disease.	Procurement and distribution of pharmaceuticals and medical inputs.	• Increase in medical waste in areas of operation • Poor hygiene, water and sanitation in health facilities negatively impacts safe delivery of health care services • Expired and damaged drugs negatively affecting communities in the areas where the project is implemented • Social ills like sale of drugs for private gain • Poor distribution and frequent stock outs affecting ability to meet the minimum project expectations	Develop WASH in health facility guidelines (covering hygiene, sanitation, safe water and waste management) for circulation to IPs Engage and train health workers on medical waste management. Develop waste management plans for each health facility. Monitor implementation during programme monitoring and supervision Conduct a diagnostic assessment to assess how the supply chain can be improved to ensure adequate delivery to health facilities located in SPLA-IO areas/former-IO areas as well as other hard-to-reach areas Procure kitted drugs, pre-packaged by MOs to reduce distribution time and risk of drug shortage at health facility level Recruit IPs with capacity in logistics and supply chain management and stock reporting while ensuring that reporting tools are available Inclusion of drug monitoring in programme design and programme documents to strengthen monitoring of drugs availability in PHCCs and PHCUs through IPs and community mobilizers working on the ground Strengthen verification along the supply chain by requesting receipts of drugs from MOs to IPs as well as from IPs to Health Facilities Monitoring of drugs will be included in all supervision visits and reports of staff and third-party monitors. Minimal quantities of drugs stocked at CHDs, PHCCs and PHCUs to minimize loss through looting. Work with IPs to gauge and stock adequate quantities per period	MOH, MO and IPs	•Number of health workers trained •Number of Guidelines Developed •Number of waste management plans •Number of programme monitoring visits •Tracking of corrective actions •Pooled procurement mechanism of drugs • Drugs and supplies are procured and kitted by UNICEF Supply HQ • Inventory count of drug supply in UNICEF warehouses • Supply chain verification in place		Weekly inspection to ensure proper hygiene, water, and sanitation in health facilities and will be followed throughout the project life cycle

				Health kits and supplies are prepositioned nearby in secured locations for emergency response/replenishment. Circulate to partners the SOP for immediate reporting of loss and looting incidents. Prioritize avoiding land acquisition altogether by considering project designs, locations, or technologies that minimize land take. Providing prompt and adequate compensation to those affected, covering the full replacement of value of land, assets, and any other losses incurred. If relocation is necessary, provide comprehensive resettlement assistance in line with the resettlement framework. Engage with affected communities and individuals throughout the land acquisition process, from planning to implementation. Ensure that the land acquisition activities comply with all applicable laws, regulations, and policies.		• Supply chain diagnostic study carried out • Drug monitoring evident in supervisions by UNICEF and Third-Party monitoring		

Equity and Social Inclusion	GBV and Sexual Exploitation and Abuse (SEA) are two areas of concern resulting from high vulnerabilities of local communities. This may arise during recruitment of workers and vendors as well as employees of the project misusing their economic position to exploit vulnerable individuals in the community. Equity issues such elite capture and social exclusion especially of the most vulnerable group		Social disruption due to perceived introduction of inequitable health services. Inequitable availability and access to service delivery in areas that are not highly vulnerable. Elite capture of services by individuals with connections or senior social status • Low capacity of BHWs and supervisors, poor linkages between BHWs and health facilities, limited equipment, and a lack of data, impede the quality of community health services	The project will implement an existing GRM developed and implemented under the COVID-19 Emergency Response and Health Systems Preparedness Project (CERHSSP) which aligns with the requirements of ESS 10 and other relevant E&S standards. Maintain the Grievance Redress Mechanism as part of MoH Accountability for Affected Populations strategy Monitor IP compliance with MO policy and measures on PSEA Involve key local stakeholders in Boma Health Workers (BHW) selection and implementation processes to ensure buy-in, recognition, and acceptability from the community. Strengthen the ability of community health leaders and structures (particularly Boma Health Committees) to enable accountability, monitor community health initiatives and support BHWs. Adapt BCC messaging to address local myths and misconceptions and to encourage care-seeking from BHWs Ensure recruitment of female CHWs (minimum 30%) to reduce gender barriers to services Ensure sufficient human resources at adjacent health facilities to carry out BHW supervision Establish referrals and counter-referral networks between BHWs and health facilities to improve the continuum of care Conduct BHWs training and supervision to ensure compliance with standard operating procedures and reporting guidelines	MOH, MO and IPs	•Number of Community Health Workers (males/females) recruited and trained • Number and type of community engagement activities •Number of people reached		During the engagement of required labour, and throughout the life cycle of the project

				Provide on-time compensation to BHWs (e.g. performance-based incentives linked to reporting) Development and distribution of community data collection tools linked to the HMIS. Use of traditional knowledge and non-discrimination.				

7. PUBLIC CONSULTATIONS AND DISCLOSURE

Since 2023 till today the MOH together with partners had held several consultation meetings on HSTP with IPs and opinion leaders on the design and contents of the project and eventual roll out selection of partnership. To date, 431 (362 Male and 69 Females) have been consulted. National consultation with CSO, and other Ministry of health line directorates was done in mid-2023. This was followed by the inception meeting with the ministry of health at national, state and county health departments including CSOs implementing partners and representatives of beneficiaries.

7.1 Communication channels

Communication will be based on existing channels with communities, and women in particular, can be strengthened by knowing the different community structures in place in the catchment area that the health facility serves. Social mapping (see attachment) is regularly conducted by MOH/UNICEF and BHI to help to establish this, in consultation with local partners. Under the guidance of MOH, UNICEF and partners will work with and empower the community leaders in these structures to foster two-way communication and community engagement. Community leaders and structures in South Sudan – such as women's groups, youth leaders, religious leaders and chiefs – play a key role. Once empowered these structures and community leaders are proactive in engaging their respective communities. So, at the onset of the project, with the support of health and social behaviour change communication counterparts, each partner will map and know the structures and communication channels in the communities that they serve. Special efforts will be made to engage women's groups, given the gender dynamics in South Sudan, as women may be reluctant to discuss issues with men but prefer to raise and discuss issues and concerns with other women (their peers). In addition, when community health workers are identified, each NGO partner will be encouraged to identify women where feasible (to obtain at least a 30 per cent quota). In addition, the humanitarian wing of the Government of South Sudan, known as the Relief and Rehabilitation Commission (RRC) will be engaged.

The BHI will be mobilized to assist with this process, given that they live in their communities and that most community engagement activities occur at the community level rather than at the health facilities. Moreover, in collaboration with other development and humanitarian partners working in South Sudan's health and protection sectors/clusters, many partners have programmes addressing GBV in South Sudan. In close collaboration with these actors and stakeholders, this project will significantly scale up attention and efforts to improve access to services for victims of GBV. For example, the project will support the work of Gender and Social Inclusion experts at MOH and MOs to scale up training programmes for health professionals and expand the network of service providers offering GBV counselling and treatment services in 10 states and 3 administrative areas.

Moreover, because of the high illiteracy rates, densely printed informational, educational and communications (IEC) materials have limited value in some communities. Messages will be therefore tailored according to the community, based on communication needs assessments – e.g. verbal notices, radion and community gatherings with local language interpretations will be done via community channels rather than through posters and other forms of written communication (e.g. megaphones). IEC materials, when used, will be visually illustrative.

7.2 Grievance redress and feedback mechanisms

MOH and Partners will develop a Grievance Redress Mechanism (GRM) for the HSTP, local structures will be mapped and used to enable patients to voice grievances and complaints. Communities will also be advised how to contact the nearest MOH and MO representatives, especially in the event of reporting serious grievances such as fraud or sexual abuse or exploitation (by phone or email). These will be escalated to MoH and MOs as per standard operating procedures and partner obligations outlined in the partnership and co-operation agreement legal framework. Furthermore, during field monitoring visits and spot checks conducted by third-party institutions and MOH and MO staff, community members will be routinely and

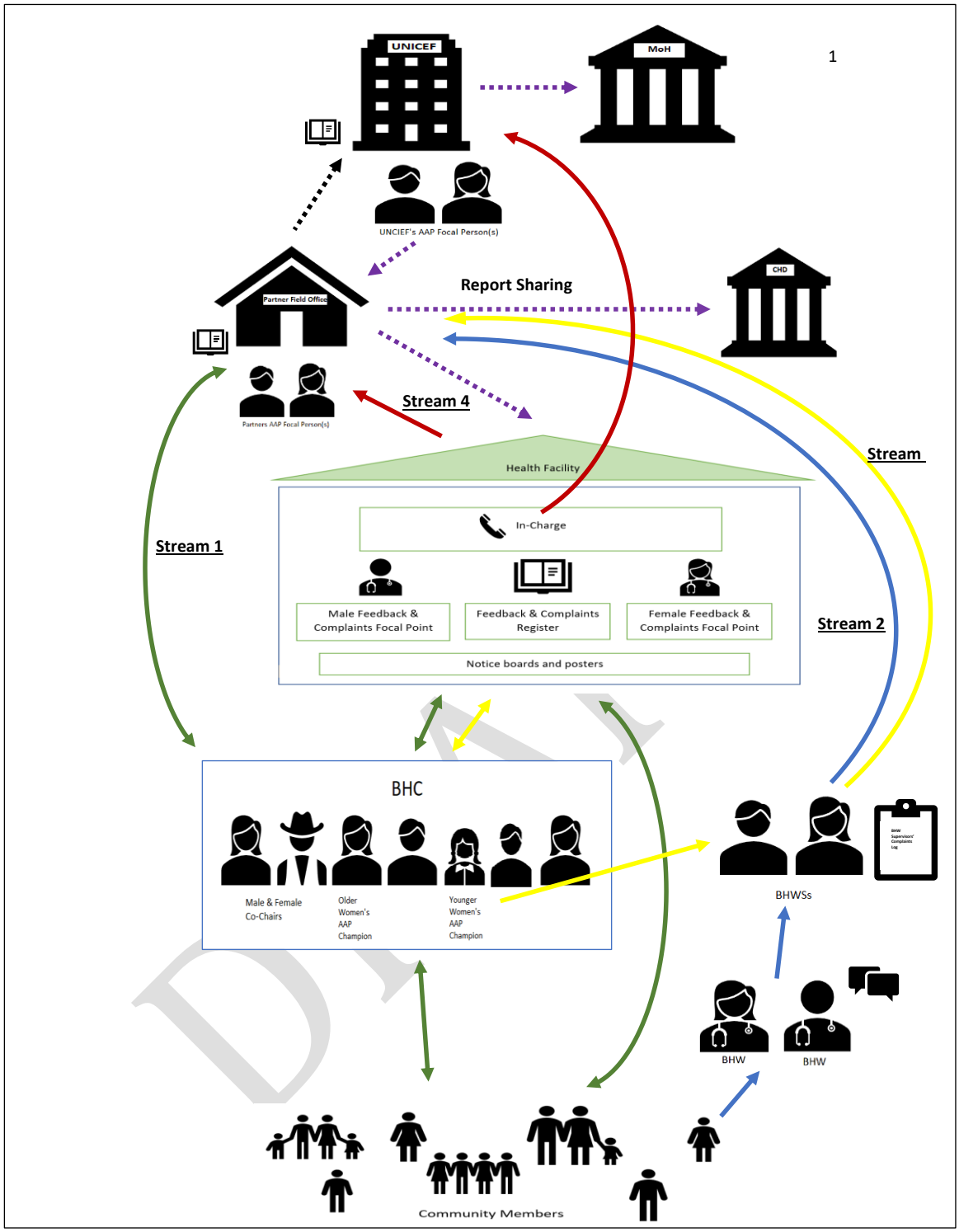
systematically consulted to allow them to air their concerns. In addition to having pictorial posters and information empowering patient communication (including how they can report their issues and concerns), healthcare workers will undergo regular capacity development on interpersonal communication (through listening, verification and feedback) as well as basic psychosocial support.

In order to address feedback, complaints and grievances, the PMU social specialist as responsible staff will ensure that complaints and questions are registered, tracked and promptly resolved in coordination with the grievance focal persons at each level. Through MOH and MO, local government officials and community leaders are to ensure prompt follow-up action in response to complaints received. Guidelines and obligations to ensure accountability to affected populations will be integrated into partnership agreements with IPs. Capacity for AAP will also be built among implementing partners, as a critical first step. The IPs will also be encouraged to have dedicated staff to look at this specific area, as well as to consolidate information and follow-up.

To do this, the GRM proposed below will be structured around the BHI, health facilities and the HSTP's existing monitoring, evaluation and learning routines. Its modular design means that its five streams can be implemented as key stakeholders' capacities are built and buy-in is secured. Each stream is designed to complement the others, with the goal of providing an inclusive and safe GRM that closes the feedback loop with communities and builds trust, sensitively handles corruption and SEA allegations, and provides the project with actionable data through which to adjust and improve its programming. UNICEF uses the term 'Accountability to Affected Populations' (AAP) to encompass activities which include a GRM; therefore, the term 'AAP' is used throughout this section. The GRM is sequenced with the AAP mechanism in such a way that the GRM offers a structured way for individuals or communities to voice their concerns, complaints, or dissatisfaction related to the project. This feedback loop is crucial for accountability, as it allows implementers to understand how their actions are perceived and experienced by those affected. By effectively coordinating these elements, GRM can be a powerful tool for promoting accountability to the affected populations and ensuring that their voices are heard, and their concerns are addressed.

Figure 2 displays the AAP mechanism. Information flows in Stream 1 are represented by green arrows, Stream 2 by blue, Stream 3 by yellow, and Stream 4 by dark red. The black dashed arrow represents data reported to UNICEF from partners, and the purple dashed arrows the sharing of reports with findings and analysis among stakeholders.

Figure 2. Multi-stream AAP mechanism



Source: Adopted from the Project ESMF.

MOH has endorsed the existing mechanisms to deal with sensitive issues from the programme i.e. Sexual Exploitation and Abuse including the step-by-step guide to prevent and respond to sexual abuse at the country level. A diagram of the process is reproduced below[2]:

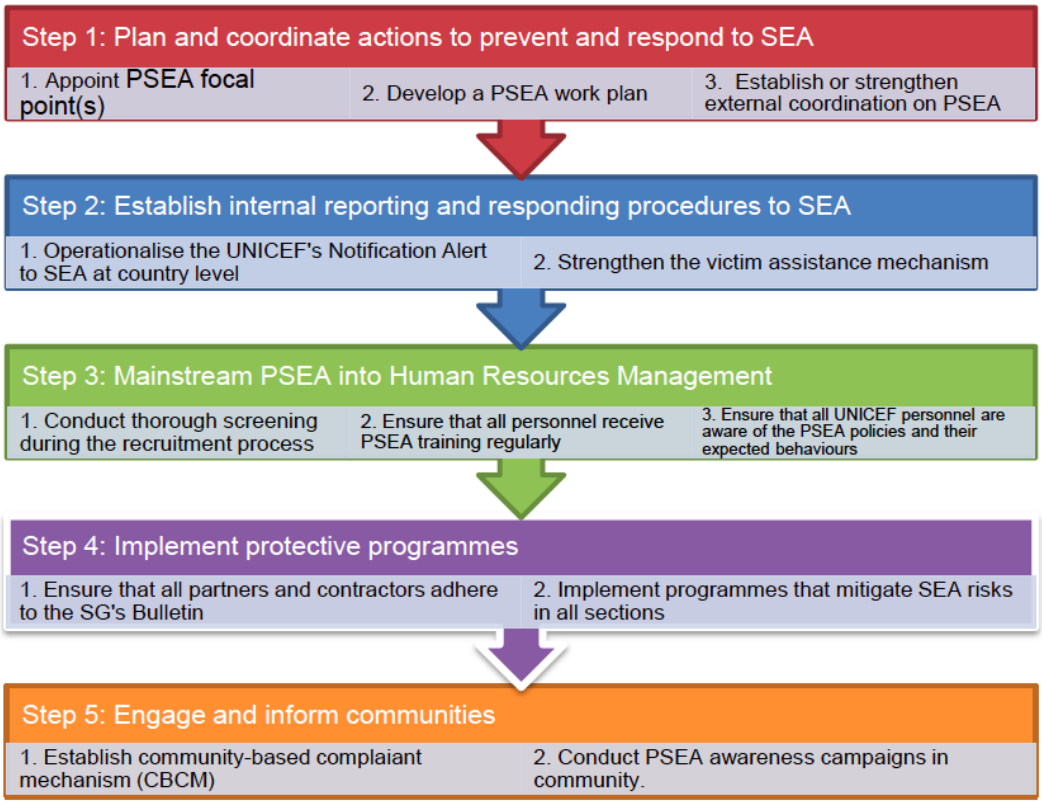


Figure 3: Five steps to respond to SEA/SH

In line with the above protocol, MoH endorses the following:

1. *Ensures that all MO and IPs staff are aware of the PSEA policies and their expected behaviours*. MO personnel and representatives are aware of PSEA policies and that these are readily accessible and visible to everyone in their offices. Existing PSEA information package already developed by the MO, which includes all essential PSEA-related information, provided to all its staff members as part of their induction.
2. *Ensures that all partners and contractors adhere to the protocol and entities in a contractual relationship with MOs are expected to abide by the international approved PSEA guideline*. Given the critical role that MO and partners and contractors play in programme implementation, MO must invest in building the capacity of those partners that do not have adequate capacity on PSEA ensuring that its standard Programme Cooperation Agreement (PCA) with civil society IPs includes prohibitions of SEA by vendor personnel.
3. *The MOs should develop and implement its internal protocols including complaint mechanism*.

4. This information will be posted by IPs at all health facilities, with the understanding that reporting is not optional and failure to report is a violation of the MOH recommendations.

5. Engage and Inform Communities
   - Establish community-based compliant mechanism
   - Conduct PSEA awareness campaigns in the community

[2] Since the time of the original report, UNICEF has significantly scaled efforts at the global, regional and country level related to PSEA systems. However, the scope of the partial update of this document did not include a complete revision of content.

8. CONCLUSIONS AND RECOMMENDATIONS

From the assessment, the region still faces several challenges that directly affect service delivery including health. The continuing conflicts, which are both ethnic and political, pose a threat to service as the resources meant for service delivery are diverted to contain the conflicts. The ethnic clashes that are constant in 10 states and 3 administrative areas further complicate service delivery. The women and children suffer most in the conflicts where children are abducted, and women face the brunt of gender-based violence in form of rape and battering. In the face of conflict, people continue moving from place to place and providing services is further constrained.

The assessment analyzed and concluded that the project activities will generate considerable social benefits to the communities, though it may not meet all the health needs. The assessment has also established a number of social consequences that the project activities are likely to induce albeit on a small and localized scale. In this regard, it is possible to mitigate these negative impacts as long as the recommendations given in the Social Development and Monitoring Plan are implemented. This is in line with the efforts of the Government to improve the health care of the population.

This assessment finds that HSTP is expected to produce considerable benefits that include adequate access to health services, improved access to health facilities for women, internally displaced persons and other vulnerable groups; reduced maternal and child morbidity and mortality rates; provision of quality health services; and procurement of pharmaceuticals. The potential negative impacts if adequate mitigation measures are not put in place include elite capture and other social ills. It is, therefore, necessary that the actions set out in this report be integrated into the project and for monitoring to be carried out to ensure compliance.

However, to realise maximum benefits, community structures where there is reasonable stability should be strengthened especially the women groups to address issues of GBV and nutrition. Mechanisms should also be put in place for rapid response in conflict prone areas to address emergencies. Infrastructure and resources also require serious consideration, but this will have to be carefully assessed and efficiently managed, including with the support of other stakeholders given the scarcity of resources. Without appropriate infrastructure such as cold chains, stores for medicines, hospital beds, wards, and human resources, service delivery becomes difficult.

In the context of the social vulnerabilities, the new project design is intended to deliver an agile mix of static primary healthcare services that are complemented by regular integrated outreach (especially during the dry season) to increase and expand equitable coverage and access, especially for mobile or hard-to-reach populations with intermittent periods of stability and access. These frontline interventions will be supported in specific areas with the rolling out of community-based health services, such as the Boma Health Initiative (including integrated community case management), to bolster community resilience and basic services provision, even while communities are exposed to shocks and cannot be accessed. This, combined with emergency preparedness and response, will ensure service continuity. Moreover, innovative new cold chain devices (such as the Arktek cold box) will be used to bolster last-mile delivery of safe, potent vaccines at service delivery points. It will also be essential to make additional efforts to address the plight of women and child survivors and that life-saving services be extended to improve accessibility. MO under the guidance of the MOH will work closely to ensure an integrated approach to improve the well-being and safety of women and children through administration of clinical management of rape services, access and provision of confidential and sensitive health services to survivors of all forms of GBV. In summary, the three main strategies will be

a. Directly supporting service delivery: under the supervision of MOH, SMoH and CHD officials, MO will support IPs (NGOs) with technical assistance, supplies, and financial support, as part of overall capacity development to strengthen the delivery of basic health services to children and women, with priority given to the poorest and most marginalized communities. This will entail a mix of national and international NGOs identified through an open selection process.
b. Enhanced routine integrated outreach: Health teams attached to health facilities will be supported to expand coverage and access to health services in areas with intermittent periods of stability and access. This would provide a broader package of services more systematically to locations outside the catchment areas of the fixed/functional health facilities and within displaced populations,

especially where there is a deficit of health and nutrition services. These integrated outreach services will be provided monthly where possible.

c. Advancing community health: Targeting communities far away from existing health facilities, through the Boma Health Initiative, a network of trained BHWs will be responsible for delivering a standard package of community health services. Delivered at the household level, these services will also focus on health education and promotion of Child Health, Safe Motherhood, and basic Community Surveillance, along with community engagement and social mobilization (e.g. during campaigns when outreach services are available).

All activities described in this document will be implemented under the guidance of MOH taking respective responsibility to ensure outcomes as outlined above, including for sub-contracted parties. The necessary resources will be as guided by approved HSTP budget or mobilized from other resources from MoH, subject to availability. MOs will regularly report to MoH on performance and eventual incidents in case necessary, and thus provide transparent information on the implementation of measures and related achievement of targets as noted in this Social Assessment.

REFERENCES

Ministry of Health (2015), *2015 Household Health Survey using Lot Quality Assured Sampling*
Ministry of Health (2016), *South Sudan, Health Sector Development Plan 2012–2016*
Ministry of Health (2017), *Health Management Information System Report for 2016*
Ministry of Health (2018), "Social Assessment (SA) Report for Rapid Results Health Project (RRHP)"
Ministry of Health South Sudan (2024) Health Sector Transformation Project, Gender Based Violence (GBV)/Sexual Exploitation and Abuse (SEA) Action Plan.
Ministry of Health South Sudan (2023) Health Sector Strategic plan.
Norwegian Refuge Council (2017) Fact Sheet South Sudan Country Programme Fact Sheet

ANNEXES

ANNEX 1: STAKEHOLDER ANALYSIS (based on secondary data analysis and consultations)

Stakeholder	Interests	Effect of project	Importance of stakeholder	Degree of involvement in the project
Government				
Ministry of Health	Service delivery and governance		Critical player	Authorization, political support, mobilization and supervision
Government healthcare facilities	Providing services	Positive as it improves people's livelihoods	Critical player	
Relief and Rehabilitation Commission	Coordination of efforts of IPs/NGOs.	Positive as it supplements its efforts	Critical player	Government Arm of coordinating Development partners. Strengthened coordination can improve service delivery.
International organizations				
World Bank	Donor		Critical player	Supporting the HSTP 2024 - 2027 in the country including the 3 administrative areas.
UNICEF	Project implementer		Key actor	UNICEF is critical in Health, Nutrition, and WASH.
WHO	Partner		Key actor	WHO is Management Organization for the Health Systems Strengthening (HSS) component of the HSTP
IOM	Partner			Runs clinic at Malakal PoC
UNHCR	Partner			Supports healthcare projects among refugees and other persons of interest in 10 states project with IMC, DRC and Relief International
NGOs				
Save the Children		Positive as it improves people's lives	Critical player	Nutrition to children and mothers, WASH, Outreach.
Lutheran World Federation		Positive as it supplements its efforts.	Very Important	Has IPs and experience in the former 10 states state. It has church roots and also engages in agricultural production as it has a big membership
Oxfam		Positive as it supplements its efforts.	Critical player	Global experience
ACTED				Small-scale health projects with refugees in Upper Nile
MSF				Providing decentralised medical outreach services to some of the most isolated places in the region from its main hospitals in the state

Interchurch Medical Assistance (IMA)	Possible IP	Positive as it improves people's livelihoods	Critical player	Subcontracts NGO partners as lead agencies in 5 counties, which support County Health Departments and all PHCCs and PHCUs in that county. IMA provides additional support to an NGO to support the county hospital in Duk. The remaining counties are served in partnership with CHDs.
NHDF (Uror Akobo), CMA(Nyirol Fangak),SMC (Bor Duk (later reassigned to CHD), JDF(Duk CH) and IMC (Akobo CH)		Positive as it improves people's livelihoods	Critical player	IPs
Health Link South Susan	Implementing Partner	Positive as it improves people's health	Critical player	Provision of health services, like routine consultations, treatment of general cases, maternity services, vaccinations within the slots allocated for them and in collaborative coordination with the actors in the actors.
Community level actors				
Women and youth groups.	Involved in selection criteria, mobilization of communities, carrying out reaches and sensitization of mothers on sanitation	Positive as such groups make the project more known and appreciated by communities. Have been trusted by people and can help the project to achieve its PDO	Critical player	Community support to the project, positive impact to the vulnerable group, which eliminates elite capture.
Community Nutrition Volunteers	Under UNICEF	Members of the community playing vital role in awareness and sensitization on nutrition mostly to mothers about children	Critical player	Community support and involvement in the project creates awareness.
Community drug distributors	Community health through drug distribution.	Bring medicine close to people and enable the project to help the most vulnerable members of the community	Critical player	Community support and involvement in the project creates awareness. Trained in assessing signs and symptoms of malaria and high fever and provided with basic equipment and patient registers
Internally displaced persons outside POCs	Beneficiaries	Crucial for meeting needs (as long as they can access primary healthcare services)	Beneficiary	Beneficiary
Internally displaced persons inside POCs	Beneficiaries (though also receiving healthcare from POC clinics outside the RRHP)	Beneficial as strengthening general healthcare in project areas	Partial beneficiary	Partial beneficiary
Persons with disabilities and elderly persons	Beneficiaries, generally requiring additional levels of healthcare support	Crucial for meeting needs (as long as they can access primary healthcare services)	Beneficiary	Beneficiary

Annex 2: Key Indictors from Health Sector Performance Review South Sudan 2023

Indicators	Abyei	CES	EES	Jonglei	Lakes	NBGS	GPAA	Ruweng	Unity	UNS	Warrap	WBGS	WES	South Sudan
Antenatal care coverage at least four visits (%)	40%	17.7%	14.2%	13.3%	19.1%	28%	8.6%	35.8%	40.6%	22.8%	27.2%	30.1%	34.8%	22.4%
Percentage of women deliveries with skilled birth attendants	10.5%	19.3%	14%	5.7%	17.1%	19.2%	8.6%	38.6%	23.1%	17.6%	17.8%	32.3%	48.2%	18.7%
Coverage of Penta -1	65.1%	91.6%	107%	58.3%	111.4%	125.4%	82.4%	129.6%	153.2%	98%	134.3%	101.5%	154.8%	107.3%
Coverage of Penta -3	50.8%	81.3%	107%	44.3%	96.7%	125%	56%	114%	130%	88.5%	129.5%	87%	135.5%	96.8%
Measles vaccination coverage	39.3%	68.7%	116%	38.7%	76.8%	93.2%	113.3%	73.9%	117.6%	68.9%	159.3%	65.9%	110.6%	89.3%
Percentage of patient with suspected malaria who received a parasitological test & treated	0%	84%	86.4%	58.6%	87.2%	49.5%	67.8%	59.2%	61.9%	71.9%	54.1%	76.6%	90.8%	71%
Number of SGBV survivors treated with assault	22	287	702	89	25	367	47	25	324	123	62	84	332	2489
Boma's health initiative coverage	0%	35.5%	43%	50.4%	67.1%	41.4%	20.6%	59.9%	31.2%	26.9%	77.3%	31.5%	64.8%	44.3%
Maternal death review	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Source: DHIS 2

The recent Government population projection for 2024 (Figure 1) shows South Sudan has large population ratio between age 10 – 29.

Annex 3: Indicators in HSTP – Result Framework (Source: Draft of HSTP Result Framework)

Indicators	Basline		Targets			Data Source	Timeline
			Year1	Year2	Year3		
Impact Indicators (Health Status)							
Maternal mortality ratio	1,223	UN MMEIG (2020)	1033	938	843	Survey	End of the project
Under five years' mortality rate (per 1000 live births)	98.69	UN IGME (2021)	80	70	60	Survey	End of the project
Children under 5 years who are wasted	16.10%	FSNMS 27	13	12	11	Survey	End of the project
Outcome Indicators (Service Coverage)							
Contraceptive prevalence rate (any method)	6%	UNFPA	8%	9%	10.50%	Survey	End of the project
Antenatal care coverage at least four visits (%)	20%	DHIS2 (2022)	37%	44%	52%	DHIS2	Quarterly
Births attended by skilled birth personnel	19%	DHIS2 (2022)	29%	36%	43%	DHIS2	Quarterly
Number of Gender based violence (GBV) survivors who received health care service	NA	DHIS2 (2022)	TP	TP	TP	DHIS2	Quarterly
Immunisation coverage rate Pentavalent 1	76%	WHO/UNICEF estimate 2022	80%	85%	90%	DHIS2 (2022)	Quarterly/Annual
Immunisation coverage rate Pentavalent 3	73%	WHO/UNICEF estimate 2022	75%	80%	85%	DHIS2 (2022)	Quarterly/Annual
Measles (MCV1) immunisation coverage	72%	WHO/UNICEF estimate 2022	75%	80%	85%	DHIS2 (2022)	Quarterly/Annual
Percentage of children aged <59 months receiving Vitamin A supplements twice a year	NA	WHO/UNICEF estimate 2022	87%	88%	85%	DHIS2 (2022)	Quarterly/Annual
Intermittent prevention of malaria during pregnancy (IPTp≥3)	11%	DHIS2 (2022)	35%	55%	75%	DHIS2	Quarterly/Annual
The proportion of patients with suspected malaria who received a parasitological test (RDT/Microscopy)	71%	DHIS2 (2023)	75%	85%	95%	DHIS2	Quarterly/Annual
Proportion of alerts investigated in 48 hrs	81%	EWARS (2023)	75%	85%	95%	EWARS/DHI	Quarterly
Proportion of health facilities that have a core set of relevant essential medicines and commodities available and affordable	73%	MOH Report	77%	79%	81%	DHIS2	Quarterly/Annual
Percentage of facilities reporting stock out of tracer commodities (medicines and laboratory reagents)	27%	MOH Report	25%	24%	22%	eLMIS/DHIS2	Quarterly/Annual
Completeness of reporting by facilities	41%	DHIS2 (2022)	60%	70%	80%	DHIS2	Quarterly
Birth registration notification coverage	0.40%	DHIS2 (2022)	2%	5%	10%	DHIS2	Quarterly
Joint supportive supervision	NA		50%	65%	85%	DHIS2	Quarterly
Percentage of SMoH/CHDs with work plans aligned to the HSSP	NA		50%	65%	85%	MOH Report	Annual
Percentage of MoH budget implemented (Budget execution rate) (PDO)	96%	MoH/MoFP report	97%	98%	99%	MoH/MoFP report	Annual
Percentage of states that conducted quarterly coordination meetings with a review of data and documented with minutes including action items and follow-up	NA		50%	60%	70%	MOH Report	Annual
Output Indicators (Access to health services)							
General service availability score	30.40%	SARA 2018	38%	42%	46%	Survey	End of the project
Number of People who have received essential health and nutrition services [disaggregated by sex and age]	NA					DHIS2	Quarterly
BHI Coverage (PDO)	16%	MOH Report (2022)	20%	25%	32%	DHIS2	Quarterly/Annual
Percentage of health facilities that have access to water, sanitation, waste management, and solar electricity/power.	NA					Survey/DHIS2	Annual
Maternal death review coverage (%)	NA		45%	50%c	55%	MOH report	Quarterly