PROJECT DOCUMENT

Project Title: Grant Cycle 7: Integrating Services for Maximum Impact

Project Number:

Implementing Partner: UNDP
Start Date: 1 January 2024 **End Date:** 31 December 2026 **PAC Meeting date:** CCM Review and Endorsement Process throughout 2023 including Funding Request, Grant Making, Signature

Brief Description

The Republic of South Sudan became the world's newest nation and Africa's 55th country in July 2011. However, civil war and ongoing conflict particularly in Decemer 2013 and July 2016, have worsened the humanitarian situation, leaving much of the population dependent on aid for their survival. South Sudan is one of the poorest nations in the world, placed at 191 of the 191 countries on the Human Development Index in 2022 (UNDP, 2022) and it is rated third on the Fragile States Index.

The HIV epidemic continues to be a considerable public health burden in South Sudan. By the end of 2022, South Sudan continued to have a generalised HIV epidemic, with some significant variations in prevalence and burden of disease by age, population and location. By December 2022, South Sudan continued to have a generalized HIV epidemic, with some variations in the prevalence and burden of disease by age, population and location. For 2022, the Spectrum model estimated an adult (15-49 years) HIV prevalence of 2.1%, ranging from 1.6% among adult males to 2.5% among adult females. According to WHO estimates, the incidence of all forms of drug-susceptible TB (DS-TB) was 227 per 100,000 population in 2021 (24,000 cases) while the incidence of drugresistant TB (DR-TB) was 5.1 per 100,000 population (550 cases). There were an estimated 3,960 TB-related deaths in 2021. However, there is no recent TB prevalence survey; hence, these estimates have remained relatively constant since 2011.

The Global Fund Grant Cycle 7 (GC7), building on the progress made under the the New Funding Model 3, (NFM 3) and in alignment with the Revised South Sudan National HIV and AIDS Strategic Plan 2024-2026 will be guided by the following vision, goals, thematic areas, strategic directions, and strategic outcomes. Mission: Ending Inequalities and Getting on Track to End AIDS in South Sudan by 2030: Vision: An AIDS-free South Sudan by 2030: Goals: By 2026, reduce new HIV infections by 25% from 2022 (11,189); by 2026, reduce AIDS-related deaths by 25% from 2022 (7,125); by 2026, reduce HIV-related discrimination and other inequalities towards PLHIV by 10% from 2022.

This will be made possible by consolidating and integrating HIV and TB services through differentiated service delivery strategy with dual emphasis on mixed facility-based and community-led interventions in estimated current 200 functional facilities. The interventions entail full integration of HIV, TB and other disease programmes; enhancing the roles of PLHIV, TB survivors and community networks including boma health workers in health facilities and communities; mobile TB/HIV services and community-led treatment services; taking full advantage of resilient and sustainable system funding to calibrate all aspects of health system strengthening (HRH, HMIS, PSCM, laboratory system and diagnostics), and ensuring that implementing partners are closely monitored and coordinated with the Ministry of Health. In addition, the C19PO has provisions for strengthening support for GBV and address human rights barriers. It is integrated within existing GC7 grant for HIV, TB, Malaria and RSSH; implementation period is aligned considerably (i.e. 2024-2025) and the interventions are meant to be implemented using existing Global Fund structures to the greatest extent feasible.

Contributing Outcome (UNDAF/CPD, RPD or GPD): Outcome 3: Children, women and men in South Sudan, particularly youth and vulnerable groups, enjoy improved coverage of inclusive, responsive, quality social services and social protection Indicative Output(s) with gender marker[2]: GEN 2	

Total resources required:	**US$83,921,204**	
	UNDP TRAC:	**US$465,000 (2024)** **US$300,000 (2025)** **Total: US$765,000**
	Donor:	**Revised Amount: US$83,156,204** **(Initial Amount US$90,682,856)**

Agreed by (signatures):

Government	UNDP
Hon. Sarah Cleto Rial Minister of Health Republic of South Sudan	**Dr. Aouale Mohamed Abchir** Resident Representative UNDP South Sudan
Date:	**Date:**

MINISTRY OF HEALTH
29 JUL 2025
MINISTER'S OFFICE
REPUBLIC OF SOUTH SUDAN

United Nations
Development Programme
South Sudan
UNDP

I. DEVELOPMENT CHALLENGE

Background and rationale for the Programme

In 2011, the Republic of South Sudan achieved independence to become the 55th country on the African continent. However significant civil, political, socio-economic and environmental challenges have substantially curtailed or reversed the health and development gains that were anticipated since that time. As a result, over a decade later, the country struggles to move out of deeply entrenched fragility and instability leaving much of the population struggling to obtain or sustain the basic necessities of survival. While the signing of a peace agreement in 2018, and subsequent progress on governance reform, recovery, and peacebuilding, has begun to move the country forward, a serious humanitarian crisis continues to affect more than half of the country's population of approximately 12 million.

By December 2022, some 8.9 million people were in immediate need of humanitarian assistance (UNOCHA 2022a). Climate shocks (flooding, drought, locust infestations) and the disruptions brought by the COVID-19 pandemic have added to these burdens and threaten to reverse tentative gains. The humanitarian response plan for South Sudan for 2023 aims to reach 7 million individuals at an estimated cost of US$1.7 billion (UNOHCA 2022b). South Sudan is the third largest response globally after Syria and Yemen). During 2023, as many as 7.8 million individuals were expected to be in immediate need of emergency food assistance making this one of the largest scale food security emergencies globally (IPC 2022).

Despite increasing revenues from expanding oil production, public expenditure in key sectors such as health remains limited at between 1%-2% of the national budget (World Bank 2022). Although budgets are approved, funds for implementation are rarely disbursed other than for infrequent payment of salaries and for some operational costs. The health sector is predominantly externally funded. The COVID-19 pandemic, and the resulting global economic shocks, particularly the sharp decline in oil values, has created new obstacles to progress. The county remains heavily indebted with debt servicing requirements frequently taking priority over other needs for use of public resources. Some initial progress has been made to revive and strengthen public sector financial management; however, full recovery of the public sector to any minimal level of functionality, including for the public health sector, is considered to be a longer-term goal (ten years or more, for example) (World Bank 2022).

The health system is decentralized and based on four levels: community level primary health care units; primary health care centers; county and state hospitals; and national referral hospitals. Although expansion of health service delivery points was made, the proportion of the population living within 5 km of facility remains low at 44%. There is a critical shortage of qualified human resources for health (HRH South Sudan has a critical shortage of qualified health workers; the estimated health workforce (doctors, nurses and midwives) density is 3.5 per 10,000 population (compared to the 44.5/10,000 recommended by WHO). Staff morale is very low and there is a very high turnover of staff from the national programs.

To address some of these challenges, the country launched the Boma Health Initiative (BHI) in March 2017, the government's flagship strategy for community-based primary healthcare, with the aim to improve access to essential health services. The BHI is alsodesigned to standardize the package of community health services, strengthen linkages between communities and primary health facilities, and improve community ownership and governance of health services. It is intended to replace and harmonize the delivery of fragmented community health services which are currently supported by nongovernmental organizations (NGOs) with funding from different donors.

Figure1: Map of South Sudan



Epidemiological Context

By December 2022, South Sudan continued to have a generalized HIV epidemic, with variations in the prevalence and burden of disease by age, population and location. For 2022, the Spectrum model estimated an adult (15-49 years) HIV prevalence of 2.1%, ranging from 1.6% among adult males to 2.5% among adult females. Further disaggregated data on age and gender were not available. According to the 2021 ANC Sentinel Surveillance Survey, HIV prevalence amongst women attending ANC was highest in the Western Equatoria, Lakes and Central Equatorial States, at 7.1%, 3% and 2.7% respectively, and lowest in Upper Nile, Jonglei and Warrap states, at 0.4%, 0.3% and 0.2%, respectively (MOH 2022e). Other data from the survey showed that HIV prevalence increased from 1.1% among 15-19-year-olds to 4.7% among 30-35-year-olds, a period that marks peak child-bearing years for women in South Sudan.

By the end of 2022, it was estimated that there were 164,453 PLHIV in South Sudan ofwhich 13,600 (8.5%) were children (0-14 years). Approximately 61% of all adult PLHIV were female. New HIV infections have continued to increase year-over-year. Between 2010 and 2021, new HIV infections increased by 21%. In 2022, there were an estimated 10,932 new HIV infections (all ages), 1,530 (14%) among children (0-14 years). Among all new adult HIV infections, 6,122 (56%) occurred among females. The annual rate of AIDS-related deaths has slowed over recent periods. In 2021, there were an estimated 7,359 AIDS-related deaths (all ages), 1,400 (19%) among children (0-14 years). With regard to South Sudan's progress against the global 95-95-95 targets by December 2022, it was estimated that 39% of all PLHIV knew their HIV status and that 32% were enrolled on ART (82% of all PLHIV who knew their status). Viral load coverage reached only 55% of PLHIV on ART in 2022. Of this group, 84% achieved viral suppression.

According to WHO estimates, the incidence of all forms of drug-susceptible TB (DS-TB) was 227 per 100,000 population in 2021 (24,000 cases) while the incidence of drug resistant TB (DR-TB) was 5.1 per 100,000 population (550 cases). There were an estimated 3,960 TB-related deaths in 2021. However, there is no recent TB prevalence survey; hence, these estimates have remained relatively constant since 2011. As a result of the lack of populations data, the true TB burden for the country is not accurately known. The many challenging features of the country context, highlighted above, constitute 'ideal conditions' for the rapid expansion of the TB burden, meaning that it may be considerably higher. With increases in coverage and uptake of TB and HIV/TB services, TB-related mortality has been declining in South Sudan. In 2021, TB related mortality was estimated at 28 per 100,000 population (approximately 3,000 TB related deaths in 2021).

Among detected cases in 2021, the treatment success rate (TSR) was 83%. The proportion of bacteriologically confirmed TB cases reached only 49% of new and relapsed cases, indicating the ongoing challenges for the accessibility of diagnostic technology in the country, including GeneXpert, despite the expansion of the diagnostic platform in recent years. As with other health programmes, the strength and achievements of the TB Programme are greatly affected by broader health system trends. Weak health systems, along with persistently unmet funding needs for the TB response, have greatly impeded progress. HIV and TB diagnosis and treatment have not been fully integrated in all functional facilities.

Gender and Human Rights Concerns

Gender inequality is a key driver of the AIDS epidemic in South Sudan. Unequal power dynamics between men and women and harmful gender norms increase the HIV vulnerability of women and girls in all their diversity, deprive them of voice and the ability to make decisions regarding their lives, reduce their ability to access services that meet their needs, increase their risks of violence or other harms, and hamper their ability to mitigate the impact of AIDS. These social, cultural, behavioural and economic disparities manifest in South Sudan where women have higher HIV infection rates—HIV prevalence amongst women is 2.9 [2.2 - 3.6] and 1.7 [1.3 - 2.2] amongst men.

Although the Transitional Constitution guarantees equality before the law and gender equality, in practice women and girls face discriminatory customary practices and traditions which often discriminate against women. For instance, in the customs of most South Sudanese communities, in case of death of the husband, the widow is not entitled to inherit the husband's property unless she accepts to be inherited by one of the husband's close relatives. These discriminatory customary practices are used by customary courts to deprive widows of the right to share in their husband's estate. The customs are premised on the belief that the woman, after payment of dowry, is the property of her husband and, therefore, does not have the right to inherit. However, she can be inherited, as property, with or without her consent.

Levels of sexual and gender-based violence are extremely high. Studies indicate that some 65 per cent of women and girls have experienced physical and/or sexual violence in their lifetime, and some 51 per cent have suffered intimate partner violence (IPV). Some 33 per cent of women have experienced sexual violence from a non-partner, primarily during attacks or raids. The majority of girls and women experience sexual violence for the first time under the age of 18. Children comprise around 25 per cent of all reported cases of conflict-related sexual violence, though there are concerns numbers may be much higher. Communities consistently cite sexual violence as the greatest protection concern for women and girls. Intimate Partner Violence (IPV) remains the most common form of GBV, which means women and girls are most at risk in their own homes, from their husbands and other family members.

The interventions proposed seek to address gender inequality and gender based violence by engaging with community, religious and opinion leaders on gender-based violence, harmful gender norms and traditional practices and by supporting women's groups to raise awareness of HIV and TB-related rights and to monitor violations and advocate for change.

Stigma, discrimination and other human rights violations in the context of HIV both reflect and drive the inequalities that undermine the HIV response. Everyone, including people living with and affected by HIV, should enjoy human rights, equality and dignity. The prevalence and effects of discrimination are often particularly severe for members of key populations, who face multiple, overlapping forms of discrimination. The levels of HIV-related stigma and discrimination in South Sudan are disturbingly high across diverse settings. In the most recent PLHIV Stigma Index Survey, half of the respondents (50%) – 72% of which were female – had experienced some direct or indirect forms of stigma and discrimination. Most respondents felt that stigma and discrimination against PLHIV was largely motivated by lack of correct knowledge and fear of infection. HIV was known by many in communities but known in negative and derogatory terms. Approximately two-thirds (60%-70%) of survey respondents had disclosed their HIV status, however only 30% had done so in family settings. More than half experienced self-stigma, in the form of shame and guilt about their HIV status, and a similar proportion indicated that fear of stigma and shame prevented them for seeking an HIV test earlier in the course of their illness.

KPs (FSW, MSM and transgender) also face stigma and discrimination in health care facilities and in the broader community. The NSP recognises MSM as a priority population and the need to provide HIV services that cater to the needs of KVP, including MSM. Despite this only 26% of MSM with HIV were reached with HIV prevention programs -defined package of services. An estimated 50% of MSM avoid seeking HIV-related health care because of stigma and discrimination.

FSW face stigma and discrimination at the hands of health care workers and police use possession of condoms as evidence of engaging in sex work and arrest FSW merely for being in possession of condoms. Instances have been reported of arrested FSW being forced by police to disclose their HIV status to the police or to undergo and HIV test.

Legal literacy on the part of PLHIV and KPs remains low. Current legal literacy interventions are extremely limited and focus primarily on FSW. Access to legal services is limited. FSW and other KPs experience difficulties in accessing legal advice or representation as there are few lawyers who are prepared to assist, particularly on a pro bono basis.

Recognising that community-led HIV responses have a crucial role to play in efforts to end AIDS the proposal includes interventions that seek to address stigma and discrimination will be scaled up through community and peer mobilisation and legal literacy will be scaled up with a focus on peer educators. New interventions will be implemented to train health care workers on human rights and to support CLM of service delivery. New interventions to increase access to justice will link CLM to legal support and the training of peer paralegals and law enforcement practices will be addressed through new interventions to provide HIV, TB and human rights training for law enforcement and CLM of policing practices. Engagements with parliamentarians will continue to increase their understanding of the role of human rights in an effective HIV and TB response and interventions will be introduced to support community led organisations of MSM and FSW to advocate for law reform to remove legal barriers to an effective HIV and TB response.

Pandemic Preparedness in South Sudan

Pandemics and large-scale disease outbreaks can claim millions of lives, disrupt societies and devastate economies. When the COVID-19 pandemic emerged, the Global Fund quickly established the COVID-19 Response Mechanism (C19RM), through which it has awarded over $63 million to South Sudan to date **(**$59,960,298 to UNDP and over $3 million to UNICEF), to support South Sudan to respond to COVID-19, mitigate the pandemic's impact on HIV, TB and malaria programs, and strengthen health systems.

As the pandemic context evolves, the Global Fund has strategically shifted focus to best serve the countries and communities supported. In Decemnber 2022, the Global Fund allowed South Sudan to be reinvest the C19RM resources in strengthening health systems and bolstering pandemic prevention, preparedness and response in five priority areas:

- Human resources for health, including community health workers and community systems
- Laboratory systems.
- Supply chains and waste management.
- Early warning surveillance and response.
- Oxygen and respiratory care systems
- Partnering with the communities services in order to maximize health equity and ensure a focus on gender equality and human rights

The Global Fund's 2023-2028 Strategy "Fighting Pandemics and Building Healthier and More Equitable World" responds directly to the dramatic changes in the global health context.

For the current allocation which is $23 million for the C19RM Portfolio Optimization (PO), please refer to a separate PRODOC on the C19RM grant (please note that the $23 million is part of the overall C19RM allocation to South Sudan mentioned above).

II. STRATEGY

Grant Cycle 7: Integrating Services for Maximum Impact
The grant builds on the achievements of the New Funding Model (NFM3) HIV/Resilient and sustainable systems for health (RSSH) and TB grants and provides integrated support to the two diseases and building resilient and sustainable systems for health for pandemic preparedness and response. The grant aims at providing comprehensive HIV and TB services across South Sudan, while creating resilient and sustainable systems for health to address any future pandemic. This will be achieved through the following strategies:

Module 1: Prevention Package for Sex Workers, their Clients and Other Sexual Partners
During 2021-2023, interventions for sex workers were provided in 16 locations (Bor, Kapoeta, Kuajok, Juba, Maban, Malakal, Maridi, Nimule, Nzara, Rumbek, Tambura, Torit, Wau, Yambio, Yei and Yirol). PEFPAR supported 6 locations, the Global Fund 10 locations. Clients of sex workers (military, boda-boda riders, truck drivers, others) were also reached in these locations. During 2021, there were 23,253 encounters with sex workers and clients who received a package of interventions, including HTS, provision of condoms and lubricants, sexual and gender-based violence (SGBV) support (including for intimate partner violence [IPV] prevention and response), family planning (including cervical cancer screening), referrals for STI services, distribution of PEP kits, referrals for ART, peer navigation and treatment adherence support. For sex workers on ART, some locations convened support groups, provided nutrition support and organised home-based care where needed. During the GC7, PrEP will be added to the package of interventions in selected locations (Juba and Wau). During the 2024-2026 grant cycle, these interventions will be continued and expanded in these locations through increasing the number of peer outreach workers and scaling up efforts to remove human rights barriers. A legal literacy package was developed during 2022 and will be rolled out in two locations in 2023. Legal literacy interventions will be scaled up in 2024 to reach all locations in 2026. New components to reduce stigma and discrimination, increase access to justice, and promote community empowerment will be added to the intervention package.

It is expected that by 2026 at least 70% (21,500/30,000) of sex workers in the 16 locations will be reached with a comprehensive package of interventions, including stigma and discrimination reduction and legal literacy, as integrated components of the package. The aim is also to boost the proportion of sex workers having tested for HIV in the past 6 months to at least 80%, and the proportion of sex workers having used condoms during their last sexual encounter to at least 70% (from the 2019 baseline of 35%). 50% of the estimated number of sex workers to be reached will be with Global Fund resources, the balance through increased investment from PEPFAR. The interventions are:

1.1. Condom and lubricant programming for sex workers ☒ Continuation
1.2. Pre-exposure prophylaxis (PrEP) programming for sex workers
1.3. HIV prevention communication, information and demand creation for sex workers
1.4. Community empowerment for sex workers
1.5. Sexual and reproductive health services, including STIs, hepatitis, post-violence care for sex workers
1.6. Removing human rights-related barriers to prevention for sex workers

Module 2: Prevention Package for Other Vulnerable Populations (OVP)
The populations covered under this module are populations of humanitarian concern (refugees in camps settings and internally displaced people [IDPs] residing in Protection of Civilian [POC] facilities), and at-risk adolescents and young people. While uniformed services are currently considered a vulnerable population for HIV and TB in South Sudan, HIV-related programming is supported under PEPFAR. During the 2021-2023 grant cycle, combination HIV prevention interventions for IDPs and refugees were supported in Bentiu, Maban, Malakal, Wau for an estimated population of 299,000 in these settings. A component of the package included demand creation for HTS in facility-based and community-based settings. During 2021, 9,225 individuals underwent HTS with 263 (3%) diagnosed HIV-positive and linked to ART.

As of December 2022, there were 53,000 IDPs living in POC sites across the country (OCHA 2022a). A further 319,000 refugees were staying in camps along border regions with Central African

Republic, Democratic Republic of Congo, Sudan and Uganda (an estimated 2.26 million South Sudanese were in refugee camps in neighbouring countries). Approximately 50% of this total was housed in settings managed by IOM in Bentiu, Maban, Malakal, Wau. Global Fund resources provide HIV-related commodities, training and quality assurance, and reporting tools in these locations supported by IOM. The support will be continued during the 2024-2026 grant cycle. During 2021-2023, using a combination resources from NFM3 and C19RM, UNFPA support institutional capacity development for youth networks to design and deliver combination HIV prevention interventions. These interventions will be sustained and scaled up during 2024-2026. Interventions for IDPs and refugees are expected to encourage 25% (46,500/186,000) to undergo HTS in facility or community setting and to know their results. The following are the approved interventions:

2.1. Condom and lubricant programming for OVP
2.2. HIV prevention communication, information and demand creation for OVP
2.3. Community empowerment for OVP
2.4. Removing human rights-related barriers to prevention for OVP

Module 3: Prevention Package for Men Who Have Sex with Men (MSM) and Transgender Persons and their Sexual Partners

Since 2018, following the interruption of PEPFAR-supported activities for MSM in Juba, including arrests and imprisonment of some participants, formal programming for this group was suspended. Some interventions were proposed under the 2021-2023 allocation period; however, they were included under the PAAR and, as of December 2022, were not funded.

There is no current information on HIV-related prevalence or incidence for MSM in South Sudan. In a 2017 formative assessment, conducted in Juba, Nimule, Torit, Wau, Yambio and Yei, found that five out of 165 participants (3.0%) tested positive for HIV; however, the study sample was too small to estimate HIV prevalence (MOH 2018). The survey was evidence enough that this population continues to exist in South Sudan and that the absence HIV and other sexual health programming leaves it at substantial risk of HIV acquisition as well as other linked sexual health challenges.

Given the absence of engagement with this population since 2018, there is a need to undertake a new formative assessment in such a way as to ensure the safety and security of participants, to re-establish trust, and to re-build linkages before any further programming can be designed and implemented. An existing KP-led CSO and the different social networks it links with will be at the centre of this renewed engagement. The legal and socio-cultural context surrounding same-sex sexualities in South Sudan remains negative and hostile. Individuals from sexual minority communities face daily risks of stigma, discrimination, and physical and sexual violence and abuse according to key informants participating in KP-led activities as part of the Country Dialogue. Across the national HIV stakeholders, there is low level of knowledge and commitment around addressing gender or sexual diversity. This has led to low levels of trust and engagement with this constituency in the national HIV response. The module is linked to interventions under **Module 15**: Reducing Human Rights-related Barriers (legal literacy and access to justice) as well as under **Module 5**: Prevention Stewardship (gender and diversity sensitivity training for national stakeholders).

Module 4. **Prevention Package for People Who Use Drugs (PUD) (injecting and non-injecting) and their Sexual Partners**

There is no current information on HIV-related prevalence of incidence for PUD in South Sudan. No previous efforts have been made to engage this population in the national HIV response, although there is a growing amount of anecdotal information available about the increasing use of a variety of substances across a number of populations groups (in 2022, 35% of sex worker respondents in the mapping study stated they were taking some form of medication to address addiction. No data were gathered on drug use, however [UNFPA 2022]). PUD were part of KP-led efforts to gather information on priorities during the Country Dialogue through which anecdotal information emerged indicating rapidly increasing drug use (in Juba, at least) and a complete absence of programming related either to HIV or to drug use itself.

To address this gap in the HIV response, a KP-led formative assessment will be carried out in Juba during 2024. This will begin to establish some links with this population group and provide information and guidance on how to begin to plan for and roll-out HIV and other health interventions. Based on the results of the assessment, an intervention strategy will be developed. Opportunities

will be sought during reprogramming to implement recommendation interventions during subsequent years. Other partners, such as PEPFAR, will be approached to support programming. This module is expected to result in establishing a pathway for engagement and trust-building with this highly marginalised population in South Sudan. This is expected to form the basis for initiation of prevention and harm reduction programming using modalities that ensure the safety and security of all involved. The interventions are listed below:
3.1. Needle and syringe programs for PUD
3.2. Condom and lubricant programming for PUD
3.3. HIV prevention and harm reduction communication, information and demand creation for PUD
3.4. Community empowerment for PUD
3.5. Removing human rights-related barriers to prevention for PUD

Module 5: Prevention Program Stewardship
Currently, South Sudan lacks critical tools to guide intensified efforts to scale up combination prevention interventions. These include lack of a prevention road-map aligned to the country context and linked to regional and global level targets for HIV prevention and incidence reduction. Guidelines for KP programming, condom programming, social behaviour change communications (SBCC) are not current and do not take account of recent global guidance and emerging best-practice for combination HIV prevention programming. Key questions remain unanswered regarding the acceptability and feasibility of voluntary medical male circumcision (VMMC) beyond the current focussed implementation in three locations for the South Sudan People's Defence Force (SSPDF). Finally, there is currently no operational platform for key prevention stakeholders to convene on a routine basis to lead and guide the national HIV prevention response. By 2026, South Sudan will have significantly strengthened the 'architecture' for a more effective and impact-oriented combination HIV prevention response. Proposed interventions include: 5.1. Prevention Program Stewardship

Module 6: Elimination of Vertical Transmission of HIV, Syphilis and Hepatitis B
Under this module to strengthen and scale up PMTCT, the grant will provide support to home visit by mentor mothers and PLHIV working in communities to increase demand for antenatal clinic (ANC) and PMTCT services and support home visit to homes of lost to follow up HIV positive pregnant women who were on PMTCT. PMTCT services will be scaled up to additional sites, performance-based support to HCWs providing PMTCT services will be provided, and periodic review of the programme performance will be supported by supporting review meetings with mother mentors and supportive supervision and mentoring to PMTCT sites. Trainings will be provided to newly on-board HCWs on PMTCT job aids and SOPs. The expected outcomes are the following: Early infant diagnosis and follow-up HIV testing for exposed infants; NSP target is at least 90% (6,430) of HIV-exposed infants complete routine EID examinations and receive their results; 95% of HIV-positive infants are initiated on ART; 95% of households with infant PLHIV on ART receive comprehensive package of support; Within allocation target is 70% (4,500) of NSP target by 2026; Baseline is 30% (Dec 2022). Retention and support for HIV-positive pregnant and breast-feeding women: NSP target is by 2026 90% (6,430) of HIV-positive pregnant women receive ART to prevent vertical transmission; Within allocation target is 70% (4,500 women) of NSP target by 2026; Baseline is 53% (Dec. 2022). The interventions areas include: 3.1. Integrated testing of pregnant women for HIV, syphilis and hepatitis B; 3.2. Prevention of incident HIV among pregnant and breastfeeding women; 3.3. Post-natal infant prophylaxis; 3.4. Early infant diagnosis and follow-up HIV testing for exposed infants and 3.5. Retention support for pregnant and breastfeeding women (facility and community)

Module 7: Differentiated HIV Testing Services
Over the 2021-2022 period, the MOH and its partners continued to scale-up HTS using a range of modalities. As a result, the proportion of PLHIV estimated to know their HIV status increased from 29% at the end of 2018 to 39% by the end of 2022. This represented 423,163 individuals undergoing HTS during 2022, an achievement that fell short of the NSP target of 540,713, however. By June 2022, HTS was offered in 223 facilities across South Sudan according to the MOH (however, not all facilities were functional and reporting on a continuous basis). HTS is offered by all implementing partners to the national HIV and TB programmes, as well as a number of health system strengthening and humanitarian partners. There are also a limited number of private sector providers offering HTS. Global Fund support is expected to increase the number of PLHIV who no

their status from 39% (64,137/164,453) in 2022 to 55% (95,169/173,033) by 2026. The interventions under this module include:
3.1. Facility-based testing for key population (KP) programmes
3.2. Facility-based testing outside of key population (KP) and adolescent girls and young women (AGYW) programmes
3.3. Community-based testing for KP programmes
3.4. Community-based testing outside of KP and AGYW programmes
3.5. Self-testing for KP programmes
3.6. Self-testing outside of KP and AGYW programmes

Module 8:Treatment, Care and Support
During 2021-2023, HIV services were offered in 170 facilities distributed across the country. This represented only 20% of the approximately 800 health facilities that were functional over that period. During 2021-2023, 80 (47%) were supported by PEPFAR for HIV services only. The remainder were supported under Global Fund to provide integrated HIV/TB services (some PEPFAR sights were supported to provide TB services under Global Fund). An analysis from June 2022 showed that 90% of PLHIV on ART attended 70 (43%) of ART sites; 27 sites had <25 PLHIV on ART, 20 of these <10; 9 reported 0 (zero) PLHIV on ART. This has identified significant opportunities for consolidation and optimisation of ART services given the limited resources available. The following outcomes are anticipated:
1.15,000 adults and children will be newly initiated and retained on ART by 2026 (5,000 per year) to reach 42% ART coverage (73,000/173,033).
2. Retention at 6 and 12 months will improve from 50%-60% to 75% or greater by 2026.
3. Viral load coverage will reach 70% of all PLHIV on ART.
4. Viral suppression will be sustained at ≥85% by 2026.
Further increases in PLHIV on ART will be budgeted under the PAAR (an additional 7,000 PLHIV on ART by 2026 to reach 46% treatment coverage [80,000/173,033]).
The interventions areas include:
3.1. HIV treatment and differentiated service delivery – adults (15 and above)
3.2. HIV treatment and differentiated service delivery - children (under 15)
3.3. Treatment monitoring - drug resistance
3.4. Treatment monitoring - viral load and antiretroviral (ARV) toxicity
3.5. Integrated management of common co-infections co-morbidities (adults and children)
3.6. Diagnosis and management of advanced disease (adults and children)

Module 9:TB/HIV
From the 2022 program review, HIV testing among TB patients was 92% in 2020 and 2021 (MOH 2022b). The program aims to maintain this achievement by ensuring continuous supply of HIV test kits and mentorship on proper recording to ensure HIV status among all TB patients is indicated.

For HIV care among TB patients, the country has maintained their performance, with 95% of TB patients noted to be on ART in 2020 and 2021, against a 100% target in the NSP. However, TSR for co-infected individuals was lower that for individuals with TB only (67% vs 86% for Cordaid in 2021). This was reported to be due to late presentation of these patients to the health system. Since TB program data is not available at case-level to ascertain detailed variables (time between HIV diagnosis and start of ART, for example) it is difficult identify more specific causes. However, though not at programme level, some SRs have a limited proportion of case-based data, and such analyses is possible from these records and this information will be used to support optimisation of TSR fo con-infected individuals. Although the TB and HIV NSPs, and the two programmes themselves, support full HIV/TB integration wherever these services are offered, it has not been fully achieved with PEPFAR-support sites (approximately 80 facilities) continuing to provide TB services only. Another partner (Cordaid or AAA) must co-locate TB services in these facilities to support access to care creating duplications and inefficiencies. As part of the COP23 negotiations (ongoing at the time of proposal development) a solution to this situation was under discussion. There is provision of TPT for PLHIV in the GC7 despite the prioritization of funding for ART and DS/DR-TB treatment. It is expected that scaling TPT roll-out will increase TPT coverage among PLHIV from 9% to 27% by 2026. The identified interventions are:
9.1. TB/HIV--Treatment and care
9.2. TB/HIV--Prevention

Module 10.TB Diagnosis, Treatment, and Care

During the current grant period, by December 2022, the national TB notifications increased from 118 per 100,000 population to 124 per 100,000 population, a modest but important improvement (MOH 2022b). This was the result of mainly passive case finding strategies and almost exclusively facility based as individuals with TB symptoms came forward on their own for screening and diagnosis, or were identified with potential symptoms for TB in HIV services or other health facility entry points. To more limited extent, some community actors, including BHWs, screened and referred individuals in communities. TB services were available in only 144 of the total number of operational facilities (800+) further limiting the ability of the TLBCP to significantly increase screening, case-finding, and TB case notifications. The expected outcomes by 2026 are:Treatment a cumulative number of 70,720 DS-TB cases (60,000 under the main allocation and 10,720 under PAAR); Screening of household contacts for bacteriologically confirmed TB patients will reach or exceed 50%; Bacteriological confirmation of a TB diagnosis using mWRDs will reach or exceed 70% by 2026. The interventions under this module include:

10.1. TB screening and diagnosis

10.2. TB treatment, care and support

Module 11: DR-TB Diagnosis, Treatment, and Care

South Sudan's capacity to screen, diagnose, treat and cure DR-TB has improved over the 2021-2023 period, although with some outstanding challenges and gaps. While the NTLBCP detected an increasing number of cases between 2020-2021 (a trend that was expected to continue for the remainder of 2022), case detection fell short at only 25% of the WHO estimate of 550 cases for 2021. Without a recent drug resistance survey, however, a more stable estimate of DR-TB incidence cannot be calculated.

Increasing the number of DR-TB notifications has been limited by a number of factors, the most important being the suspension of DST at the NTRL due to a prolonged breakdown in the negative pressure system. This is expected to be fully resolved in 2023. Once this occurs, intensive efforts will be made to restore DST services, with activities planned to boost demand for DST and to ensure that sample transportation and results reporting systems can reliability and efficiently process samples and results. This includes improving and optimising sample transport systems to also provide for the full range of baseline investigations required to screen, diagnose and initiation DR-TB patients on treatment. In 2022, the programme review identified that the NTLBCP programme was continuing the 9-month Bdq960-CFZ-LFX-LZD-DLM regimen which was costly and outdated largely because of the gaps in laboratory diagnostic and monitoring capacity. As these gaps are addressed, this regimen will be adjusted to aligned with WHO recommendations. While the programme recorded a high TSR for 2021 (involving DR-TB patients treated starting in 2019), there is a risk that more recent results will be lower, given the effects of the ongoing economic recession. As a result, the NTLBCP has recommended that the package of patient support be reviewed and the monetary portion be adjusted upwards if required. The expected outcomes, by 2026, are the following: 21788 of TB patients will undergo DST; a cumulative 924 individuals with DR-TB will be screened, diagnosed and successfully treated in their communities (using the WHO-recommended regimens); By 2026 100% of individuals referred for DR-TB treatment will complete baseline and follow-up investigations.

The interventions under this module are:

11.1. DR-TB diagnosis/ drug susceptibility testing (DST)

11.2. DR-TB treatment, care and support

Module 12: TB Prevention

In South Sudan, screening for TB disease and initiation of TPT has only been done among PLHIV. Most HCWs are unfamiliar with the recommended algorithm for investigating presumptive TB among HHCs. This is important because its critical that contacts are investigated appropriately to r/o active disease before initiating TPT. The country therefore proposes to initiate and track contact investigation and contact screening, prioritizing HHC of BAC+ pulmonary TB and DR-TB patients. Many activities targeting IPC programming are cross-cutting and feature in the RSSH module, such as waste management, including disposal of expired drugs. However, the NTP would like to propose new interventions targeting IPC practice targeting reduction of TB transmission through respiratory protection particularly within the hospital/clinic environment. These include systematic bi-annual

screening of HCWs for TB through GeneXpert testing and inclusion of IPC module in the integrated revised TB guidelines. The expected outcomes by 2026 are the following: 70% of diagnosed TB patients undergo contact investigation: 70% of identified contacts are screened and referred and at least 70% of HCWs in designated facilities complete biannual screening.

Module 13: Key and Vulnerable Populations (KVP) –TB/DR-TB

Contact screening and investigation (ACF in children)

The sensitivity of symptom screening, especially in children is sub-optimal at 50%.[1] WHO recommends chest-xray screening for child contacts <15 years with human reader interpretation, as most CAD algorithms are not validated for this population. In the absence of this, mWRD tests would aid diagnosis in this population. As such, South Sudan would like to prioritize training of HCWs in gastric aspiration techniques, allowing for use of alternative samples for GeneXpert testing. Child contacts who test negative will then be started on TPT.

Contact screening and investigation (ACF in children):
The sensitivity of symptom screening, especially in children is sub-optimal at 50%.1 WHO recommends chest-xray screening for child contacts <15 years with human reader interpretation, as most CAD algorithms are not validated for this population. In the absence of this, mWRD tests would aid diagnosis in this population. As such, South Sudan would like to prioritize training of HCWs in gastric aspiration techniques, allowing for use of alternative samples for GeneXpert testing. Child contacts who test negative will then be started on TPT.

Many caregivers in South Sudan tend to be women. Given the level of illiteracy and social disempowerment in South Sudan following the prolonged civil war, the level of awareness on TB in general and preventive treatment in particular is quite low. As such, they may lack the resources needed to bring back their child household contacts for TB investigation. It is therefore critical to support such women and children to come back to the health facility for evaluation to r/o active TB disease and start TPT.

TPT in child contacts <15 years:
South Sudan has been offering TPT to PLHIV who screen negative for TB at a small scale. We would like to scale this up to prioritize children < 15 years who are contacts of BAC+ pulmonary TB patients, an at-risk population not offered TPT previously.

Shorter second-line treatment for children with DR-TB:
In line with the country's adoption of 6-month BPaL/M for as the second-line treatment for DR-TB, South Sudan plans to have child-friendly formulations for this regimen.

Active Case Finding among mobile populations:
South Sudan has 3 main refugee camps where primary health services are provided by UNHCR. TB services are typically provided in TGF-supported facilities near the camps. Although there are some TB awareness activities within the camps, these are not regular nor monitored. This at-risk group require targeted ACF activities and would benefit from periodic regular outreach activities using the WHO-recommended algorithm for at -risk populations, which includes use of X-rays for screening and mWRD for diagnosis. The interventions are as below:
13.1. KVP - Children and adolescents
13.2. KVP - Mobile population (migrants/refugees/IDPs)

Module 14: Collaboration with Other Providers and Sectors

In 2020, the SMOH for Central Equatoria (which in includes Juba) reported there were 340 health facilities (private hospitals, medical centres, and clinics), largely in Juba, compared to 486 private facilities across the entire state (Armand et al. 2021). The large scale of private healthcare providers underscores the need to understand and quantify the pathways through which patients access TB services, and that significant engagement with the private sector is critical if the country is to achieve or exceed improved case notification rates.

In 2022, as part of the programme review, it was noted that a number of private facilities are offering microscopy services and sending any AAFB+ individuals to public health facilities for treatment (MOH 2022b). However, these private providers are not linked to the NTLBCP reporting systems. There is no supervision or quality assurance of these services by the NTLBCP. Only 2 private facilities have ever notified any TB cases, and these two have been equipped with GeneXpert machines. While the NTLB CP has intended to undertake a mapping of private sector provision of TB services (including private laboratories), by June 2022 this had not been completed. As a result, there is no information on the number of individuals who seek TB-services in the private sector nor on the number of private providers that offer TB services. This includes companies such as those working in the oil and gas industry, whether or not they support employees, and their dependents should they acquire TB. All of these constitute significant missed opportunities for increasing access to TB services through increased engagement and partnership with the private sector. While the country has a plan to develop a comprehensive national policy on engagement of the private sector (Module 16), it is critical that the TB program develop a public-private-mix (PPM) framework of engagement with the private sector urgently, with prioritization of Central Equatoria state.

The community component of the national TB response is divided between BHI workers and other community actors, including PLHIV working as community counsellors, community volunteers and mentor mothers/ fathers. Cordaid and AAA, the SRs implementing TB activities, have provided training to BHI workers on TB prevention, health promotion, contact tracing, adherence and treatment follow-up support. As of June 2022, there were approximately 100 BHI workers integrating TB-related activities into their broader health promotion roles. There is more limited engagement of community actors through community-based/community-led responses. To complement scale up of the BHI, the NTLBCP will intensify its partnerships with community actors to increase the number of CSOs supporting the national TB response. Through private partner engagement, South Sudan hopes to increase the number of private providers reporting on DHIS from 2 to 20 by the end of 2026, having developed a PPM strategic plan and engagement framework. Though it seems a modest target, it is a feasible projection, given the challenging environment and that this would be complementary to the RSSH modules. The intervention areas are as below:

14.1. Private provider engagement in TB/DR-TB care
14.2. Community-based TB/DRTB care

Module 15: Reducing Human Rights-related Barriers to HIV and TB Services

The national strategic plans for HIV and TB identiy that stigma and discrimination constitute key structural drivers and barriers to effective HIV and TB prevention and control for South Sudan (MOH 2022f, SSAC 2023). In 2019, for example, half of the respondents – 72% of which were female – to the HIV Related Stigma, Discrimination, Human Rights and Vulnerability Survey: The Republic of South Sudan had experienced some direct or indirect forms of stigma and discrimination (SSNeP+). Approximately two-thirds of respondents had disclosed their HIV status; however, only 30% had done so in family settings. More than half experienced self-stigma, and a similar proportion indicated that fear of stigma and shame prevented them for seeking an HIV test earlier in the course of their illness. This high level of stigma and discrimination may deter individuals from seeking to know their status and for those diagnosed HIV-positive, from enrolling and sustaining themselves on ART. Although the data is five-years-old, given limited investments in interventions to reduce HIV-related stigma and discrimination since that time, these results are not likely to have changed (a new PLHIV Stigma Index is planned during the 2024-2206 grant cycle). No similar data are available in the context of TB. However, anecdotal accounts collected as part of the TB programme review indicated that TB-related stigma and discrimination was frequent and well-entrenched in communities (MOH 2022b).

Key and vulnerable populations in South Sudan also face HIV and TB-related stigma and discrimination in health care facilities and in the broader community. The HIV NSP recognises MSM as a priority population and the need to provide HIV services that cater to the needs of KVP, including MSM (SSAC 2023). Despite this, in 2017 (the most recent data) only 26% of MSM with HIV were reached with HIV prevention programs (MOH 2018a). An estimated 50% of MSM avoided seeking HIV-related health care altogether because of concerns regarding stigma and discrimination.

FSW in South Sudan have consistently reported facing stigma, discrimination and violence at the hands of health care workers, the police, the military, and local authorities, including mayors.

Instances have been reported of arrested FSW being forced by police to disclose their HIV status to the police or to undergo and HIV test (SSAC 2022). Access to legal services is limited. FSW and other KPs experience difficulties in accessing legal advice or representation as there are few lawyers who are prepared to assist, particularly on a pro bono basis (SSAC 2022). Legal literacy on the part of PLHIV and KPs remains low. Current legal literacy interventions are extremely limited and focus primarily on FSW. Further anecdotal evidence from communities, some of which was shared during Country Dialogue, indicate how a number of other individuals and groups may face HIV-related stigma and discrimination related to age (being young and sexually active), gender or cultural or tribal identities and affiliations.

To address these challenges, some limited interventions have been undertaken, particularly during the 2021-2023 grant cycle. These included the dissemination of materials to improve knowledge about HIV, and to reduce HIV-related stigma and discrimination; engagements at the Payam level to address to shift gender norms; the integration of stigma and discrimination reduction in the HIV-related activities through facilities and in communities and legal literacy training materials with mixed groups of community actors, KPs and PLHIV. During the 2024-2026 grant cycle interventions to address stigma and discrimination will be scaled up through community and peer mobilisation and legal literacy will be scaled up with a focus on peer educators. New interventions will be implemented to train health care workers on human rights and to support CLM of service delivery. New interventions to increase access to justice will link CLM to legal support and the training of peer paralegals and law enforcement practices will be addressed through new interventions to provide HIV, TB and human rights training for law enforcement and CLM of policing practices. Engagements with parliamentarians will continue to increase their understanding of the role of human rights in an effective HIV and TB response and interventions to address gender discrimination will focus on working with community, traditional and religious leaders and supporting women's groups to monitor violations and to advocate for change. New interventions will be introduced to support community-based/community-led organsiations of MSM and FSW to advocate for law reform.The following are the interventiona areas:

15.1. Eliminating stigma and discrimination in all settings
15.2. Legal literacy ("Know Your Rights" campaign)
15.3. Ensuring non-discriminatory provision of health care
15.4. Increasing access to justice
15.5. Ensuring rights-based law enforcement practices
15.6. Improving laws, regulations and polices relating to HIV and HIV/TB
15.7. Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity

Module 16. RSSH: Health Sector Planning and Governance for Integrated People-centred Services

As described in Section 1.3 (below), the health sector in South Sudan is reliant in donors and implementing partners in order for a minimum package of primary health services to be available to at least a proportion of the population. Current levels of domestic funding provided to the MOH at central and decentralised levels are inadequate and unreliable to achieve this goal on their own. AS the MOH continues to rely on partners to provide essential health services, it has encountered both successes and challenges. With regard to the former, by 2023, all ten states were support by either the HPF3 or the CERHSSP initiatives, constituting close to 900 health facilities. These initiatives are delivered by a range of implementing partners working at state, country and facility levels. Given this geographic scope and the number implementing partners that are needed, there have been ongoing challenges for coordination and coherence, including for the HIV, TB and malaria components. While significant progress has been made to integrate malaria services within the primary health care package, HIV and TB remain largely vertical interventions operating only where specific implementing partners are present (ICAP, IntraHealth, Cordiad and AAA).

The MOH has made different efforts to improve integration, coordination, coherence and related monitoring and accountability mechanisms. This included evolving the Health Sector Working Group to the Health Sector Steering Committee which has a clearer and strong mandate for coordination and integration. During the development of the situational analysis that informed the drafting of the HSSP 2023-2027, this achievement was noted along with some ongoing gaps for

achieving durable change (MOH 2023a). This included the lack of a clear and binding policy framework governing partnerships for the health sector (similar to Kenya's Health Sector Partnership & Coordination Framework 2018-2030, for example), and for related monitoring, accountability and reporting mechanisms based in the MOH's Directorate of International Health and Coordination. Strength these capacities within the MOH for partnership coordination, leadership and accountability has been prioritised under the new HSSP as one of the building blocks for health system recovery and renewal.

South Sudan has an growing and incompletely regulated private health sector. The sector is filly critical gaps in health services availability and reliability, particularly for HIV, TB and malaria services. The contributions have not been comprehensively mapped nor quantified in terms of technical capacities as well as for contributions to health outcomes. As the recovery of the public health system moves forward, the role of the private sector remains crucial give the mid- to longer-term time horizons for the recovery effort. To more effectively leverage and benefit from the private health sector contribution to population health for South Sudan, including for HIV, TB and malaria, in addition to the mapping, a comprehensive policy framework is required to guide public-private partnerships over future periods. The policy framework should be linked to monitoring, accountability and reporting mechanisms, all of which has also be prioritised in the revised HSSP.

16.1. Health sector planning and governance for integrated people-centred services
16.2. Supporting private sector engagement

The expected outputs and outcomes include:
1. A robust and effective policy framework, and linked monitoring and accountability mechanisms, to strengthening alignment of health sector partners with the health and development priorities of the MOH and the GRSS.
*2.*Increased operational and technical capacity of the MOH to guide and monitor health sector partners and to hold them accountable for aligning with the health and development priorities for the country.
3. A robust and enabling policy framework for responsible and quality assured private sector engagement in meeting the health needs of the South Sudanese population, including for HIV, TB and malaria.
4. Increased capacity within the MOH to engage, monitor and report on the health outcomes of private sector engagement in the provision of essential health services, including for HIV, TB and malaria.

17. RSSH: Community Systems Strengthening
During the 2021-2023 grant cycle, community-based and community-led components of the HIV, TB and malaria programmes expanded but only to a modest degree. Much of what was prioritised by the constituencies was shifted to the PAAR component and, as at December 2022, remained unfunded. Under the main allocation, three networks (two PLHIV and one youth network) where provided with enhanced operational support and participated in capacity-strengthening interventions. Concerns were raised by the civil constituency regarding the transparency and inclusiveness of these choices. However, the absence of additional funds, even after reprogramming prevented the CCM and others from address the concerns by expanding opportunities for civil society engagement in grant implementation.

Through the C19RM support to South Sudan, funds were mobilised to support the roll-out of community-led monitoring (CLM) on a limited scale. By December 2022 a lead organisation for CLM had been selected and tools and guidelines prepared. The first round of monitoring was to take place during the first semester of 2023. An ongoing challenge for guiding investments in CSS has been the lack of a strategic framework, developed by the CSOs themselves, and a clear prioritisation as part of the framework in terms of how to implement a significant scale up of community-based/community led responses for HIV, TB and malaria in South Sudan. To address this gap, as part of the current C19RM reprogramming request (that is pending final approval by Global Fund), a programme of work has been proposed. This includes the creation of national Civil Society Reference Group (CSRG) linked to the CCM. The membership of the reference group will include the main civil society networks and stakeholders active in HIV, TB and malaria, along with technical partners and other potential donors (including PEPFAR). The CSRG will oversee the completion of

a mapping of civil society capacities, opportunities and gaps, the development of a framework for greater and more meaningful civil society engagement (including as direct implementers of Global Fund-supported programmes), and comprehensive, costed plan for additional capacity strengthening and engagement. Finally, a web-based directly will be developed to be a reference point for identifying and engaging civil society partners at all levels of the HIV, TB and malaria responses.

To complement and leverage these activities, a comprehensive set of interventions has been prioritised for this funding request. A component has also been requested under the C19RM portfolio optimisation. As part of these interventions more CSOs will be engaged and equipped (technically and operational) to address critical gaps in quality and comprehensiveness of the HIV, TB and malaria programmes, particularly for demand creation, health literacy, enhanced retention and support for treatment, strengthened support to address psycho-social and mental health challenges, and working alongside the BHI to extend primary health services to communities and households not reached by facility-based health services. Community-based/community-led responses will be critical to achieving optimisation and consolidation of HIV and TB services, for reducing stigma and discrimination, for monitoring the quality and comprehensiveness of programmes (CLM), and for supporting ICCM and other prioritised components of the community-based response for malaria. Finally, the scale up of community-based/community-led responses will include equipping and empowering the grown present of KP-led CSOs and network to play more central roles in delivering and maintaining interventions for KPs in communities. Interventions to support and strengthen the capacity of community led and community-based organisations to conduct CLM in locations where HIV/TB/malaria services are available will contribute to ensuring access to non-discriminatory to HIV, TB and malaria services and to improving service quality, continuity of care, and retention. Linkages between CLM and community paralegals (see Module 15) will facilitate access to justice for people whose rights have been violated in accessing services and information gathered will inform advocacy for advocate for improved access to HIV, TB and malaria services for the general population as well as for key and vulnerable populations. The intervention areas are as below:
17.1.Community-led monitoring
17.2.Community-led research and advocacy
17.3.Community engagement, linkages and coordination
17.4.Capacity building and leadership development

18. RSSH: Health Products Management Systems
In 2021, the MOH along with its stakeholders launched the Pharmaceutical Strategy for South Sudan covering the 2021-2026 period and meant to be renewed every five years after that (MOH 2021b). The main overall goal of the strategy is to promote sustainable and equitable access to pharmaceuticals and related health technologies leveraging the existing context for all persons living in South Sudan. It has five strategic objectives addressing governance, pharmaceutical systems, supply chain, regulatory framework, and partnerships and collaboration. One of the reasons for creating and launching the strategy was to ensure that the investments and efforts of health system partners were aligned under one common approach and focused needs and aspirations of the national health sector. Strengthening product selection and rational use is one of the policy areas covered by the strategy, including the Essential Medicines List as the main policy document governing which medicines are prioritised in South Sudan to support primary health care services, including HIV, TB and malaria services. Given the rate of innovation in the global pharmaceutical sector and that pace at which donors and partners update their product lists, there is a need to routinely review and update the EML. The current version was last updated in 2018. A number of changes have been introduced since then to the range of products used in South Sudan. The EML needs to be current to continue to guide health sector partners and to ensure accountability for quality medicines. This priority is linked to strengthening nationally owned processes for production selection and monitoring.

Ensuring adequate and secure storage for pharmaceutical in also a pillar of the strategy. The Global Fund has been supporting the operations cost of the main central storage facilities for HIV, TB and malaria medicines and other health products. Global Fund supported is requested again for the 204-2026 grant cycle, support that will eventually transition to the MOH wants additional domestic resources become available. Operational support for the regional warehouse in Wau is included in

the country's C19RM portfolio optimisation request. As these are only available until December 2025, support for 2026 has been requested under this module. The Wau warehouse has become an important regional facility for timely and effectively storage and distribution of HIV, TB and malaria commodities for north-western region of the country. As a component of improving last-mile-delivery (LMD) and the visibility of health products as the move through the supply chain from the central to the facility and community levels, a electronic logistics management information system (eLMIS) is being pilot in 2023 using C19RM resources. An allocation has been made in the C19RM portfolio optimisation request to roll-out the eLMIS to at least six states following the pilot. Operations costs for the eLMIS have been included for 2026 in this request. As an additional component of improving LMD county level prepositioning hubs will be established as part of the C19RM portfolio optimisation investment. Operations support for these hubs has been included for 2026 in this request.

Finally, as per the strategy and the legal and regulatory framework for South Sudan, the Drug and Food Control Authority has the mandate to assure the safety and quality of all health products. Currently, its capacity is limited in relation to the volume of products that are important and flow through the country, including those linked to HIV, TB and malaria services. To address this gap, support has been requested to procure equipment (HPLC and minilabs) and provide for the operational and support costs, as well as to build and sustain the capacity of DFCA pharmacists to routinely examine and quality assure health products. Other partners providing health services in South Sudan (including under the HPF3 and CERHSSP initiatives) will contribute to maintaining these quality assurance processes. The intervention areas are outlined below:
18.1. Policy, strategy, governance
18.2. Storage and distribution capacity, design & operations
18.3. Planning and procurement capacity
18.4. Regulatory and quality assurance support
18.5. Avoidance, reduction and management of health care waste
18.6. Supply chain information systems

Module 19: RSSH/PP: Human Resources for Health (HRH) and Quality of Care
Starting in 2013, as a result of the outbreak of conflict and insecurity, South Sudan's health workforce began to enter into a serious state of fragility and decline. In 2018, for example, the country's Service Available and Readiness Assessment, found only 7.6 health workers (all cadres per 10,000 population, below the country's own target of 10 and far below the WHO-recommended minimum of 44.5 (MOH 2020c). Despite health human resources being prioritised as part of the 2017-2022 HSSP, only limited progress was made to address these enormous gaps and challenges which are occurring across all domains, including production, recruitment and retention, and for the provision of safety and security. During 2021, South Sudan was able to graduate 1,343 new health workers, including nurses, midwives, clinical officers and technicians (laboratory, pharmacy and theatre) (MOH 2021a). However, this fell far short of the countries needs. One of the most significant barriers to improving the availability of health workers (whether newly graduated or already in service) has been the challenge of remuneration. Health workers receive very low rates of remuneration that are not adjusted to inflation. Salaries are paid infrequently and unpredictably (as they are throughout the public sector).

With the roll-out of the HPF3 and the CERHSSP initiatives, there has been some stabilisation of the health work through routine payment of incentives (although using different rates between implementing partners) and through improvements in working conditions in hospitals and health facilities. Partners have made recent effort to harmonise the incentive process with the MOH issuing guidance on standardised incentive rates. However, monitoring and accountability mechanisms remain inadequate. Even within the HIV and TB programmes, health workers deployed in the same facilities may be paid different rates using different modalities, including direct salaries (ICAP, for example), monthly incentives for US$100 (for the component of HIV or TB service provision) or US$400-600 as a monthly incentive in addition to a government salary. In the larger country context of an ongoing economic crisis and growing food insecurity, it is no wonder that health workers will continually move to where there remuneration packages are the most advantageous. In the absence of a standardise approach, this turnover creates significant challenges for efficiency and quality where, for example, health workers trained to provide HIV or TB service move to other facilities and are replaced by individuals without such training.

The MOH is aware of these challenges and has been utilising different means available to it to try to address it. The large role that partners play technically and operationally to support health service delivery, and the large number of partners contributing to the health sector, make this work difficult. Currently, important tools are outdated or unavailable that could assist the MOH to press for greater integration, consistency and accountability. Important policy documents, such as the South Sudan Human Resource Policy for Health, and the Strategic Plan for Human Resources for Health remain are out of date (both expired in 2017). No comprehensive situational assessment has been completed to guide the development of new policy documents. Similar, the country's health human resource information system (HRIS) has ceased to function due to lack of operational and technical resources. As South Sudan moves forward, although gradually, to restore and strengthen its health workforce, these gaps should be resolved. The contributions of partners to health sector are essential. However, in the absence of policy and regulator tools to more effectively guide and coordinate these efforts, progress toward recovery will be limited. Allocation is proposed in this funding request to support the MOH to address these critical gaps, complementing additional efforts by PEPFAR, WHO, UNICEF, the World Bank, and the bilateral partners that constitute the HPF3.

As a unique component of renewing the health system in South Sudan, the MOH created the Boma Health Initiative (BHI) in 2017 (MOH 2017). Through deploying Boma Health Workers (BHWs) in communities, critical linkages between the limited number of health facilities and the growing population were to be addressed through the delivery of primary health interventions at household level. The BHI was also envisioned to be South Sudan's main pathway towards achieving universal health coverage (UHC). Since then, there has been limited scale up of the BHI using investment from HPF3 and the CERHSSP (MOH 2019). The results achieved have been impressive with, for example, 5,016 BHWs reaching 4.5 million children at the household level to provide a package of preventive and curative services, including immunisation, and treatment of diarrhoea, pneumonia and malaria, all leading causes of child mortality for the country (MOH 2022d). Other components of the package of interventions include safe motherhood, family planning, screening and referral, WASH and health promotion. A mid-term evaluation, conducted in 2022, found largely positive results, particularly for efficiency, coherence and sustainability (MOH 2022d). Some challenges were also identified, including low levels of educational attainment compared to the 'ideal' level outlined in the BHI recruitment plan, a gender imbalance (60% BHWs were male when the BHI was meant to prioritise women given the health priorities it addresses), inconsistent levels of remuneration and gaps in terms of equipment and support needed by BHWs and BHI supervisors to effectively fulfil their roles. An investment case has been completed indicating how further scale up of the BHI could deliver significant health gains. The MOH, World Bank and other donors have pledged to continue their support for the BHI. In this request, an allocation has been included to complement this support in order to address important programmatic gaps for HIV (PMTCT, EID, community-based HTS and adherence and support for adults and children on ART), TB (community TB activities, including prevention, DOTS, childhood TB, and household screening and contact tracing) and malaria (integrated community case management). The intervention areas are as follow:

19.1. HRH planning, management and governance including for community health workers (CHWs)
19.2. Education and production of new health workers (excluding community health workers)
19.3. Community health workers: selection, pre-service training and certification
19.4. Community health workers: contracting, remuneration and retention
19.5. Community health workers: In-service training
19.6. Community health workers: Integrated supportive supervision

Module 20 RSSH: Monitoring and Evaluation Systems

As the HMIS is expanding throughout South Sudan, there are corresponding efforts to improve the policy framework and the operational and technical architecture that support one country-wide, reliable and secure platform for all health information (including for pandemic preparedness and response). While the country may be at some distance from achieving this, important progress is being made. Different assessments, including a DHIS2 maturity assessment, have identified a range of ongoing gaps and weaknesses, but have also provide guidance in terms of priorities for technical and operational support (MOH 2023e) This information has assisted to better position Global Fund resources under current grants, as well as the investments of other partners, both current and planned (PEPFAR, CDC, HPF3, World Bank, and WHO, among others). The progress to draft the HMIS Strategic Plan 2023-2027, to cost it, and to prioritise it, has pulled together these

different inputs into one overall strategic direction for the development, maintenance and sustainability of a single, comprehensive HMIS for South Sudan (MOH 2023c). The strategic plan has been complemented by a draft HIS Policy and a draft South Sudan DHIS2 Integration Road Map (MOH 2023b,d). Initial work has stated on a South Sudan Digital Health Strategy.

As the HMIS is expanding throughout South Sudan, there are corresponding efforts to improve the policy framework and the operational and technical architecture that support one country-wide, reliable and secure platform for all health information (including for pandemic preparedness and response). While the country may be at some distance from achieving this, important progress is being made. Different assessments, including a DHIS2 maturity assessment, have identified a range of ongoing gaps and weaknesses, but have also provide guidance in terms of priorities for technical and operational support (MOH 2023e) This information has assisted to better position Global Fund resources under current grants, as well as the investments of other partners, both current and planned (PEPFAR, CDC, HPF3, World Bank, and WHO, among others). The progress to draft the HMIS Strategic Plan 2023-2027, to cost it, and to prioritise it, has pulled together these different inputs into one overall strategic direction for the development, maintenance and sustainability of a single, comprehensive HMIS for South Sudan (MOH 2023c). The strategic plan has been complemented by a draft HIS Policy and a draft South Sudan DHIS2 Integration Road Map (MOH 2023b,d). Initial work has stated on a South Sudan Digital Health Strategy.

The DHIS2 maturity assessment identified that for many of the foundations of a robust and reliable, country-wide HMIS system there was only limited progress. In terms of priority gaps, the assessment identified low rates of timeliness (36%) and completion (48%) for routine reporting; gaps in required ICT infrastructure; shortage of recording and reporting tools; inadequate levels of training and retention of capacity on DHIS2 (and HMIS more generally); inconsistent data quality; low level of information use; poor rates of retention of human resources at all levels; and ongoing critical gaps in policy and planning frameworks, particularly for system integration and digitalisation, as well as in the architecture for system integrity, security and stability (both operationally and technically) from the central to the facility levels. Noting that it would be challenging to address all gaps simultaneously, the assessment proposed priorities for system strengthening, particularly the following:
a) Strengthen the core of the DHIS2 platform through completion of the metadata clean-up and a DHIS2 upgrade.
b) Strengthen and sustain the capacity of the central level core team, including providing them with tools and resources (policies, guidelines, SOPs, digital device management and security tools) for system governance, oversight, management and security.
c) Enhance support at state, county and facility levels (using a phased approach that engages all partners) including capacity building (training, mentoring, supportive supervision), provision of tools (including digital devices and tools), human resources support, and strengthening state and county level processes for continuous data quality assurance.
d) Accelerate progress towards integration and consolidation around one national HMIS system supporting all health data requirements (regardless of partner or funding source).
e) Accelerate progress towards digitisation through piloting 'paperless' systems (electronic medical record) in designated locations.
f) Roll-out the eLMIS.
g) Strengthen systems and processes data sharing and data use, and for decision-making and improving the performance of the health system.
h) Integrate additional modules/components into the DHIS2 linked to TB/HIV/Malaria/ EPI programmes (surveillance, tracking, etc.) and pandemic preparedness and response.

Different partners, including the Global Fund, support the strengthening of the HMIS for South Sudan, particularly PEPFAR. Of the listed priorities, items b), c), d), g) are prioritised for the GC7 request. Item f) is included in the C19RM portfolio optimisation submission (operations and maintenance costs for 2026 are include in Module 18 of this submission). All of these investments will be overseen by a revived and fully functional HMIS TWG that will meet on a routine basis to review progress and to identify opportunities for linkages, synergies, efficiencies and reinvestment/reprogramming. The intervention areas as spelt out below:
20.1. Routine reporting
20.2. Surveillance for HIV, tuberculosis and malaria

20.3. Surveys
20.4. Data quality
20.5. Analyses, evaluations, reviews and data use

Module 21 : Laboratory Systems (including national and peripheral)
The provision of laboratory services in South Sudan is guided by the National Laboratory Strategic Plan 2019-2023 and the National Laboratory Policy (MOH 2018b,c). Both are comprehensive documents addressing all laboratory pillars, including regulatory framework, standards, human resources, quality management, infrastructure, equipment and equipment maintenance, supply chain, laboratory information systems, biosafety and biosecurity. Through the Global Fund, PEPFAR and other partners, laboratory systems in South Sudan have benefited from different cycles of investments that have strengthened infrastructure (including the installation of solar power to reduce reliance on diesel generators), improved the technical and operational capacity of the diagnostic network (laboratory equipment and consumables), and strengthened human resources (workforce stabilisation and capacity development). As a result of COVID-19, additional investments were made to move towards multi-disease diagnostic platforms linked with reliable and responsive sample transport systems and to strengthen surveillance. The collective result of these systems strengthening interventions has been significant progress to expand the availability and reliability of laboratory services down to the facility levels and to bring laboratory systems closer to achieving and sustaining minimum standards for quality, safety and continuous availability.

Despite these improvements, some challenges remain, particularly for the HIV, TB and malaria programmes. Access and uptake for critical diagnostics remains low (viral load coverage was 50% in 2022, bacteriological confirmation for TB was 43% and DST remained inoperable, and utilisation for RDTs for malaria remained below the programmatic targets, for example). Sample transportation networks had yet to achieve adequate coverage and reliability (due in part to the limited number of qualified transport provider and other substantial challenges for terrain and security that remain in many parts of the country). In 2022, the Global Fund supported technical assistance to assess the diagnostic network and to propose further strengthening and optimisation (MOH 2022c). The following priorities were identified:
a) Support the re-establishing the directorate of laboratory services in Ministry of Health. As laboratory systems recovery and strengthening progress, there is an important need to re-establishment of the Directorate of Laboratory Services. Currently, NPHL staff play dual roles for systems management and oversight as well as for operations of the NPHL.
b) Establish a national Laboratory Services TWG. This group should oversee laboratory services in the country, including the progress and results for systems strengthening interventions and investments.
c) Deploy strong and competent regional, state and county laboratory coordinators. Given the challenges of the country context, a decentralised management and coordination structure is imperative.
d) Further integrate laboratory services across the country, leveraging on the systems/infrastructure developments and lessons learnt from implementation of the HIV, TB and malaria implementation programmes. There is an urgent need to design and implement strategies to integrate all laboratory services across the country. A newly developed National Essential Diagnostic List should guide the integration.
e) Optimise and strengthen hubs to enhance and sustain comprehensive multi-disease diagnostic capability and continuous availability (particularly for pandemic preparedness and response). A number of hubs are not optimised or integrated. A newly developed National Essential Diagnostic List should guide the optimisation and integration.
f) Scale up and strengthen laboratory quality management systems. Ensure that all laboratories (technically and operationally) are equipped to particate in LQMS programmes and to comply with national standards for quality and reliability.
g) Improve laboratory logistics management. Investments are required (technical and operational) to improve logistics, forecasting and management for all laboratory consumables to significantly reduce stock-outs, to improve efficiencies, and to limit interruptions to the continuous availability of the diagnostic network.
h) Expand and strengthen the LIMS. Currently, the LMIS is limited to some HIV diagnostics. The LMIS should be expanded in phases using advanced capabilities, including digitalisation, web-based dashboards and remote printing of results, amongst other improvements.

i) Enhance biosafety, biosecurity and waste management. As the laboratory systems strengthens, corresponding investments (technical and operational) are needed for biosafety, biosecurity, and medical waste management.
j) Fully engage and link the private sector to the provision of high quality and reliable diagnostic services for the country. As part of the COVID-19 response, private laboratories significant enhanced diagnostic capacity alleviating tremendous pressures on the public sector as the demand of COVID-19 testing escalated dramatic. There are lesson learnt from the situation that can be applied for further public-private collaboration to address and close gaps for capacity and accessibility.

This is list of opportunities is comprehensive and extensive. The laboratory stakeholders convened during the preparation and this funding request and as part of the PEPFAR COP 23 negotiation (which is also prioritising laboratory systems strengthening) to identify what to prioritise under the different funding streams (COP 23, GC7, C1RM Portfolio Optimisation, and the Integrated Lab Systems Strengthening Catalytic Initiative. For the GC7 submission, including the catalytic matching funds, items a)-f) and h) have been prioritised. PEPFAR will contribute to items ??. Under the C19RM opportunities, ?? and i) have been prioritised. The interventions areas are as below:
21.1. National laboratory governance and management structures
21.2. Quality management systems and accreditation
21.3. Laboratory Information Systems
21.4. Network optimization and geospatial analysis
21.5. Specimen referral and transport system
21.6. Biosafety and biosecurity, infrastructure and equipment

---

TRAC ALLOCATION TO THE GLOBAL FUND PROGFRAMME IN 2024

Background
UNDP has been the Principal Recipient (PR) of the Global Fund grants on behalf of the Government of the Republic of South Sudan since 2004. During this time, under the oversight of the Country Coordination Mechanism and working in partnership with the Ministry of Health, UNDP has been managing the country's Global Fund grants for HIV, TB and resilient and sustainable systems for health (RSSH). Startin in 2020, UNDP has also been responsible for contributions to South Sudan under the Global Fund's COVID-19 response mechanism (C19RM).

From 2021-2023, the total value of Global Fund resources managed by UNDP was US$104 million. UNDP worked with a number of partners or Sub-Recipients, including the Ministry of Health, the South Sudan AIDS Commission, the Arkangelo Ali Association, Cordaid, AMREF, ICAP and the United Nations Populations Fund. Among the Sub-sub-Recipients were the South Sudan Network of People Living with HIV/AIDS (SSNeP+) and the National Empowerment of Positive Women United (NEPWU). Starting in January 2024, UNDP will take on responsibility for new Global Fund grants under the Grant Cycle 7 (GC7) allocation period from 2024-2026. These amounts include US$50 million for HIV, US$17 million for TB, US$24 million for RSSH, and US$23 million under the C19RM for pandemic preparedness and additional RSSH support. In addition to continuing to support the national responses for HIV and TB, this new portfolio has a significant emphasis on building and sustaining resilient health and community systems as a legacy contribution to South Sudan's ongoing effort towards achieving lasting peace, reconciliation, recovery and resilience. The total Global Fund portfolio value of US$114 million is the largest to be under UNDP's management since independence.

While the Global Fund investment is comprehensive, it does not necessarily address all needs, particularly for some key partners, such as the CCM and SSAC, and for ongoing technical support needs to ensure timely and high-quality grant implementation. While UNDP benefits from in-kind technical support and guidance from the UNDP-Global Fund Partnership and Health Systems Team, this too does not address all priorities for effective grant implementation. For this reason, the Global Fund Unit has, for some years, relied on additional contributions from TRAC as a key enabler of high-quality grants management and grants performance. The 2024 request is for a total **US$465,000** to address high priority needs in this regard. The request also includes additional support for communications and public relations to ensure greater visibility of UNDP's partnership

with Global Fund and the immense contributions it makes to the health and prosperity of the people of South Sudan.

1. Activities to be Supported under TRAC

The following list of activities has been requested to be supported under the TRAC allocation for 2024.

TRAC Activity 1: Support to CCM Activities in 2024 - $50,000

The oversight of Global Fund investments in South Sudan is the responsibility of the CCM. CCM members represent the interests of country-level stakeholders in the fight against HIV, TB, and malaria. As individuals, CCM members are accountable to their core constituency and, as a group, the CCM is accountable to the nation through its identified reporting channels, including CCM meetings and CCM Dashboards.

In South Sudan, the CCM is the only multi-sectoral coordination body in the country that brings together Government and non-government sectors to coordinate resource mobilization and provide oversight of Global Fund grant implementation. As a result, the South Sudan CCM plays the role of the Project Board for the Global Fund grants managed by UNDP and UNICEF. All funding requests to the Global Fund, material budget revisions and other major adjustments to the Global Fund grants are endorsed by the CCM before submission to the Global Fund for approval. Providing resources to the CCM is crucial to strengthening its role in resources mobilization, governance and oversight of the national response to HIV, TB and Malaria in South Sudan. The CCM receives limited funding from the Global Fund, therefore additional funding is needed to ensure that the CCM fulfils its role.

The main objective for the request for the TRAC allocation to the CCM is to strengthen the CCM's governance and oversight capacity to coordinate resource mobilization and provide oversight on the implementation and management of national response against HIV, TB, and malaria in South Sudan. 2024 is a critical year for the Global Fund programme in South Sudan because it is the start of a new grant implementation cycle, Grant Cycle 7 (GC7). The CCM will have leadership and oversight responsibility for US$165 million, which is comprised of US$52 million for HIV, US$17 million for TB, US$23 million for RSSH, US$52 million for malaria, and an additional US$23 million under the C19RM programme optimisation opportunity. To fulfil its leadership and oversight responsibility, the CCM will require additional support for the operational costs of the Secretariat and for meetings of key committees and the full CCM board.

TRAC Activity 2: Support to South Sudan AIDS Commission (SSAC)- $100,000

As the HIV epidemic has evolved for the country, SSAC has continued to work to fulfil its mandate and to maintain a relevant presence at the helm of the national HIV response. However, in recent times, SSAC has encountered serious set-backs, particularly in 2013 and 2016 when it experienced devastating losses from which it is still attempting to recover. Since 2013, after the closure of the World Bank's Multi-Donor Trust Fund-South Sudan initiative, it has struggled to mobilise resources for both its core operations and its programmes. And while the leadership continues to appeal for support, from the national fiscus and from partners, progress is slow.

With the collaboration of UNAIDS and UNDP, in 2022 SSAC undertook a functional review of its operational modalities with a view to identifying how these processes can be optimised to enable it to regain and retain its effectiveness within the national, multisectoral HIV response, both currently and with regard to how the response may evolve in future periods.

The functional review indicated that to support its programme needs, SSAC must seek support from partners which has been diminishing in recent periods. This support is largely focussed on programmatic outputs and does not reach other functional areas of SSAC causing challenges for recruitment and retention. The findings for the review also affirmed that the viability of SSAC may be becoming increasingly precarious. Absent support from partners for the limited activities it currently undertakes, SSAC's ability to function at all would be significantly impaired.

UNDP has been supporting SSAC to continue in its role to achieve and deliver meaningful results to the national HIV response, and to the broader health of the population in the most efficient and sustainable manner available. In line with the revised National Strategic Plan (NSP), the new Global

AIDS Strategy 2021-2026: End Inequalities, End AIDS, TRAC funds are requested to support SSAC in the area of human resources and technical assistance for SSAC to renew its emphasis on existing structural inequities in South Sudan and how they are impeding further progress in HIV responses at all levels of engagement, from the local to the global.

For a revitalised and streamlined SSAC, it is critical that the national coordination is led by an experienced and dedicated person. We request TRAC funds to support the current Director General for Programme Coordination for 2024 in order that recommendations that came out of the functional review are properly translated into operational plan and that resources are mobilized to ensure the viability of SSAC.

TRAC Activity 3: PSEAH training and planning for SRs and service providers - $15,000
Starting in 2021, the Global Fund introduced a robust and comprehensive approach for the prevention of sexual exploitation, abuse and harassment (PSEAH).[1] The framework is aligned to international best-practices and commitments. It aims to "embed PSEAH across all Global Fund activities and describes accountability and ownership for each component of the organization's approach. Global Fund activities include all activities that the Global Fund engages in or finances, directly or indirectly, in whole or in part, through grant programs or any other form of payment, worldwide." The framework, and the accountabilities it imposes, extends to PRs, SRs and all contactors and service providers engaged through the use of Global Fund resources.

The accountabilities that the Global Fund currently extends to PRs include expectations that these entities, and the SRs and suppliers they engage, will have policies and measures in place to prevent and respond to SEAH, including the facilitation or provision of assistance to victim/survivors related to their safety and protection, medical care, psychosocial support, legal services, and access to a remedy.

PRs have additional, specific requirements, to:
- Communicate the Global Fund's expectations regarding PSEAH to all entities receiving Global Fund resources;
- Integrate the principles of the Global Fund's approach to PSEAH within any existing guidelines or codes of conduct applicable to entities receiving Global Fund resources;
- Take all reasonable steps to ensure that all entities receiving Global Fund resources have in place systems and processes to meet Global Fund's expectations regarding PSEAH;
- Take immediate action to end and correct behaviour that is not compliant with Global Fund's expectations regarding PSEAH.

These requirements make clear that the PR is responsible for the compliance of its SRs and other entities it finances using Global Fund resources with the PSEAH framework. Non-compliance by PRs is subject to sanctions, which may include suspension of disbursements or termination of funding, money and asset recovery, and possible debarment from further activities involving Global Fund grants.

To ensure that UNDP fully meets and exceeds its Global Fund-related responsibilities regarding PSEAH, proposed SRs for the GC7 grant have completed comprehensive capacity assessments, which include a component on PSEAH. Not all SRs meet minimum requirements. In addition, there is a need to take a portfolio-wide approach to PSEAH and to link this to both UNDP's corporate policies and processes as well as the broader inter-agency efforts in South Sudan. To achieve this, the PMU is requesting support for a three-day training and planning workshop to include 40 representatives of proposed SRs, SSRs, CCM representatives, suppliers and other key stakeholders that are integral to a robust and comprehensive approach to PSEAH across the Global Fund programme in South Sudan. To plan and conduct the workshop, the PMU will engage with relevant PSEAH experts and focal points within UNDP.

[1] The framework is available at: https://www.theglobalfund.org/media/11239/core_pseah-related-abuse-power_framwork_en.pdf

TRAC Activity 4: TA for optimization of grant implementation and performance - $ 100,000

The Global Fund grant portfolio for the 2024-2026 period has a heavier emphasis than previous grants on building and maintaining health and community systems as legacy investments contributing to peace, reconciliation and resilience for South Sudan. The portfolio is also of a higher magnitude than previous periods bringing with it an increased administrative burden and oversight responsibility for UNDP as the PR. While the Global Fund allows the PR to include within the grant budget capacity development and technical support needs, the intensive prioritization that occurs for Global Fund in South Sudan means that not all of these needs are ultimately addressed. The PMU has therefore consistently relied on TRAC support to address high priority areas were additional capacity development and technical support is required. While UNDP South Sudan makes full use of the UNDP Global Fund and Health Implementation technical support resources, these are not always adequate or fully configured to the unique needs of the South Sudan context hence the essential nature of the TRAC contribution to ensure a fully optimized PMU for high quality grant performance.

For 2024, the PMU has prioritised the following technical support needs for optimising grant implementation and grant performance:

- **TRAC Activity 4a: TA to develop a long-term maintenance and sustainability plan (including relevant SOPs) for energy optimization installations supported through the Global Fund**

Starting in 2021, UNDP embarked on an initiative to significantly scale-up the use of solar power in health facilities supported through the Global Fund programme. By the end of 2023, over 30 facilities will have benefited from this initiative. The shifts in the quality and availability of health services in local communities resulting from these installations has been immense. While efforts to-date have focused on scale-up, an approach that will continue during 2024-2026 as additional facilities are prioritised, there is a corresponding need to build and maintain capacity for optimal management of these installations, including for routine maintenance, security and sustainability. TRAC funds are requested for a senior expert to assist the PMU to develop a longer-term maintenance, security and sustainability plan, including SOPs and other tools to be taken up by local-level focal points at the facilities where solar installations have been completed or are planned to be completed by 2026.

- **TRAC Activity 4b: TA to redesign and digitize monitoring and reporting mechanisms for SRs and other implementers of Global Fund supported programmes**

Monitoring and reporting processes for Global Fund grant implementation have complex administrative requirements. Currently, in South Sudan, processes are largely paper-based or use basic electronic formats, such as Word documents or Excel spreadsheets. While these modalities are highly appropriate, they can be cumbersome, particularly for the PR that must consolidate programmatic and financial details from numerous sources in order to prepare routine monitoring and accountability reports for both the Global Fund and the Local Fund Agent. To make these processes more efficient and less cumbersome, PRs in other jurisdictions have transitioned to web-base platforms that allow for electronic data entry in the first instances using interfaces that automatically consolidate and analyse data into formats aligned to Global Fund reporting requirements. It is timely that the South Sudan PMU consider a similar evolution of its systems and processes for Global Fund monitoring and reporting, particularly given that the 2024-2026 grants are larger and more complex than in previous periods. UNDP will need to report on two grants simultaneously, the GC7 grant and the C19RM PO contribution. This will require the PMU to review and revise its tools and processes. This should be done with a view to transitioning to web-based and digitized modalities. TRAC funds are requested for a senior expert to assist the PMU to design context-relevant web-based solutions and to develop and implement a transition plan.

- **TRAC Activity 4c: TA to support capacity development of NEPWU to achieve minimum requirements for Global Fund sub-recipient status**

Over successive Global Fund grant implementation periods, there have been repeated calls to the CCM and UNDP to appoint national entities as SRs. While UNDP has always been committed to this goal, and processes to recruit SRs have been open and transparent, to-date no national entities have met the minimum standards for this role, as articulated by Global Fund and subsequently reiterated by UNDP through its framework agreement with the Global Fund. National entities have plaid different roles as SSRs, including under NFM3. This includes SSNeP+ and NEPWU who are

SSRs under UNFPA for a range of community-based interventions led by PLHIV. During the NFM3 period (2021-2023) both networks achieved significant milestones for capacity development and accountability in relation to Global Fund resources with both now receiving direct disbursements through UNFPA and successfully absorbing and accounting for these funds.

To document these achievements, and to identify further areas for capacity strengthening, both networks were recently included in UNDP's SR capacity assessment process. These assessments are carried out using UNDP tools and are a mandatory component at the start of each Global Fund grant implementation period. The results for each network work were highly significant, with NEPWU showing the most promise for achieving minimum thresholds for requirements for SRs. To support NEPWU to fully meet these threshold requirements by the end of 2024, UNDP will engage in further capacity development of this key national stakeholder. The results of the assessment indicate that further strengthening is needed in the areas of governance and leadership, human resource management, and in further strengthening both financial management and monitoring and reporting processes.

TRAC funds are request to engage capacity development practitioners to assist NEPWU to address these capacity development priorities in time for a report capacity assessment at the end of 2024. The ongoing capacity development of SSNeP+ will continue as part of the SR agreement with UNFPA. SSNeP+ will be reconsidered for its potential as an SR in a subsequent Global Fund grant.

- **TRAC Activity 4d: Additional support to PMU**

Due to pressures in the grant development process to minimise the proportion of the grant allocated to grants management, some core activities for PMU were not included in the approved grant. These relate to planning and team-building in order to maintain a focussed, optimally functional PMU team. Support is requested under TRAC to convene an annual planning and team-building event as well as to provide for additional engagement activities with partners at national and state level throughout the year.

TRAC Activity 5: Support for Communications and Public Relations - $100,000

Both UNDP and the Global Fund have a shared aspiration for robust communication. The recently approved UNDP Programme and Operations Policies and Procedures (POPP) on Programme and Project Management (PPM) elevates communications from an ***afterthought*** to a ***central thought*** in UNDP programming. This is critical for UNDP to remain a thought leader and a partner of choice in achieving sustainable development. In addition, timely communication of development results to partners and the public is also a globally accepted instrument for delivering development support in a transparent and accountable manner.

Similarly, the Global Fund recognizes the importance of robust and comprehensive communications to demonstrate its results and its development potently. The new Global Fund Strategy (2023-2028) observes that the organization has made considerable progress on saving lives and on reducing infection across all the three diseases – HIV, TB and malaria. It thus calls for an intensified focus on the awareness of prevention and treatment options across all the three diseases. Central to achieving this is robust communication and public awareness to profile its work and empower the citizenry in the countries where it operates to shun stigma and discrimination, and to embrace desired health outcomes on infection prevention, control and treatment.

While the UNDP – Global Fund Project in South Sudan has been at the helm of major transformational, impactful and lifesaving interventions for the country, the project's positioning, visibility and profiling have not been well matched with the extent and scale of its interventions, leading to limited visibility and public awareness about the project activities and results. Therefore, getting a clearer message out in a bolder, more proactive and consistent manner is a gap that should be closed. A major step was taken in August 2023 to second a Communications Specialist to the project. One of the major milestone's since then was the completion of a communications strategy. A request is being made to TRAC to support prioritised activities from the strategy for 2024. The prioritised activities aim towards creating maximum visibility for the UNDP-Global Fund partnership in South Sudan as well as making a major contribution to the larger visibility and impact of UNDPs more comprehensive work in South Sudan.

III. RESULTS AND PARTNERSHIPS

Expected Results

In line with the revised National Strategic Plan for HIV and AIDS, the project aims at reduction of new HIV infections by 25% by 2026 (from 2022 levels): reduction in AIDS-related deaths by 25% by 2026 (from 2022 levels); reduction of HIV-related stigma and discrimination towards PLHIV by <10% and increase TB detection by 40% and reduce mortality rate by 35% by 2028 compared to 2022
The project's expected outcomes are: to scale up combination HIV prevention to reach 70% of key, vulnerable and priority populations, and other individuals and groups at risk for HIV by 2026; to reach 60% of all PLHIV, in all their diversity, with fully differentiated, person-centred ART services and a minimum package of complementary health and social support interventions; to remove human rights, gender and equity-related barriers for all PLHIV and key, vulnerable and priority populations; to increase the number of MDR/RR-TB cases notified from 176 in 2022 to at least 490 by 2028 and their treatment success rate to at least 85% by 2028; to enhance TB prevention through i) tuberculosis preventive therapy of, at least, 70% of household contacts and 27% PLHIV starting TPT every year and ii) strengthening infection control; to promote enabling environments, in collaboration with partners and affected communities, key indicator being enhancing private sector provider engagement, targeting to increase proportion of notified TB cases from private providers; to roll out an electronic TB case-based surveillance system, lab and commodity management in all health facilities offering TB services in the country, to improve and strengthen the governance and the programmatic management capacities for the provision of TB services at national, state and county levels.

The project has a performance framework (PF), with key impact, outcome and output undicators and targets reported to the Global Fund according to the set timeframe. The release of funds to UNDP is subject to achieving these targets.

Resources Required to Achieve the Expected Results

There is an allocation of USD90,982,856 by the Global Fund for the period 2024-2026 towards achieving the expected reslts of the project. The achievement of the results will be complemented by PEPFAR's investments where implementing partners of both the Global Fund and PEPFAR's projects will ensure efficient utilisation of resources and coordination to avoid duplication. In addition, the domestic investment by the Government will leverage the available resources for the projects and ensure that they are linked to investments linked with primary health care services for maximal impact of the project. In addition, the Global Fund unit is requesting TRAC for an amount of US$ 300,000 to support results communication activities, the CCM functions, the coordination and integration of health programmes by the Ministry of Health and the facilitation of the GC7 implementation. Below is the summary budget by intervention:

Table: Global Fund GC7 HIV/TB/RSSH Approved Budget

Module	Intervention	Year 1	Year 2	Year 3	Total	%
Differentiated HIV Testing Services	Facility-based testing for key population (KP) programs	51,740	0	0	51,740	0.06%
Differentiated HIV Testing Services	Facility-based testing outside of key population (KP) and adolescent girls and young women (AGYW) programs	1,911,059	1,910,975	1,936,718	5,758,752	6.35%
Differentiated HIV Testing Services	Self-testing for KP programs	0	4,320	0	4,320	0.00%
Differentiated HIV Testing Services	Self-testing outside of KP and AGYW programs	35,589	37,814	40,039	113,442	0.13%
Drug-resistant (DR)-TB diagnosis, treatment and care	DR-TB diagnosis/drug susceptibility testing (DST)	613,575	810,986	679,896	2,104,457	2.32%
Drug-resistant (DR)-TB diagnosis, treatment and care	DR-TB treatment, care and support	230,483	202,538	202,595	635,616	0.70%
Elimination of vertical transmission of HIV, syphilis and hepatitis B	Early infant diagnosis and follow-up HIV testing for exposed infants	737,282	672,074	715,091	2,124,448	2.34%
Elimination of vertical transmission of HIV, syphilis and hepatitis B	Integrated testing of pregnant women for HIV, syphilis and hepatitis B	190,098	90,000	90,000	370,098	0.41%
Elimination of vertical transmission of HIV, syphilis and hepatitis B	Post-natal infant prophylaxis	80,247	81,640	88,980	250,867	0.28%
Elimination of vertical transmission of HIV, syphilis and hepatitis B	Prevention of incident HIV among pregnant and breastfeeding women	18,360	0	0	18,360	0.02%
Key and vulnerable populations (KVP) – TB/DR-TB	KVP - Children and adolescents	126,050	165,694	150,350	442,094	0.49%
Key and vulnerable populations (KVP) – TB/DR-TB	KVP - Mobile population (migrants/refugees/IDPs)	26,105	26,105	26,105	78,315	0.09%
Prevention package for men who have sex with men (MSM) and their sexual partners	Community empowerment for MSM	53,136	0	0	53,136	0.06%
Prevention package for other vulnerable populations (OVP)	Community empowerment for OVP	38,580	38,580	38,580	115,740	0.13%
Prevention package for other vulnerable populations (OVP)	HIV prevention communication, information and demand creation for OVP	252,400	235,800	235,800	724,000	0.80%
Prevention package for people who use drugs (PUD) and their sexual partners	Community empowerment for PUD	49,139	0	0	49,139	0.05%
Prevention package for people who use drugs (PUD) and their sexual partners	Needle and syringe programs for PWID	30,939	8,608	10,173	49,720	0.05%
Prevention package for sex workers, their clients and other sexual partners	Community empowerment for sex workers	20,985	20,985	20,985	62,955	0.07%
Prevention package for sex workers, their clients and other sexual partners	HIV prevention communication, information and demand creation for sex workers	98,805	53,985	53,985	206,775	0.23%
Prevention package for sex workers, their clients and other sexual partners	Pre-exposure prophylaxis (PrEP) programing for sex workers	42,413	43,026	48,746	134,185	0.15%
Prevention package for sex workers, their clients and other sexual partners	Removing human rights-related barriers to prevention for sex workers	13,082	13,082	13,082	39,246	0.04%
Prevention package for sex workers, their clients and other sexual partners	Sexual and reproductive health services, including STIs, hepatitis, post-violence care for sex workers	189,677	159,448	167,457	516,582	0.57%

Module	Intervention	Year 1	Year 2	Year 3	Total	%
Prevention program stewardship	Prevention program stewardship	127,018	0	0	127,018	0.14%
Program management	Grant management	6,428,488	6,493,612	7,163,821	20,085,920	22.15%
Reducing human rights-related barriers to HIV/TB services	Eliminating stigma and discrimination in all settings	250,890	20,400	20,400	291,690	0.32%
Reducing human rights-related barriers to HIV/TB services	Improving laws, regulations and polices relating to HIV and HIV/TB	7,460	7,460	7,460	22,380	0.02%
Reducing human rights-related barriers to HIV/TB services	Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity	30,435	30,435	30,435	91,305	0.10%
RSSH/PP: Human resources for health (HRH) and quality of care	RSSH/PP: Community health workers: contracting, remuneration and retention	1,654,200	1,654,200	3,316,200	6,624,600	7.31%
RSSH/PP: Human resources for health (HRH) and quality of care	RSSH/PP: Quality improvement and capacity building for quality of care	90,920	0	0	90,920	0.10%
RSSH/PP: Laboratory systems (including national and peripheral)	RSSH/PP: Biosafety and biosecurity, infrastructure and equipment	359,600	310,850	175,725	846,174	0.93%
RSSH/PP: Laboratory systems (including national and peripheral)	RSSH/PP: National laboratory governance and management structures	402,114	1,248,163	69,863	1,720,139	1.90%
RSSH/PP: Laboratory systems (including national and peripheral)	RSSH/PP: Network optimization and geospatial analysis	219,415	137,236	137,236	493,887	0.54%
RSSH/PP: Laboratory systems (including national and peripheral)	RSSH/PP: Quality management systems and accreditation	81,560	273,055	81,560	436,175	0.48%
RSSH/PP: Laboratory systems (including national and peripheral)	RSSH/PP: Specimen referral and transport system	186,720	171,766	171,766	530,253	0.58%
RSSH: Community systems strengthening	Community engagement, linkages and coordination	431,785	416,168	416,168	1,264,121	1.39%
RSSH: Community systems strengthening	Community-led monitoring	0	0	156,600	156,600	0.17%
RSSH: Health products management systems	Planning and procurement capacity	41,180	0	0	41,180	0.05%
RSSH: Health products management systems	Policy, strategy, governance	82,168	0	0	82,168	0.09%
RSSH: Health products management systems	Regulatory/quality assurance support	470,654	131,812	131,812	734,278	0.81%
RSSH: Health products management systems	Storage and distribution capacity, design & operations	1,009,977	793,743	795,794	2,599,515	2.87%
RSSH: Monitoring and evaluation systems	Analyses, evaluations, reviews and data use	0	133,819	0	133,819	0.15%
RSSH: Monitoring and evaluation systems	Data quality	157,509	218,353	0	375,862	0.41%
RSSH: Monitoring and evaluation systems	Operational Research	150,000	0	150,000	300,000	0.33%
RSSH: Monitoring and evaluation systems	Routine reporting	725,786	1,152,740	616,392	2,494,918	2.75%
TB diagnosis, treatment and care	TB screening and diagnosis	169,264	69,638	28,874	267,776	0.30%
TB diagnosis, treatment and care	TB treatment, care and support	2,869,307	3,080,793	3,117,323	9,067,424	10.00%
TB/DR-TB Prevention	Infection prevention and control (IPC)	20,468	23,576	19,868	63,913	0.07%

Module	Intervention	Year 1	Year 2	Year 3	Total	%
TB/DR-TB Prevention	Preventive treatment	113,071	117,930	116,505	347,506	0.38%
TB/DR-TB Prevention	Screening/testing for TB infection	0	31,412	0	31,412	0.03%
TB/HIV	TB/HIV - Collaborative interventions	87,695	97,507	70,883	256,085	0.28%
TB/HIV	TB/HIV - Prevention	177,059	129,855	53,054	359,968	0.40%
TB/HIV	TB/HIV - Screening, testing and diagnosis	59,894	49,113	49,113	158,120	0.17%
TB/HIV	TB/HIV - Treatment and care	30,095	30,095	30,095	90,285	0.10%
Treatment, care and support	Diagnosis and management of advanced disease (adults and children)	70,005	71,197	69,036	210,238	0.23%
Treatment, care and support	HIV treatment and differentiated service delivery - adults (15 and above)	6,314,550	4,470,978	7,001,604	17,787,132	19.61%
Treatment, care and support	HIV treatment and differentiated service delivery - children (under 15)	559,827	359,354	378,525	1,297,705	1.43%
Treatment, care and support	Integrated management of common co-infections and co-morbidities (adults and children)	687,937	205,730	251,196	1,144,864	1.26%
Treatment, care and support	Treatment monitoring - Viral load and antiretroviral (ARV) toxicity	1,789,715	2,025,367	2,338,440	6,153,522	6.79%
	Total	**30,666,508**	**28,532,016**	**31,484,333**	**90,682,856**	**100%**

Table: Approved TRAC Funds for 2024 – Global Fund Programme

Ref	Item	Amount
1	**Support to CCM**	
	Operational Support	60,000.00
	Subtotal	60,000.00
2	**Support to SSAC**	
	Salary support	24,000.00
	Operational Support	16,000.00
	World AIDS Day	50,000.00
	Zero Discrimination Day	10,000.00
	Subtotal	100,000.00
3	**Support for optimising grant performance**	
	Integration TA	72,000.00
	Programme Analyst	50,000.00
	Other TA/PMU retreat	33,000.00
	Support to NEPWU	50,000.00
	Subtotal	205,000.00
4	**Communications support**	**100,000.00**
	Communications activities	100,000.00
	Subtotal	100,000.00
	TOTAL	**465,000.00**

Collaboration with UNDP projects

The project will create synergy with the other UNDP projects to ensure that resources are leveraged for better efficiency and timely delivery of GF results. The global fund project will benefit from Access to Justice (A2J) project that has enabled the functions and capacity of rule of low institutions to deliver accountable, effective and equitable justice services. This is particularly critical to the large proportion of the beneficiaries of the GF project: adolescents and young populations, women, and PLHIV who are the most vulnerable population segments to injustice, insecurity and lack of justice and lack of legal services. The Global Fund project will leverage the resources and expertise of A2J project in preventing and responding to sexual and gender-based violence. The project will also capitalize on the Access to Justice project's mechanisms put in place and its engagement and infrastructure within the communities and the civil society for better integration of the two projects' interventions. In addition, the Global Fund project will continue to collaborate with other UNDP projects and any other projects in the pipeline in areas of technical collaborations and operational synergies.

Partnerships

The Health Sector Transformation Project (HSTP) and the associated Multi-Donor Trust Fund (MDTF) – the GC7 HIV/TB/RSSH and C19RM PO (worth $116m for 3 years) are coming at a time when the entire health sector is in a transformative phase as it transitions to new arrangements for operational support, service delivery and systems strengthening. Also launched in January 2024, and fully aligned to the Health Sector Strategic Plan 2023-2027, the HSTP and the associated MDTF will usher in a new era for the health system. Starting in July 2024, under the leadership of the MOH, and in collaboration with the World Bank, UNICEF, World Health Organisation (WHO), bilateral partners and other stakeholders, almost 1,200 health facilities will be supported to deliver a comprehensive package of primary health care and nutrition services, inclusive of a comprehensive community component led by the Boma Health Initiative (BHI). Linked investments in system strengthening will support a reliable and stable complement of health workers, systems for the supply and distribution of essential commodities, reliable health information systems, and coordination and integration from the local to the national level.

The changes will bring important opportunities for Global Fund investments to be fully aligned with the HSTP so that critical synergies are realised and a way forward is opened up for the ultimate integration of all essential health services, including for HIV, TB and malaria, within a comprehensive and equitable primary health care platform. Identifying and maximising the value of these opportunities will, however, require consistent focus and engagement in key processes, and with key stakeholders sharing the vision of health sector transformation.

WHO is the implementing partner for the HSTP RSSH component, focusing on the following interventions: (1) Emergency Preparedness and Response, (2) Laboratory Systems, (3) Blood Transfusion, (4) Health Information System, (5) Health Financing, (6) Governance, Leadership and Partnerships, (7) Partnerships, (8) Medicines and Supplies, (9) Quality of Care, (10) Human Resources for Health, and (11) Disease Control.

Global Fund and GAVI Partnership – during the Global Fund mission the Joint High-Level Mission to South Sudan in June 2024, the Global Fund and GAVI signed a 'Declaration of Commitment and Joint Collaboration to Fight HIV, TB and Malaria, and Strengthen Immunization And Health Systems. Reaffirming the importance of the Global Fund and Gavi Alliance partnership with South Sudan, combining the strength of government, civil society, private sector and people affected by HIV, TB and Malaria, low vaccine coverage and weak health systems, the undersigned commit to continue cooperation and partnership to improve the response to HIV, TB, Malaria, and immunization coverage. The PR aims to collaborate with GAVI in the following RSSH related areas: LMIS, HMIS, Warehousing and the BHI.

Health Sector Planning and Governance for Integrated People-centred Services – the main idea behind this module is for the MOH to take the lead in ensuring the full intergration of HIV, TB and Malaria services in the Basic Package of Health and Nutrition Services (BPHNS). Malaria interventions are intergrated to a certain extent, while HIV and TB remain vertical, supported by the Global Fund and PEPFAR implementing partners (Cordaid, AAA, Intrahealth, ICAP, CMMB, JPIEGO).

Private provider engagement in HIV and TB/DR-TB care – engaging provate service providers for the provision of comprehensive TB services.

Health Products Management Systems – based on the Pharmaceutical Strategy for South Sudan covering the 2021-2026 period, to ensure that the investments and efforts of health system partners were aligned under one common approach and focused needs and aspirations of the national health sector.

National sypply chain system – one nationally coordination supply chain system is essential for improving commodity security and for reducing the costs of inefficiency, duplication and the lack of collaboration amounts partners. As signalled in the 2021-2023 funding request, the non-functionality of the national PSM system means that partners have used their own systems and resulted processes for the supply, management and distribution of essential commodities. In some cases, this has in the over-supply of commodities that subsequently expired, or the under-supply of critical items due to an inability to accurately forecast and quantify demand. One single streamlined national PSM system is essential to address these issues; and this application prioritises working towards putting a functional PSM system in place. Under the leadership of the MOH through its national Procurement Technical working Group (PTWG) with the support of the Global Fund and relevant technical partners, Step 1 would be that the several partners involved in parallel investments will meet at least three times a year to exchange experiences on the supply chain, plan procurements and be urged to develop joint quantification and forecasting, pooled procurement where possible and to enter into a joint distribution system. The next step is to have one national autonomous CMS where all procurement functions will be coordinated under the leadership of MOH and board members (partners and civil society). A project to develop a national CMS is already in development but not yet implemented. Acting as one PSM national autonomous but accountable body through an executive board, it will absorb all parallel quantification processes, all fragmented procurement, distribution, storage and LMIS system-related interventions to achieve efficiency.

Enhanced Coordination among partners to avoid missed opportunities for TB screening, diagnosis and care - A similar lesson learnt was described in South Sudan's 2021-2023 submission. Major health sector interventions are currently being implemented in parallel with limited to no horizontal integration of TB components. Under HPF3, for example, over the 2020-2021 period (the latest available data) 1.3 million children under 5 years were treated in outpatient settings and a further 1.4 million in community settings for a variety of childhood health conditions. However, there was no systematic screening for TB as this was not a mandated component nor a key performance indicator under the HPF3 agreement. This represented a significant missed opportunity. As with South Sudan's previous application, efforts to address coordination and integrate all diseases are prioritised under this application, both within the disease components and within RSSH.

Risks and Assumptions

The following are the major risks in the implementation of the HIV/TB Programme in South Sudan:

i. Disruption of services due to worsening of insecurity which negatively affects distribution of key drugs and commodities and also results in displacement of populations and health care workers.

ii. High cost of providing services due to deterioration in the macroeconomic environment: The major implication is the exchange rate misalignment that would impact on service delivery. There is a risk that the resulting high cost would lead to key players in the sector scaling down implementation and adopting a more focused approach to implementation. In addition, this scenario is likely to lead to an even further reduction in the government support to the health sector leading to further losses of health care workers, deterioration of health facilities and overall weaken government service-delivery capacity.

iii. Suboptimal performance and delivery of the project due to limited budget for ‘soft’ programme activities due to channeling of most investment to procurement of drugs and commodities (as directed by the Global Fund) which has made a major deviation of the funding from its original proposal

iv. Potential loss of health sector assets arising from theft and conflict: During NFM2 and to some extent in NFM3, there were loss of assets such as vehicles, equipment, facilities and health

commodities due to conflict. Hence, there is potential risk to the security of key health sector assets.

v. Lack of full integration of HIV services in subsisting TB Facilities may hinder the project's realization of integrated services and scaled up services across the country. Mitigation measures to tackle this risk include clear scope of work and terms of reference between the SRs and UNDP on integration of TB and HIV services at all health facilities; strengthening the capacity of state and county M&E personnel to monitor the implementation of integrated TB/HIV services at facility level; revitalizing TB/HIV collaboration bodies at national and state level to oversee the integration services.

vi. Suboptimal programming (not achieving targets/impact) because of rapid changes in operating environment mostly due to:
    a. Migration of intended beneficiaries outside South Sudan where they cannot access services through current grants / changes in beneficiary needs and locations
    b. Limited access of implementers and partners to key areas due to insecurity
    c. Implementation of activities delayed or postponed or cancelled
    d. Insecurity undermines scale up plans to increase coverage

vii. Inadequate M&E and Low Data Quality for informed and evidence-based programming. Data is key for planning, review and evaluation of program performance. However, there is risk that important data will continue to be unavailable as some important activities such as surveys, routine reporting and operations research will not be undertaken due to inadequate funding.

Refer to Annex 1 for the Risk and Assurance Matrix for comprehensive list of risks and mitigating actions

Stakeholder Engagement

There are several strategies that will be used to engage the various stakeholders. These are outlined below.

- The CCM are national committees in each country that submit funding applications to the Global Fund on behalf of the entire country. They include representatives of all sectors involved in the response to the diseases: multilateral or bilateral agencies, nongovernmental organizations, academic institutions, faith-based organizations, the private sector and – especially – people living with the diseases. They are a key element of the Global Fund partnership. During the implementation of the grant the role of the CCM is to
    - Oversee the implementation of the approved grant
    - Approve any reprogramming requests that UNDP will propose
    - Ensures linkages and consistency between Global Fund grants and other national health and development programs in South Sudan

  The CCM holds regular meetings at which the PRs are asked to present their updates on grant implementation and the CCM members provide their feedback.

- The direct beneficiaries of the project are as follow: adults and children living with HIV/AIDS receiving ARV treatment; TB patients on treatment; key and vulnerable populations including sex workers and their clients, IDPs, prisoners; General population at risk of HIV/AIDS and TB; Health sector overall (through improved coordination, human resources, and information systems)

- The HIV/AIDS and TB Technical Working Group (TWG) chaired by the MOH HIV/AIDS/STIs Departmenntand the National TB, Leprosy, and Buruli Ulcer Control Programme are platforms that will be used to engage stakeholders. The TWGs meet every month and their membership include international organizations, donors, and non-governmental and governmental organizations. Furthermore, the project will continue to engage other stakeholders including PEPFAR, Health Pooled Fund (HPF) led by the UK Department for International Development in collaboration with the US Agency for International Development (USAID), Canada, Sweden and the EU; and the Rapid Results Health Project support through the World Bank (WB), which is financing primary healthcare services across the 10 states of South Sudan.

With the launch of the South Sudan Health Strategic Plan 2024-2027, all partners are to roll out comprehensive and integrated services including HIV and TB services. The HIV/AIDS/STIs Department and the National TB Programme intend to pursue this new policy directive so as to leverage resources for HIV/AIDS and TB control in the country.

Knowledge

Knowledge products to be produced include an update to the Cohort Analysis Report, Cascade Analysis report, HIV Spectrum Estimates, Annual Joint review Report, Midterm Review Report to inform the development of a new grant cycle. A robust programme evaluation will also be conducted at the end of the implementation.

Sustainability and Scaling Up

A key factor that impacts the sustainability of HIV and TB programs is the overreliance on donor funding. The HIV and TBprogrammes in South Sudan rely primarily on external assistance. In order to mitigate the risk, the government is encouraged to start allocating resources to the two disease programming.

The national HIV programme interventions are mainly supported by the Global Fund and PEPFAR, including programme activities and procurement of drugs and commodities. The TB programme on the other hand is solely supported by the Global Fund. The global Fund also provides an interim salary support and incentives to the national HIV and TB programme staff at central, state and facility level. The interim salary support also includes staff from the National Public Health Laboratory (NPHL) and National Blood Trasfusion Services (NBTS), pharmaceutical services and the national M&E programme. The national HIV programme is therefore heavily dependent on the Global Fund and PEPFAR, while the TB programme is fully dependent on the Global Fund and sustainability is an issue that needs to be addressed.

The government's contribution is through the payment of salaries of civil servants at central, state, county, facility level, as well as at community level through the Boma Health Initiative. The majority of the health workers at health facilities are civil servants whose salaries are paid by the government, and with the ongoing integration of comprehensive TB and HIV services at all levels of care, most of the health workers will be directly involved in providing TB and HIV services as opposed to parallel services provided at earlier established TB and HIV sites. Additionally, most of the health facilities in South Sudan are owned and managed by the government and therefore the government provides the infrastructure and operational costs. Partners such as GF, HPF, RRHP, PEPFAR, etc. provide retention incentives to civil servants and/or recruit additional health workers to complement the government cadre. NGO/FBO owned health facilities do exist and receive minimal financial support from the government to complement their budgets for infrastructure and operational costs. Additionally NGO/FBO facilities are also supported in terms of oversight, policy and treatment protocols.

In addition to the Government contribution to the MOH, the Government provides separate resources to SSAC and the Food and Drug Control Authority (DFCA) which is responsible for providing tax exemptions to HIV, TB and Malaria commodities. The government also supports SSAC and DFCA in terms of infrastructure, HR and operational costs at all levels. Lastly, the Government also allocates funding to the SPLA HIV/AIDS Secretariat as part of the health services for the Ministry of Defence.

Key driver of cost in HIV and TB programming is the procurement of drugs. For the 2024-2026 Funding Request, drugs make up almost 60% of the total budget. Currently, the government's contribution to the HIV and TB programme is the provision of human resource capacity and infrastructure, with the drugs for the treatment component being procured and provided by the development partners, in the main Global Fund.

As with the 2021-2023 NFM3 grant, the government will continue supporting human resources for the HIV and TB programs in the GC7 funding request. The human resources component for the GC7 Funding Request, will mainly target all public health facilities including preventive component of the public health. It will also continue supporting laboratory management.

IV. PROJECT MANAGEMENT

Cost Efficiency and Effectiveness

As noted earlier, UNDP shall work with its key implementing partners identified in the implementation map to achieve Value for Money (VfM) through the continuous and deliberate adoption of strategies aimed at achieving budget efficiencies. Such strategies will improve programming in terms of economy, efficiency and effectiveness.

1. Cost sharing: The Global Fund Project will leverage the available resources within the Country Office to complement the Global Fund resources in areas such as human resources, security, communications, transport, etc.
2. Collaborative partnership with PEPFAR on programme activities at all levels including service delivery, human resources, and supply chain management.
3. Collaborative Partnership in Supply Chain Management: UNDP will partner with UNICEF, Principal Recipient for the Malaria Grant in terms of load consolidation, warehousing and pre-postitioning of HIV commodities and pharmaceuticals.
4. Delivering Programs in Partnerships with Humanitarian Organizations: UNDP is a member of the TB TWG and Joint United Nations Team on AIDS (JUNTA). Through these platforms, UNDP has continued to benefit from the expertise of humanitarian organizations that are members which participate and deliver services in various parts of the country.
5. Collaboration with partners managing grants for the Basic Package for Health Services: UNDP will continue collaboration with PEPFAR and other partners to ensure integration of HIV and TB services as indicated in the basic health package for health services. UNDP will advocate with the Ministry of Health to ensure these partners intergrate comprehensive HIV and TB services in primary health care.
6. Strengthening Sample Transportation: the Ministry of Health is being supported to strengthen its sample transportation from the periphery areas to Central Public Health Laboratory and to sites earmarked for placement of Gene Xpert machines to collect and transport samples for EID, Viral Load, Gene Xpert and TB Culture samples. ICAP has been selected by PEPFAR to lead the integrated specimen transporation in the country. Thus, UNDP will partner with ICAP to support the implementation of specimen transportation for the two disease programmes.
7. Bulk Procurement: UNDP globally procures large quantities of health commodities and supplies. During the next implementation period, UNDP will continue to benefit from efficiencies realized through economies of scale realized through bulk procurements made through the corporate-level Long Term Agreements (LTA) with various approved suppliers. The aim is to ensure that commodities are procured at the lowest possible cost but of the required standard.
8. Streamlining of the community outreach activities: this will be done through aligning with the Boma Health Initiative. The community counsellors, peer counsellors, mentor mothers, and treatment adherence supporters currently working in the HIV Program will be integrated with the Boma Health Teams in order for communities to continue to benefit from this skilled cadre of human resource.
9. Optimizing Program Management and Service Delivery: this will be achieved through streamlining the human resource costs by reviewing the human resource allocations.

Project Management

South Sudan remained under the Global Fund's Additional Safeguards Policy (ASP) following independence in July 2011 and remains under this policy during the current (2024-2026) allocation period until notified otherwise. This means, among others, that any nomination of Principal Recipients for the next implementation period is made directly by the Global Fund, ensuring consultation with the CCM and other development partners, and the selection of sub-recipients is subject to specific approval by the Global Fund. ASP countries are therefore exempted from the assessment of the open and transparent PR selection process by the CCM at the time of submission of the Funding Request.

UNDP has been the PR for the Global Fund grants in South Sudan since 2004, namely, rounds 2 TB and Malaria, round 4 HIV, round 5 TB/HIV, round 7 TB, including COS and TFMs, round 9 HSS, and the TB and HIV NFMs. UNDP was nominated by the Global Fund, and it works under the general guidance of the CCM. Therefore, UNDP will remain as PR for the current grant that consists of TB, HIV, and cross-cutting Resilient and sustainable systems for health (RSSH) components.

The PR is responsible for programme management, financial accountability, procurement of goods & services, and Monitoring and Evaluation. To avoid disruption, it is anticipated that current institutional arrangements will continue during the life of the new funding application. Currently, government and national civil society institutions require further capacity building, while the health sector only covers about 44% of the population. New implementation structures should focus on strengthening technical and institutional capacity to meet or surpass Global Fund standards. Under the GC7, a Programme Management Unit is expected to be established to start the process of institutional capacity building for the MOH to be able to assume full ownership and responsibility for managing the grants in the future.

UNDP has well established systems and capacities required to manage the Global Fund grant in South Sudan, namely, Governance and Oversight, Programme Management Capacity, Financial Management and Systems, M&E, and Pharmaceutical and Health Products Management. These systems have been with the Global Fund assistance, and are working. Through the management of grants since 2004, UNDP South Sudan has established itself to become a solid PR in managing the Global Fund HIV, TB and RSSH grants in South Sudan.

Under the ASP, the PR sub-contracts a limited number Sub-recipients (SRs) to implement several modules of the grant. Government Institutions, National and International Organisations may serve as sub-recipients or even sub-sub-recipients (SSRs). In this way, financing effectively cascades down to smaller organizations, and programs can be carried out to reach those populations or groups which a government may not able to reach effectively. Accountability, transparency and effectiveness are key. PRs select SRs through a national, open and transparent process, and are expected to assess the capacity of potential SRs to carry out the work as well as to meet the required standards of accountability and transparency. Under the ASP, selection of SRs is subject to Global Fund approval based on the assessment of risks. The Secretariat may require and be involved in the assessment of SRs and in certain cases, contractors, and sub-contractors. The assessment would include their financial management systems, institutional and programmatic structures, procurement systems, and where appropriate their monitoring and evaluation structures. The assessments are conducted through the Capacity Assessment Tool (CAT) tool.

Project Alignment

The project was designed to align with UNDP's country programme document (CPD), Strategic Plan (SP), the UN Sustainable development Cooperation Framework (UNSDCF) and the National Development Strategy (NDS) of South Sudan. Accordingly, the outputs were aligned with UNDP's strategic outcome of advancing poverty eradication in all its forms and dimensions by ensuring that the project enables the government of South Sudan to markedly reduce the burden of HIV/AIDS and TB and improve access to health care through resilient and strengthened systems for health – thus, improving productivity of the population and contributing to the eradication of poverty. The project's interventions towards developing the capacity of the government structure and functions, the national NGOs, CSOs and networks aligns with the UNSDCF Outcome 3: Children, women, and men in South Sudan, particularly youth and vulnerable groups, enjoy improved coverage of inclusive, responsive, quality social services and social protection.The project's ouputs also align with the Results and Resources Framework (IRRF)'s Output 3.1. National health service delivery strengthened through scaling up HIV and tuberculosis services and building resilient health systems**.** Through scaled up HIV, TB and other primary health services across South Sudan, the project aligns with the NDS outcome of 'Increase support to the social sector for human capital development and protect the vulnerable population, to leave no one behind' and Strategic Plan Outcome 2: 'No one left behind centering on equitable access to opportunities and a rights-based approach to human agency and human development'.

V. RESULTS FRAMEWORK[2]

[2]UNDP publishes its project information (indicators, baselines, targets and results) to meet the International Aid Transparency Initiative (IATI) standards. Make sure that indicators are S.M.A.R.T. (Specific, Measurable, Attainable, Relevant and Time-bound), provide accurate baselines and targets underpinned by reliable evidence and data, and avoid acronyms so that external audience clearly understand the results of the project.

EXPECTED OUTPUTS	OUTPUT INDICATORS[3]	DATA SOURCE	BASELINE		TARGETS			DATA COLLECTION METHODS
			Value	Year	Year 1	Year 2	Year 3	
Output 1:Improved TB case notification and enhanced quality of TB programme	1.Number of notified cases of all forms of TB, new and relapse	*Facility Reports*	19659	2022	24,879	25,879	26,879	DHIS2, Quarterly Programme reports from MOH and SRs
	2. Treatment success rate - all forms: percentage of TB cases, all forms treated among all TB cases registered for treatment during a specified period.	*Facility Reports*	83%	2022	85%	87%	90%	Same as above
	TBDT-4 Percentage of new and relapse TB patients tested using WHO recommended rapid diagnostic tests at the time of diagnosis	*Facility reports*		2024	7,915/ 12,439 63.63%	9,572/ 12,939 73.98%	11,390/ 13,439 84.75%	Same as above
	3. Percentage of laboratories showing adequate performance in external quality assurance for smear microscopy among the total number of laboratories that undertake	*Facility Reports*	86%	2022	89%	92%	95%	Same as above
Output 2: Improved MDR-TB cases detection and quality of MDR-TB care	1.Number and proportion of MDR-TB cases notified	*Facility Reports*	171	2022	230	260	300	Same as above
	2. MDR TB-3(M) Number of cases with RR-TB and/or MDR-TB that began second-line treatment	*Facility Reports*	93%	2022	95%	95%	95%	Same as above
	3. MDR TB-9 Treatment success rate of RR TB and/or MDR-TB: Percentage of cases with RR and/or MDR-TB successfully treated	*Facility Reports*	91%	2022	93%	94%	95%	Same as above
Output 3: HIV Prevention programmes, differentiated HIV testing services scaled up	KP-1c(M) Percentage of sex workers reached with HIV prevention programs - defined package of services	*SR Reports*	77%	2022	67%	72%	77%	SR/SSR reports
	HTS-3c(M) Percentage of sex workers that have received an HIV test during the reporting period and know their results	*SR Reports*	61%	2022	52%	56%	60%	Same as above
Output 4: Human rights-related barriers to HIV/TB services are reduced	N/A	*N/A*						N/A
Output 5: High quality HIV treatment, care and support provided to PLHIV	TCS-1.1(M) Percentage of people on ART among all people living with HIV at the end of the reporting period	*Facility Reports*	56079/164 453 (34%)	2022	75,500/ 144,108 52.42%	83,500/ 144,018 57.98%	91,500/ 144,018 63.53%	DHIS2, Routine HMIS HIV quarterly reports and programme reports
	TCS-1b Percentage of adults (15 and above) on ART among all adults living with HIV at the end of the reporting period	*Facility Reports*	53340/149 705 (36%)	2022	71,612/ 131,798 54.33%	78,958/ 131,798 59.91%	86,394/ 131,798 65.55%	Same as above

	TCS-1c Percentage of children (under 15) on ART among all children living with HIV at the end of the reporting period	*Facility Reports*	2739/14748 (19%)	2022	3,888/ 12,220 31.82%	4,542/ 12,220 37.17%	5,106/ 12,220 41.78%	Same as above
	TB/HIV-6(M) Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	*Facility Reports*	90%	2022	95%	95%	95%	Same as above
	TB/HIV-5 Percentage of registered new and relapse TB patients with documented HIV status	*Facility Reports*	92%	2022	95%	95%	95%	Same as above
	TB/HIV-7.1 Percentage of people living with HIV currently enrolled on antiretroviral therapy who started TB preventive treatment (TPT) during the reporting period	*Facility reports*	9%	2022	23%	25%	27%	Same as above
Output 6: Prevention of mother-to-child transmsion of HIV enhanced	TCS-10 Percentage of HIV-positive women who received ART during pregnancy and/or labour and delivery	*Facility Reports/2022 Spectrum Estimates*	4905/7233 (68%)	2022	5406/7233 (37%)	5606/7202 (39%)	5806/7144 (41%)	Same as above
	VT-2 Percentage of HIV-exposed infants receiving a virological test for HIV within 2 months of birth	*Facility Reports*	1655/7233 (23S%)	2022	1714/7233 (12%)	1766/7233 (12%)	1836/7144 (13%)	EID registers, DHIS2
Output 7: Resilient and sustainable systems for health established	M&E-2a Completeness of facility reporting: Percentage of expected facility monthly reports (for the reporting period) that are actually received	*Facility Reports*	512/570 (90%)	2022	512/570 (90%)	512/570 (90%)	512/570 (90%)	Same as above
	RSSH/PP HRH-5 Percentage of facilities that implement supportive supervision (meeting all key attributes)			2024				Targets to come from the Targeted Health Facility Assessment (THFA) to be conducted in 2024
	RSSH/PP HRH-7 Percentage of facilities providing patient-centered quality of care			2024				Same as above
	RSSH/PP LAB-5 Percentage of health facilities that have an appropriate set of diagnostics for their healthcare facility level, based on the WHO's model list of essential in vitro diagnostics (EDL 3)			2024				Same as above
	CSS-3 Percentage of health service delivery sites with a community-led monitoring mechanism in place			2024				Same as above

[3]It is recommended that projects use output indicators from the Strategic Plan IRRF, as relevant, in addition to project-specific results indicators. Indicators should be disaggregated by sex or for other targeted groups where relevant.

VI. MONITORING AND EVALUATION

In accordance with UNDP's programming policies and procedures, the project will be monitored through the following monitoring and evaluation plans

Monitoring Plan

Monitoring Activity	Purpose	Frequency	Expected Action	Partners (if joint)	Cost (if any)
Track results progress	Progress data against the results indicators in the RRF will be collected and analysed to assess the progress of the project in achieving the agreed outputs.	Quarterly, or in the frequency required for each indicator.	Slower than expected progress will be addressed by project management.	MoH, Implementing Partners	
Monitor and Manage Risk	Identify specific risks that may threaten achievement of intended results. Identify and monitor risk management actions using a risk log. This includes monitoring measures and plans that may have been required as per UNDP's Social and Environmental Standards. Audits will be conducted in accordance with UNDP's audit policy to manage financial risk.	Quarterly	Risks are identified by project management and actions are taken to manage risk. The risk log is actively maintained to keep track of identified risks and actions taken.	MoH, Implementing Partners	
Learn	Knowledge, good practices and lessons will be captured regularly, as well as actively sourced from other projects and partners and integrated back into the project.	At least annually	Relevant lessons are captured by the project team and used to inform management decisions.	MoH, WHO, Implementing Partners	
Annual Project Quality Assurance	The quality of the project will be assessed against UNDP's quality standards to identify project strengths and weaknesses and to inform management decision making to improve the project.	Annually	Areas of strength and weakness will be reviewed by project management and used to inform decisions to improve project performance.		
Review and Make Course Corrections	Internal review of data and evidence from all monitoring actions to inform decision making.	At least annually	Performance data, risks, lessons and quality will be discussed by the project board and used to make course corrections.		
Project Report	A progress report will be presented to the Project Board and key stakeholders, consisting of progress data showing the results achieved against pre-defined annual targets at the output level, the annual project quality rating summary, an updated risk log with mitigation measures, and any evaluation or review reports prepared over the period.	Quarterly, Annually, and at the end of the project (final report)		MoH, WHO, CCM Implementing Partners and health sector stakeholders	
Project Review (Project Board)	The project's governance mechanism (i.e., project board) will hold regular project reviews to assess the performance of the project and review the Multi-Year Work Plan to ensure realistic budgeting over the life of the project. In the project's final year, the Project Board shall hold an end-of project review to capture lessons learned and discuss opportunities for scaling up and to socialize project results and lessons learned with relevant audiences.	Quarterly, Annually	Any quality concerns or slower than expected progress should be discussed by the project board and management actions agreed to address the issues identified.	CCM	

Evaluation Plan[4]

Evaluation Title	Partners (if joint)	Related Strategic Plan Output	UNDAF/CPD Outcome	Planned Completion Date	Key Evaluation Stakeholders	Cost and Source of Funding
Mid-Term Review	MOH and SSAC	**Output 1.2.** Vulnerable population groups have access to tuberculosis, HIV and AIDS prevention, care, and treatment	**Outcome No.3** Children, women, and men in South Sudan, particularly youth and vulnerable groups, enjoy improved coverage of inclusive, responsive, quality social services and social protection	December 2025	MoH, WHO, Implementating Partners, donors, beneficiaries	GFATM
End-Term Review	MOH and SSAC	**Output 1.2.** Vulnerable population groups have access to tuberculosis, HIV and AIDS prevention, care, and treatment	Outcome No.3 Children, women, and men in South Sudan, particularly youth and vulnerable groups, enjoy improved coverage of inclusive, responsive, quality social services and social protection	December 2026	MoH, WHO, Implementating Partners, donors, beneficiaries	GFATM

[4] Optional, if needed

VII. MULTI-YEARWORK PLAN [56]

	01/Jan/24 31/Dec/24	01/Jan/25 31/Dec/25	01/Jan/26 31/Dec/26			
By Module	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**	**%**
Differentiated HIV Testing Services	1.480.713	1.456.713	1.482.886	0	4.420.313	5%
RSSH/PP: Laboratory systems (including national and peripheral)	790.910	2.628.675	606.818	0	4.026.403	4%
Elimination of vertical transmission of HIV, syphilis and hepatitis B	702.263	500.262	520.752	0	1.723.277	2%
Prevention package for men who have sex with men (MSM) and their sexual partners	53.136	0	0	0	53.136	0%
Prevention package for other vulnerable populations (OVP)	253.180	236.580	236.580	0	726.340	1%
Prevention package for people who use drugs (PUD) and their sexual partners	80.078	8.608	10.173	0	98.859	0%
Prevention package for sex workers, their clients and other sexual partners	254.770	173.174	184.565	0	612.509	1%
Prevention program stewardship	127.018	0	0	0	127.018	0%
Treatment, care and support	9.564.178	9.801.565	10.342.860	0	29.708.603	33%
RSSH/PP: Human resources for health (HRH) and quality of care	1.745.120	1.654.200	3.316.200	0	6.715.520	7%
TB diagnosis, treatment and care	2.893.291	2.904.901	2.966.956	0	8.765.147	10%
TB/DR-TB Prevention	136.895	137.030	136.651	0	410.576	0%
Drug-resistant (DR)-TB diagnosis, treatment and care	1.232.534	1.062.280	1.283.099	0	3.577.913	4%
TB/HIV	354.743	306.569	203.145	0	864.458	1%
Key and vulnerable populations (KVP) – TB/DR-TB	152.155	191.799	176.455	0	520.409	1%
Reducing human rights-related barriers to HIV/TB services	316.385	85.895	85.895	0	488.175	1%
RSSH: Community systems strengthening	425.660	410.043	566.643	0	1.402.346	2%
RSSH: Health products management systems	1.626.949	925.555	927.606	0	3.480.111	4%
RSSH: Monitoring and evaluation systems	883.295	1.504.912	616.392	0	3.004.599	3%
Total	**29.396.281**	**30.571.836**	**30.714.740**	**0**	***90.682.856**	**100%**

Under revision based on the notification for reduction

[5] Cost definitions and classifications for programme and development effectiveness costs to be charged to the project are defined in the Executive Board decision DP/2010/32

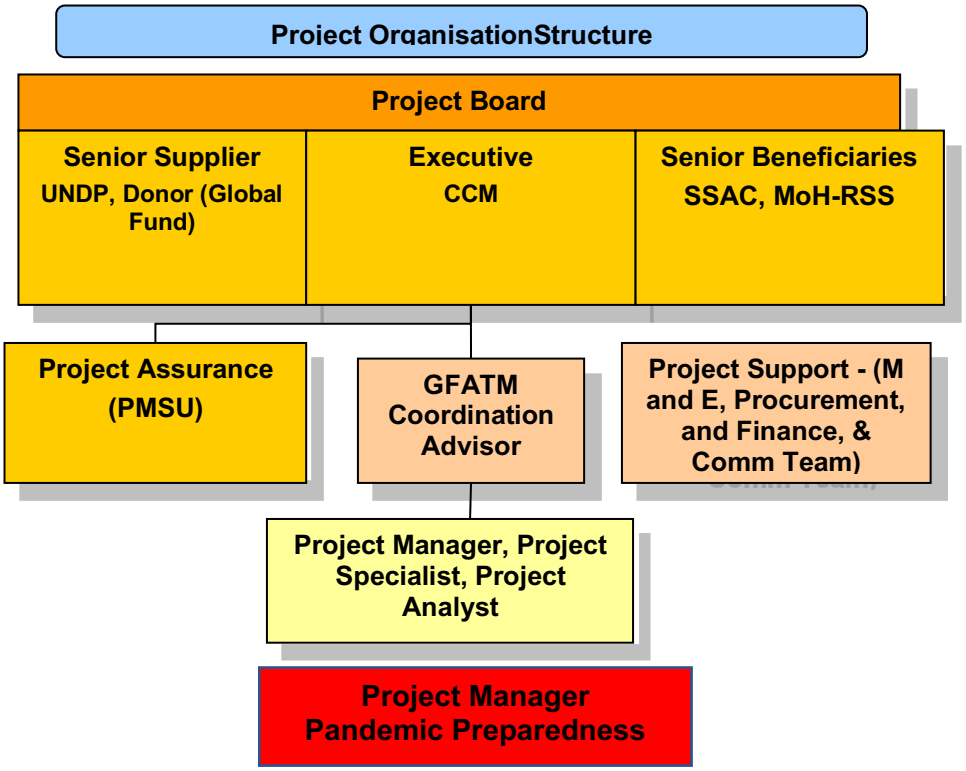
[6]Changes to a project budget affecting the scope (outputs), completion date, or total estimated project costs require a formal budget revision that must be signed by the project board. In other cases, the UNDP programme manager alone may sign the revision provided the other signatories have no objection. This procedure may be applied for example when the purpose of the revision is only to re-phase activities among years.

VIII. GOVERNANCE AND MANAGEMENT ARRANGEMENTS

The project will be managed by UNDP under UNDP's Direct Implementation Modality (DIM)in close collaboration with the Ministry of Health (MoH) and the South Sudan AIDS Commission (SSAC). The project will operate under the oversight of a Project Board which includes the Chair Person of Country Coordinating Mechanism South Sudan (CCM-SS), SSAC and MoH. The Project Board meets on a quarterly basis. The Project Board is responsible for the overall direction and oversight of the project and has responsibility and authority for the project within thelimit of the project mandate. The Project Board approves all major plans and authorises any major deviation from agreed plans. It is the authority that signs off the completion of each year of the project, as well as authorises the start of the next year. It ensures that required resources are committed, and arbitrates on any conflicts within the project, negotiating solutions to any problems between the project and external bodies.

The Project Board is ultimately responsible for assuring that the project remains on course to deliver the desired outcome of the project as defined in the Project Document. According to the size, complexity and risk of the project, the Project Board may decide to delegate some of this Project Assurance responsibility.

The overall project organisation structure is as follows:



The Global Fund project is a standalone project that reports to the Deputy Resident Representative (Programme) and is supported by the Programme Management Support Unit (PMSU) for project assurance and other Units for collaborative works. In South Sudan, UNDP has been serving as theinterim Principal Recipient (PR) since 2004 for five GFATM grants. The PR works in collaboration with national and international partners involved in the fight against HIV and AIDS. The Global Fund resources are additional to national resources as well as resources from other partners.

The Country Coordination Mechanism (CCM) performs the oversight function as well as monitoring and evaluation of the Global Fund projects in the country. Different stages of project implementation such as project amendments and no cost extension requests are cleared by and submitted to the Global Fund through the CCM.

The Local Fund Agent (LFA)serves as Global Fund's representative in the country. For South Sudan's Global Fund project, the LFA designated by the Global Fund is KPMG. It provides conducts verification of the programmatic and financial reports semi-annually and makes recommendations to the Global Fund with regards to project progress and disbursement of funds. The project does not directly report to the LFA but it ensures that all supporting documents are made available during the verification and questions/issues raised by the LFA team are responded to satisfactorily.

The Project management Unit (PMU) of the PR has four major functions detailed below.

Project Management: This is comprised of a GF Coordination Advisor, a Project Manager, Project Manager, C19RM, a Project Specialist and a Project Analyst. The GF Coordination Advisor is fully responsible for the overall coordination of the project activities. The GF Coordination Advisor and the Project Manager work in close collaboration with national counterparts and other stakeholders to implement the project. An important piece of the project management functions is the management of the Sub-Recipients (SRs) who directly implements the project activities and at times also do so through Sub-Sub Recipients (SSRs).

Procurement and Supply Chain Management: This team is headed by a Procurement and Supply Chain Management Specialist and supported by a Procurement Analyst and an Associate. Under the grant agreement signed between UNDP as PR and the Global Fund, all procurement activities are exclusively done by the PR. The PR, in collaboration with the Ministry of Health, is responsible for the quantification of all drugs and supplies. It is also responsible for proper storage of these drugs and other consumables and timely distribution to various health facilities. The PR conducts support supervision to the health facilities and trains the health care providers in the rational use of drugs.

Finance Management: This team is made up of a Finance Specialist, an Analyst, two Finance Associates, and one Administrative Assistant. The finance team is responsible for budget management.

Monitoring and Evaluation: This team is composed of an M&E Specialist and two Data Analysts based within the PMU.The team is responsible for monitoring of project activities, review and verification of data and preparation of progress reports to the donor. In addition, the team works to strengthen the M&E systems of the Ministry of Health at all levels.

The PR will subcontract six agencies (Sub-Recipients – SRs) to execute this project as follows:

(i) Government agencies: Ministry of Health and SSAC
(ii) NGOs: AAA, Cordaid, AMREF and ICAP
(iii) UN agency: UNFPA

IX. LEGAL CONTEXT

This document together with the CPAP signed by the Government and UNDP which is incorporated by reference constitute together a Project Document as referred to in the SBAA and all CPAP provisions apply to this document.

Consistent with the Article III of the Standard Basic Assistance Agreement, the responsibility for the safety and security of the implementing partner and its personnel and property, and of UNDP's property in the implementing partner's custody, rests with the implementing partner.
The implementing partner shall put in place an appropriate security plan and maintain the security plan, taking into account the security situation in the country where the project is being carried; assume all risks and liabilities related to the implementing partner's security, and the full implementation of the security plan.

UNDP reserves the right to verify whether such a plan is in place, and to suggest modifications to the plan when necessary. Failure to maintain and implement an appropriate security plan as required hereunder shall be deemed a breach of this agreement.

The implementing partner agrees to undertake all reasonable efforts to ensure that none of the UNDP funds received pursuant to the Project Document are used to provide support to individuals or entities associated with terrorism and that the recipients of any amounts provided by UNDP hereunder do not appear on the list maintained by the Security Council Committee established pursuant to resolution 1267 (1999). The list can be accessed viahttp://www.un.org/Docs/sc/committees/1267/1267ListEng.htm.This provision must be included in all sub-contracts or sub-agreements entered into under this Project Document".

X. RISK MANAGEMENT

Government Entity (NIM)

1. Consistent with the the Supplemental Provisions to the Project Document, the responsibility for the safety and security of the Implementing Partner and its personnel and property, and of UNDP's property in the Implementing Partner's custody, rests with the Implementing Partner. To this end, the Implementing Partner shall:
   a) put in place an appropriate security plan and maintain the security plan, taking into account the security situation in the country where the project is being carried;
   b) assume all risks and liabilities related to the Implementing Partner's security, and the full implementation of the security plan.

2. UNDP reserves the right to verify whether such a plan is in place, and to suggest modifications to the plan when necessary. Failure to maintain and implement an appropriate security plan as required hereunder shall be deemed a breach of the Implementing Partner's obligations under this Project Document.

3. The Implementing Partner agrees to undertake all reasonable efforts to ensure that no UNDP funds received pursuant to the Project Document are used to provide support to individuals or entities associated with terrorism and that the recipients of any amounts provided by UNDP hereunder do not appear on the list maintained by the Security Council Committee established pursuant to resolution 1267 (1999). The list can be accessed via http://www.un.org/sc/committees/1267/aq_sanctions_list.shtml.

4. Social and environmental sustainability will be enhanced through application of the UNDP Social and Environmental Standards (http://www.undp.org/ses) and related Accountability Mechanism (http://www.undp.org/secu-srm).

5. The Implementing Partner shall: (a) conduct project and programme-related activities in a manner consistent with the UNDP Social and Environmental Standards, (b) implement any management or mitigation plan prepared for the project or programme to comply with such standards, and (c) engage in a constructive and timely manner to address any concerns and complaints raised through the Accountability Mechanism. UNDP will seek to ensure that communities and other project stakeholders are informed of and have access to the Accountability Mechanism.

6. All signatories to the Project Document shall cooperate in good faith with any exercise to evaluate any programme or project-related commitments or compliance with the UNDP Social and Environmental Standards. This includes providing access to project sites, relevant personnel, information, and documentation.

7. The Implementing Partner will take appropriate steps to prevent misuse of funds, fraud or corruption, by its officials, consultants, responsible parties, subcontractors and sub-recipients in implementing the project or using UNDP funds. The Implementing Partner will ensure that its financial management, anti-corruption and anti-fraud policies are in place and enforced for all funding received from or through UNDP.

8. The requirements of the following documents, then in force at the time of signature of the Project Document, apply to the Implementing Partner: (a)UNDP Policy on Fraud and other Corrupt Practices and (b)UNDP Office of Audit and Investigations Investigation Guidelines. The Implementing Partner agrees to the requirements of the above documents, which are an integral part of this Project Document and are available online at www.undp.org.

9. In the event that an investigation is required, UNDP has the obligation to conduct investigations relating to any aspect of UNDP projects and programmes. The Implementing Partner shall provide its full cooperation, including making available personnel, relevant documentation, and granting access to the Implementing Partner's(and its consultants', responsible parties', subcontractors' and sub-recipients') premises, for such purposes at reasonable times and on reasonable conditions as may be required for the purpose of an investigation. Should there be a limitation in meeting this obligation, UNDP shall consult with the Implementing Partner to find a solution.

10. The signatories to this Project Document will promptly inform one another in case of any incidence of inappropriate use of funds, or credible allegation of fraud or corruption with due confidentiality.

    Where the Implementing Partner becomes aware that a UNDP project or activity, in whole or in part, is the focus of investigation for alleged fraud/corruption, the Implementing Partner will inform the UNDP Resident Representative/Head of Office, who will promptly inform UNDP's Office of Audit and Investigations (OAI). The Implementing Partner shall provide regular updates to the head of UNDP in the country and OAI of the status of, and actions relating to, such investigation.

11. UNDP shall be entitled to a refund from the Implementing Partner of any funds provided that have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of the Project Document. Such amount may be deducted by UNDP from any payment due to the Implementing Partner under this or any other agreement. Recovery of such amount by UNDP shall not diminish or curtail the Implementing Partner's obligations under this Project Document.

    Where such funds have not been refunded to UNDP, the Implementing Partner agrees that donors to UNDP (including the Government) whose funding is the source, in whole or in part, of the funds for the activities under this Project Document, may seek recourse to the Implementing Partner for the recovery of any funds determined by UNDP to have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of the Project Document.

Note: The term "Project Document" as used in this clause shall be deemed to include any relevant subsidiary agreement further to the Project Document, including those with responsible parties, subcontractors and sub-recipients.

12. Each contract issued by the Implementing Partner in connection with this Project Document shall include a provision representing that no fees, gratuities, rebates, gifts, commissions or other payments, other than those shown in the proposal, have been given, received, or promised in connection with the selection process or in contract execution, and that the recipient of funds from the Implementing Partner shall cooperate with any and all investigations and post-payment audits.

13. Should UNDP refer to the relevant national authorities for appropriate legal action any alleged wrongdoing relating to the project, the Government will ensure that the relevant national authorities shall actively investigate the same and take appropriate legal action against all individuals found to have participated in the wrongdoing, recover and return any recovered funds to UNDP.

14. The Implementing Partner shall ensure that all of its obligations set forth under this section entitled "Risk Management" are passed on to each responsible party, subcontractor and sub-recipient and that all the clauses under this section entitled "Risk Management Standard Clauses" are included, *mutatis mutandis*, in all sub-contracts or sub-agreements entered into further to this Project Document.

CSO/NGO/Non-UN or other IGO with no signed SBEAA with UNDP

1. Consistent with the Article III of the SBAA *[or the Supplemental Provisions to the Project Document]*, the responsibility for the safety and security of the Implementing Partner and its personnel and property, and of UNDP's property in the Implementing Partner's custody, rests with the Implementing Partner. To this end, the Implementing Partner shall:
   a) put in place an appropriate security plan and maintain the security plan, taking into account the security situation in the country where the project is being carried;
   b) assume all risks and liabilities related to the Implementing Partner's security, and the full implementation of the security plan.

2. UNDP reserves the right to verify whether such a plan is in place, and to suggest modifications to the plan when necessary. Failure to maintain and implement an appropriate security plan as required hereunder shall be deemed a breach of the Implementing Partner's obligations under this Project Document and the Project Cooperation Agreement between UNDP and the Implementing Partner[7].

3. The Implementing Partner agrees to undertake all reasonable efforts to ensure that no UNDP funds received pursuant to the Project Document are used to provide support to individuals or entities associated with terrorism and that the recipients of any amounts provided by UNDP hereunder do not appear on the list maintained by the Security Council Committee established pursuant to resolution 1267 (1999). The list can be accessed via http://www.un.org/sc/committees/1267/aq_sanctions_list.shtml.

4. Social and environmental sustainability will be enhanced through application of the UNDP Social and Environmental Standards (http://www.undp.org/ses) and related Accountability Mechanism (http://www.undp.org/secu-srm).

5. The Implementing Partner shall: (a) conduct project and programme-related activities in a manner consistent with the UNDP Social and Environmental Standards, (b) implement any management or mitigation plan prepared for the project or programme to comply with such standards, and (c) engage in a constructive and timely manner to address any concerns and complaints raised through the Accountability Mechanism. UNDP will seek to ensure that communities and other project stakeholders are informed of and have access to the Accountability Mechanism.

[7] Use bracketed text only when IP is an NGO/IGO

6. All signatories to the Project Document shall cooperate in good faith with any exercise to evaluate any programme or project-related commitments or compliance with the UNDP Social and Environmental Standards. This includes providing access to project sites, relevant personnel, information, and documentation.

7. The Implementing Partner will take appropriate steps to prevent misuse of funds, fraud or corruption, by its officials, consultants, responsible parties, subcontractors and sub-recipients in implementing the project or using the UNDP funds. The Implementing Partner will ensure that its financial management, anti-corruption and anti-fraud policies are in place and enforced for all funding received from or through UNDP.

8. The requirements of the following documents, then in force at the time of signature of the Project Document, apply to the Implementing Partner: (a)UNDP Policy on Fraud and other Corrupt Practices and (b)UNDP Office of Audit and Investigations Investigation Guidelines. The Implementing Partner agrees to the requirements of the above documents, which are an integral part of this Project Document and are available online at www.undp.org.

9. In the event that an investigation is required, UNDP has the obligation to conduct investigations relating to any aspect of UNDP programmes and projects. The Implementing Partner shall provide its full cooperation, including making available personnel, relevant documentation, and granting access to the Implementing Partner's(and its consultants', responsible parties', subcontractors' and sub-recipients') premises, for such purposes at reasonable times and on reasonable conditions as may be required for the purpose of an investigation. Should there be a limitation in meeting this obligation, UNDP shall consult with the Implementing Partner to find a solution.

10. The Implementing Partner will promptly inform UNDP in case of any incidence of inappropriate use of funds, or credible allegation of fraud or corruption with due confidentiality.

    Where the Implementing Partner becomes aware that a UNDP project or activity, in whole or in part, is the focus of investigation for alleged fraud/corruption, the Implementing Partner will inform the UNDP Resident Representative/Head of Office, who will promptly inform UNDP's Office of Audit and Investigations (OAI). The Implementing Partner shall provide regular updates to the head of UNDP in the country and OAI of the status of, and actions relating to, such investigation.

11. UNDP shall be entitled to a refund from the Implementing Partner of any funds provided that have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of this Project Document. Such amount may be deducted by UNDP from any payment due to the Implementing Partner under this or any other agreement. Recovery of such amount by UNDP shall not diminish or curtail the Implementing Partner's obligations under this Project Document.

    Where such funds have not been refunded to UNDP, the Implementing Partner agrees that donors to UNDP (including the Government) whose funding is the source, in whole or in part, of the funds for the activities under this Project Document, may seek recourse to the Implementing Partner for the recovery of any funds determined by UNDP to have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of the Project Document.

    Note: The term "Project Document" as used in this clause shall be deemed to include any relevant subsidiary agreement further to the Project Document, including those with the Implementing Partner, responsible parties, subcontractors and sub-recipients.

12. Each contract issued by the Implementing Partner in connection with this Project Document shall include a provision representing that no fees, gratuities, rebates, gifts, commissions or other payments, other than those shown in the proposal, have been given, received, or promised in connection with the selection process or in contract execution, and that the recipient of funds

from the Implementing Partner shall cooperate with any and all investigations and post-payment audits.

13. Should UNDP refer to the relevant national authorities for appropriate legal action any alleged wrongdoing relating to the project, the Government will ensure that the relevant national authorities shall actively investigate the same and take appropriate legal action against all individuals found to have participated in the wrongdoing, recover and return any recovered funds to UNDP.

14. The Implementing Partner shall ensure that all of its obligations set forth under this section entitled “Risk Management Standard Clauses” are passed on to each responsible party, subcontractor and sub-recipient and that all the clauses under this section entitled “Risk Management” are included, *mutatis mutandis*, in all sub-contracts or sub-agreements entered into further to this Project Document.

XI. ANNEXES

Annex 1: SOUTH SUDAN – RISK & ASSURANCE MATRIX
Annex 2: SESP
Annex 3: TOR- Senior Project Staff

Annex 1: SOUTH SUDAN – RISK & ASSURANCE MATRIX

Annex 1: RISK MATRIX FOR THE GLOBAL FUND PROGRAMME (GC7 HIV/TB/RSSH AND C19RM GRANTS)												
CPD Outcome 3: Children, women and men in South Sudan, particularly youth and vulnerable groups, enjoy improved coverage of inclusive, responsive, quality social services and social protection Indicative Output(s) with gender marker 2: GEN 2 **Output 3.1.:** *National health service delivery strengthened* through scaling up HIV and tuberculosis services and *building resilient health systems.*												
N.	**Risk Category**	**Risk Statement**	**Activity/Intervention Affected**	**Risk Owner (accountable team, or unit for overall monitoring/managing of risk)**	**Likelihood**	**Impact**	**Rating**	**Risk Mitigation Measure (s)**	**Person(s)/Position(s) Responsible**	**Residual Risk**	**Additional Mitigation Measures**	**Frequency of Review**
1	Social & environmental	Community safety and security incidents can impede implementation of priority interventions at local, community levels.	HIV and TB service delivery in local health facilities; delivery of interventions for KPs in affected locations; RSSH interventions in affected locations; payment of incentives in affected locations.	UNDP Global Fund PMU (Programme Management Team)	4	5	4	a) Utilise UNDSS reports for timely monitoring of localised risk of conflict; b) Have routine engagements with SRs and other partners to continuously monitor and anticipate risks; c) work with MOH and other SRs to have in place contingency plans (including identification of alternative service deliver points) in case of localised service interruptions; d) have in place contingency plans for the protection of assets (GeneXperts, tablets, for example) and security of data in areas with localised insecurity and/or service interruptions.	a) PMU team; b) Project Managers; c) Project Managers; d) Finance Specialist, Asset Management Focal Point, M&E Specialist	3	Work with MOH and SRs to relocate service delivery in sites where security risks are elevated.	This risk is reviewed weekly.
2	Social & environmental	Human rights and gender-related barriers impede access, uptake and retention in services.	HIV and TB service delivery; delivery of interventions for KPs.	UNDP Global Fund PMU (Programme Management Team)	3	3	3	Work with MOH, SSAC, SSNeP+, NEPWU, UNAIDS and KP networks to implement stigma reduction measures and to ensure access to legal support for adversely affected individuals.	Project Manager (GC7), Project Analysts	3	Engage SSAC and MOH to provide support where there are elevated frequencies of stigma, discrimination or violence.	The risk is reviewed quarterly.
3	Financial	Limited asset management and asset protection capabilities lead to loss or damage of Global Fund-supported assets deployed by UNDP to SRs and,	HIV and TB service delivery, particularly diagnostic services; infrastructure projects; monitoring and reporting (including eLMIS).	UNDP Global Fund PMU (Finance and Asset Management Team, Procurement and Warehouse Team)	3	4	3	a) maintain enhanced asset management modality with SRs (joint committee, SR asset focal points); b) develop and roll-out revised asset management SOP; c) implement digital asset tracking solutions to enhance real-time visibility of high-value/high-risk assets.	Finance Specialist, Asset Management Focal Point, Procurement Specialist, Warehouse Manager	3	a) delay deployment of high-value assets in locations where security risks are high; b) proactively move high-value assets to secure locations when security risks are elevated.	The risk is reviewed monthly.

Annex 1: RISK MATRIX FOR THE GLOBAL FUND PROGRAMME (GC7 HIV/TB/RSSH AND C19RM GRANTS)												
CPD Outcome 3: Children, women and men in South Sudan, particularly youth and vulnerable groups, enjoy improved coverage of inclusive, responsive, quality social services and social protection Indicative Output(s) with gender marker 2: GEN 2 **Output 3.1.:** *National health service delivery strengthened* through scaling up HIV and tuberculosis services and *building resilient health systems.*												
N.	**Risk Category**	**Risk Statement**	**Activity/Intervention Affected**	**Risk Owner (accountable team, or unit for overall monitoring/managing of risk)**	**Likelihood**	**Impact**	**Rating**	**Risk Mitigation Measure (s)**	**Person(s)/Position(s) Responsible**	**Residual Risk**	**Additional Mitigation Measures**	**Frequency of Review**
		onwards, to health facilities.										
4	Financial	Ineffective financial oversight leads to unrecovered disallowed costs and low value-for-money in terms of outputs, outcomes and impacts of Global Fund investments.	All funded interventions.	UNDP Global Fund PMU (Finance and Asset Management Team)	2	3	3	a) develop and implement a revised financial management guideline for SRs; b) provide capacity-building, continuous mentoring and close supervision of SR financial management functions; c) maintain monthly financial reporting cycles; d) provide timely transaction reviews with clear recommendations/advice on addressing any gaps and challenges (including disallowed costs); e) respond proactively to evidence (or emerging signs) of financial mismanagement.	Finance Specialist, Quality Assurance Analysts	2	a) proactively change funding modality; b) institute temporary suspensions of SR disbursements.	The risk is reviewed monthly.
5	Operational	There is ineffective oversight of SRs leading to low implementation quality and poor value-for-money from Global Fund investments.	All interventions implemented by SRs.	UNDP Global Fund PMU (Programme Management Team)	2	3	2	a) develop and implement a revised SR management guideline; b) maintain weekly/monthly/quarterly schedule of SR engagements; c) provide continuously capacity-building/mentorship to improve/maintain implementation quality; d) proactively document and address quality concerns through Management Letters at least quarterly.	Project Managers (GC7 & C91RM), M&E Specialist, Finance Specialist	3	a) proactively escalate risk mitigation interventions to address SRs that are faltering; b) alter/suspend SR agreement until quality concerns are addressed.	The risk is reviewed monthly.

Annex 1: RISK MATRIX FOR THE GLOBAL FUND PROGRAMME (GC7 HIV/TB/RSSH AND C19RM GRANTS)

CPD Outcome 3: Children, women and men in South Sudan, particularly youth and vulnerable groups, enjoy improved coverage of inclusive, responsive, quality social services and social protection Indicative Output(s) with gender marker 2: GEN 2
Output 3.1.: *National health service delivery strengthened* through scaling up HIV and tuberculosis services and *building resilient health systems.*

N.	Risk Category	Risk Statement	Activity/Intervention Affected	Risk Owner (accountable team, or unit for overall monitoring/managing of risk)	Likelihood	Impact	Rating	Risk Mitigation Measure (s)	Person(s)/Position(s) Responsible	Residual Risk	Additional Mitigation Measures	Frequency of Review
6	Operational	There is ineffective or incomplete sustainability and transition planning for key RSSH investments, arising largely from limitations in the capacity of the MOH and other government entities to assume full responsibility and ownership.	Priority RSSH interventions, particularly laboratory systems strengthening, health waste management, solarisation, medical oxygen, eLMIS, and health management information strengthening.	UNDP Global Fund PMU	3	3	3	a) Produce and administer templates (MOUs, etc.) for sustainability and transition of priority investments (solar power installations, incinerators, etc.); b) provide TA and other capacity-building support to relevant MOH counterparts (including at state, county and facility level) for long-term ownership/maintenance of assets; c) support MOH to mobilise additional technical/operational resources to ensure sustainability (through HSTP, for example).	Project Managers (GC7 & C19RM), Finance Specialist, Asset Focal Point, Procurement Specialist	3	a) Delay or revise implementation plans to limit risks regarding sustainability and transition.	The risk is reviewed quarterly.
7	Organisational	There are procurement delays and/or in-country risks that prevent the timely supply and distribution of essential commodities to heath facilities providing HIV and TB services, increasing the risk of supply interruptions and stock-outs.	HIV and TB service delivery, including diagnostic services; delivery of interventions for KPs.	UNDP Global Fund PMU (Procurement & Supply Management Team (including Warehouse Team)	2	4	3	a) have in place an annual procurement plan with appropriate milestones/thresholds to anticipate procurement delays; b) include appropriate buffer stocks in annual quantification of essential commodities; c) establish and maintain an electronic stock management system, covering all HIV and TB service delivery sites, with real-time visibility of commodity stocks and movements; d) continuously build the capacity of SRs to support relevant focal points, including health workers, for supply management and timely submission of restocking	Project Managers (GC7 & C19RM), Procurement Specialist, M&E Specialist, Warehouse Manager	3	a) preposition essential commodities in sub-national, secure storage sites to anticipate supply chain interruption; b) increase buffer stocks in anticipation of extended delays in procurement.	The risk is reviewed quarterly.

Annex 1: RISK MATRIX FOR THE GLOBAL FUND PROGRAMME (GC7 HIV/TB/RSSH AND C19RM GRANTS)

CPD Outcome 3: Children, women and men in South Sudan, particularly youth and vulnerable groups, enjoy improved coverage of inclusive, responsive, quality social services and social protection Indicative Output(s) with gender marker 2: GEN 2
Output 3.1.: *National health service delivery strengthened* through scaling up HIV and tuberculosis services and *building resilient health systems.*

N.	Risk Category	Risk Statement	Activity/Intervention Affected	Risk Owner (accountable team, or unit for overall monitoring/managing of risk)	Likelihood	Impact	Rating	Risk Mitigation Measure (s)	Person(s)/Position(s) Responsible	Residual Risk	Additional Mitigation Measures	Frequency of Review
								requests; e) maintain a comprehensive contingency strategy to address unanticipated supply chain interruptions (due to conflict, for example).				
8	Organisational	There is poor quality, including incompleteness or extended delays, in programmatic data reporting and other routine monitoring mechanisms.	All funded interventions.	UNDP Global Fund PMU (M&E and Programme Management Teams)	3	3	3	a) undertake routine capacity-building/mentorship with SRs to improve/maintain quality of data and timeliness of reporting; b) support MOH and SRs to continue to strengthen facility-level reporting and data quality assurance processes; c) maintain a comprehensive supportive supervision process, with tracking and follow-up mechanisms to address and resolve identified gaps.	M&E Specialist	3	a) work with MOH and SRs to have in place additional data security measures, including more frequent back-ups of electronically collected data and increased reporting frequency (weekly instead of monthly, for example).	The risk is reviewed quarterly.
9	Reputational	Poor overall grant performance leads to UNDP being perceived as an ineffective health partner.	All funded interventions.	UNDP Global Fund PMU	2	3	2	a) maintain monthly and quarterly grant performance monitoring processes; b) routinely communicate achievements to CCM, Country Team and other stakeholders to maintain the positive profile of UNDP's Global Fund programme.	Programme Coordination Advisor; Project Managers (GC7 & C19RM); M&E Specialist; Communications Analyst	1	a) undertake additional, proactive public relations interventions to mitigate risks of negative reporting on UNDP performance.	The risk is reviewed quarterly.

Annex 1: RISK MATRIX FOR THE GLOBAL FUND PROGRAMME (GC7 HIV/TB/RSSH AND C19RM GRANTS)

CPD Outcome 3: Children, women and men in South Sudan, particularly youth and vulnerable groups, enjoy improved coverage of inclusive, responsive, quality social services and social protection Indicative Output(s) with gender marker 2: GEN 2
Output 3.1.: *National health service delivery strengthened* through scaling up HIV and tuberculosis services and *building resilient health systems.*

N.	Risk Category	Risk Statement	Activity/Intervention Affected	Risk Owner (accountable team, or unit for overall monitoring/managing of risk)	Likelihood	Impact	Rating	Risk Mitigation Measure (s)	Person(s)/Position(s) Responsible	Residual Risk	Additional Mitigation Measures	Frequency of Review
10	Strategic	Frequent leadership changes at the MOH (and/or in broader governance mechanisms) impede timely grant implementation and effective oversight.	All funded interventions.	UNDP Global Fund PMU	3	4	3	a) maintain positive relations with government counterparts to have proactive knowledge/awareness of pending transitions; b) have in place briefing packages and other materials to rapidly orient newly appointed officials; c) liaise with CCM to routinely engage government to mitigate negative effects of frequent transitions.	Programme Coordination Advisor; Communications Analyst	2	a) engage Country Team to mitigate against risk of disruptions; b) draw on UNDP Country Office counterparts to mitigate against risk of disruptions due to leadership changes.	The risk is reviewed quarterly.
11	Safety & Security	Safety and security risks (including armed conflict, civil unrest and political instability) slows or blocks/suspends grant implementation, including as a result of stringent security measures (mobility restrictions and/or evacuation/relocation).	All funded interventions.	UNDP Global Fund PMU	4	5	4	a) engage proactively with CCM, government counterparts, SRs, Global Fund Country Team and others for 'early warnings' of potentially disruptive trends and events; b) have in place contingency plans involving the MOH and SRs for continuous delivery of HIV and TB services during periods of escalating security risks; c) maintain effective partnership with other health partners, particularly humanitarian partners, to assist with service continuity where required; d) maintain a comprehensive Business Continuity Plan for the UNDP Global Fund programme.	Programme Coordination Advisor; Project Managers (GC7 & C19RM); Procurement Specialist; Communications Analyst	3	a) implement relevant components of the Business Continuity Plan.	The risk is reviewed weekly.

XII. ANNEX 2: UNDP SOCIAL AND ENVIRONMENTAL SCREENING TEMPLATE (V. JULY 2022)

Project Information

Project Information	
1. Project Title	Grant Cycle 7 – Integrated Services for Maximum Impact
2. Project Number (i.e. Atlas project ID, PIMS+)	01001758
3. Location (Global/Region/Country)	South Sudan
4. Project stage (Design or Implementation)	Approval for Implementation
5. Date	30/01/2024

Part A. Integrating Programming Principles to Strengthen Social and Environmental Sustainability

QUESTION 1: How Does the Project Integrate the Programming Principles in Order to Strengthen Social and Environmental Sustainability?
Briefly describe in the space below how the project mainstreams the human rights-based approach
Module 1: Prevention Package for Sex Workers, their clients, and Other Sexual Partners; Module 2: Prevention Package for Other Vulnerable Populations (OVP); Module 3: Prevention Package for Men Who Have Sex with Men (MSM) and Transgender Persons and their Sexual Partners); Module 4. Prevention Package for People Who Use Drugs (PUD) (injecting and non-injecting) and their Sexual Partners as well as under Module 5: Prevention Stewardship (gender and diversity sensitivity training for national stakeholders) all incorporate interventions on removing human rights-related barriers to prevention for OVP and are linked to interventions under Module 15: Reducing Human Rights-related barriers (legal literacy and access to justice
Briefly describe in the space below how the project is likely to improve gender equality and women's empowerment
Under Module 15: Reducing Human Rights-related Barriers to HIV and TB Services, there are interventions aimed at reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity. Similarly, under the complementary C19RM Portfolio Optimization Project, there are interventions to address Gender-based violence prevention and post violence care (COVID-19)
Briefly describe in the space below how the project mainstreams sustainability and resilience
The project will work with the government of South Sudan through (i) integration of TB, HIV, and other health programmes such as the transformative health project; (ii) supporting the government to consolidate domestic resources mobilization; (iii) Building the capacity of national NGOs and CSOs in resource mobilization to support the maintenance of provision of health services. (iv) synergize with the C19RM Portfolio Optimization funding to strengthen health systems in South Sudan.
Briefly describe in the space below how the project strengthens accountability to stakeholders
UNDP will contract the SRs that performed well under the NFM3 grant implemented from 2021 to 2023 (Ministry of Health, South Sudan AIDS Commission, AAA and Cordaid, UNFPA, AMREF, NEPWU) and plus a may also bring on board an additional new SR for the RSSH component. Under this grant, the government institutions are appointed as SRs for activities within their mandate and where they have comparative advantage over non-governmental entities. Hence, the Ministry of Health

(MOH) will be responsible for oversight of implementation of the project activities and coordinating the development of treatment policies and guidelines. The South Sudan HIV/AIDS Commission (SSAC) will be responsible for the HIV and AIDS response leadership, policy, coordination, advocacy, etc. Historically, priority has always been given to government institutions in order to promote country ownership of the programme and build capacity of national institutions in managing the Global Fund grants. In this grant, key modules that specifically focus on leadership, coordination of the disease programmes are assigned to the MOH and SSAC, while the rest of the modules that focus on direct implementation are assigned to national and international NGOs through a competitive process, which involved the MOH, SSAC and the CCM. One of the national NGOs (NEPWU) has recently transitoned from SSR to SR. Capacity strengthening of NEPWU and SSNEP+ will continue so that they can take on more responsibilities and strengthen their community networks.

Part B. Identifying and Managing Social and Environmental Risks

QUESTION 2: What are the Potential Social and Environmental Risks? *Note: Complete SESP Attachment 1 before responding to Question 2.*	**QUESTION 3: What is the level of significance of the potential social and environmental risks?** *Note: Respond to Questions 4 and 5 below before proceeding to Question 5*			**QUESTION 6: Describe the assessment and management measures for each risk rated Moderate, Substantial or High**
Risk Description (broken down by event, cause, impact)	***Impact and Likelihood (1-5)***	***Significance (Low, Moderate Substantial, High)***	***Comments (optional)***	***Description of assessment and management measures for risks rated as Moderate, Substantial or High***
Risk 1: Disruption of services due to the current security status which negatively affects distribution of key drugs and commodities and also results in displacement of populations and health care workers.	I =3 L=3	Substantial		-A draft document of commodities security developed and currently under review, providing a contingency plan for commodities security in various stages of crisis -UNDP will work with humanitarian agencies in early assessment, monitoring of security situations -Specialized agencies will be utilized in delivery of essential health commodities -More regular meetings with security agenda and risk mitigation measures -Local/national NGOs and local networks of PLHIV will be capacitated to provide services
Risk 2: Suboptimal programming *(not achieving targets/impact*) because of rapid changes in operating environment mostly due to internal and external displacement of populations due to insecurity or natural disasters such as flooding Changes in beneficiary needs and locations, leading to limited access of implementers and partners to key areas due to insecurity. Delay or postponement or cancellation activity implementation Influx of refugees and returnees from Sudan due to the conflict between the government and the RSF Overstretched facilities, commodities, and human resources	I =3 L=3	Substantial		-Ensure joint programming and collaboration with other UN Agencies and humanitarian actors in entry corridors such as Renk in Upper Nile State. -Mechanisms put in place for easy tracking of patients and other beneficiaries
	QUESTION 4: What is the overall project risk categorization?			

	Low Risk	☐			
	Moderate Risk	☐			
	Substantial Risk	X			
	High Risk	☐			
	QUESTION 5: Based on the identified risks and risk categorization, what requirements of the SES are triggered? (check all that apply)				
	Question only required for Moderate, Substantial and High Risk projects				
	Is assessment required? (check if "yes")	**X**			***Status? (Completed, planned)***
	if yes, indicate overall type and status		**X**	Targeted assessment(s)	1. Capacity Assessment of SRs completed. 2. Targeted Health Facility Assessment (tHFA) completed by Q2 2025
			☐	ESIA (Environmental and Social Impact Assessment)	
			☐	SESA (Strategic Environmental and Social Assessment)	
	Are management plans required? (Check if "yes)	☐	**NO**		
	If yes, indicate overall type		☐	Targeted management plans (e.g. Gender Action Plan, Emergency Response Plan, Waste Management Plan, others)	

			☐	ESMP (Environmental and Social Management Plan which may include range of targeted plans)	
			☐	ESMF (Environmental and Social Management Framework)	
	Based on identified <u>risks</u>, which Principles/Project- level Standards triggered?		**Comments (not required)**		
	Overarching Principle: Leave No One Behind				
	Human Rights	**X**			
	Gender Equality and Women's Empowerment	**X**			
	Accountability	**X**			
	1. Biodiversity Conservation and Sustainable Natural Resource Management	☐			
	2. Climate Change and Disaster Risks	☐			
	3. Community Health, Safety and Security	☐			
	4. Cultural Heritage	☐			
	5. Displacement and Resettlement	☐			
	6. Indigenous Peoples	☐			
	7. Labour and Working Conditions	☐			
	8. Pollution Prevention and Resource Efficiency	☐			

Final Sign Off

Final Screening at the design-stage is not complete until the following signatures are included

Signature/Name	*Date*	*Description*
QA Assessor (SES Developer) _____ David Ayoola OWOLABI M&E Specialist		UNDP staff member responsible for the project, typically a UNDP Programme Officer. Final signature confirms they have "checked" to ensure that the SESP is adequately conducted.
QA Approver (PMSU) _____ Amit Arora M&E Specialist		UNDP senior manager, typically the UNDP Deputy Country Director (DCD), Country Director (CD), Deputy Resident Representative (DRR), or Resident Representative (RR). The QA Approver cannot also be the QA Assessor. Final signature confirms they have "cleared" the SESP prior to submittal to the PAC.
PAC Chair (DES) _____ Sheila Ngatia DRR-P		UNDP chair of the PAC. In some cases, PAC Chair may also be the QA Approver. Final signature confirms that the SESP was considered as part of the project appraisal and considered in recommendations of the PAC.

SESP Attachment 1. Social and Environmental Risk Screening Checklist

Checklist Potential Social and Environmental Risks	
Overarching Principle: Leave No One Behind **Human Rights**	**Answer (Yes/No)**
P.1 Have local communities or individuals raised human rights concerns regarding the project (e.g. during the stakeholder engagement process, grievance processes, public statements)?	Yes
P.2 Is there a risk that duty-bearers (e.g. government agencies) do not have the capacity to meet their obligations in the project?	Yes
P.3 Is there a risk that rights-holders (e.g. project-affected persons) do not have the capacity to claim their rights?	Yes
Would the project potentially involve or lead to:	
P.4 adverse impacts on enjoyment of the human rights (civil, political, economic, social or cultural) of the affected population and particularly of marginalized groups?	No
P.5 inequitable or discriminatory impacts on affected populations, particularly people living in poverty or marginalized or excluded individuals or groups, including persons with disabilities?[8]	No
P.6 restrictions in availability, quality of and/or access to resources or basic services, in particular to marginalized individuals or groups, including persons with disabilities?	No
P.7 exacerbation of conflicts among and/or the risk of violence to project-affected communities and individuals?	No
Gender Equality and Women's Empowerment	
P.8 Have women's groups/leaders raised gender equality concerns regarding the project, (e.g. during the stakeholder engagement process, grievance processes, public statements)?	Yes
Would the project potentially involve or lead to:	
P.9 adverse impacts on gender equality and/or the situation of women and girls?	No
P.10 reproducing discriminations against women based on gender, especially regarding participation in design and implementation or access to opportunities and benefits?	No
P.11 limitations on women's ability to use, develop and protect natural resources, taking into account different roles and positions of women and men in accessing environmental goods and services? *For example, activities that could lead to natural resources degradation or depletion in communities who depend on these resources for their livelihoods and well being*	No
P.12 exacerbation of risks of gender-based violence? *For example, through the influx of workers to a community, changes in community and household power dynamics, increased exposure to unsafe public places and/or transport, etc*.	No

[8] Prohibited grounds of discrimination include race, ethnicity, sex, age, language, disability, sexual orientation, gender identity, religion, political or other opinion, national or social or geographical origin, property, birth or other status including as an indigenous person or as a member of a minority. References to "women and men" or similar is understood to include women and men, boys and girls, and other groups discriminated against based on their gender identities, such as transgender and transsexual people.

Sustainability and Resilience: Screening questions regarding risks associated with sustainability and resilience are encompassed by the Standard-specific questions below		
Accountability		
Would the project potentially involve or lead to:		
P.13	exclusion of any potentially affected stakeholders, in particular marginalized groups and excluded individuals (including persons with disabilities), from fully participating in decisions that may affect them?	No
P.14	grievances or objections from potentially affected stakeholders?	No
P.15	risks of retaliation or reprisals against stakeholders who express concerns or grievances, or who seek to participate in or to obtain information on the project?	No
Project-Level Standards		
Standard 1: Biodiversity Conservation and Sustainable Natural Resource Management		
Would the project potentially involve or lead to:		
1.1	adverse impacts to habitats (e.g. modified, natural, and critical habitats) and/or ecosystems and ecosystem services? *For example, through habitat loss, conversion or degradation, fragmentation, hydrological changes*	No
1.2	activities within or adjacent to critical habitats and/or environmentally sensitive areas, including (but not limited to) legally protected areas (e.g. nature reserve, national park), areas proposed for protection, or recognized as such by authoritative sources and/or indigenous peoples or local communities?	No
1.3	changes to the use of lands and resources that may have adverse impacts on habitats, ecosystems, and/or livelihoods? (Note: if restrictions and/or limitations of access to lands would apply, refer to Standard 5)	No
1.4	risks to endangered species (e.g. reduction, encroachment on habitat)?	No
1.5	exacerbation of illegal wildlife trade?	No
1.6	introduction of invasive alien species?	No
1.7	adverse impacts on soils?	No
1.8	harvesting of natural forests, plantation development, or reforestation?	No
1.9	significant agricultural production?	No
1.10	animal husbandry or harvesting of fish populations or other aquatic species?	No
1.11	significant extraction, diversion or containment of surface or ground water? *For example, construction of dams, reservoirs, river basin developments, groundwater extraction*	No
1.12	handling or utilization of genetically modified organisms/living modified organisms?[17]	No
1.13	utilization of genetic resources? (e.g. collection and/or harvesting, commercial development)[18]	No
1.14	adverse transboundary or global environmental concerns?	No
Standard 2: Climate Change and Disaster Risks		
Would the project potentially involve or lead to:		No

[17] See the Convention on Biological Diversity and its Cartagena Protocol on Biosafety.

[18] See the Convention on Biological Diversity and its Nagoya Protocol on access and benefit sharing from use of genetic resources.

2.1	areas subject to hazards such as earthquakes, floods, landslides, severe winds, storm surges, tsunami or volcanic eruptions?	No
2.2	outputs and outcomes sensitive or vulnerable to potential impacts of climate change or disasters? *For example, through increased precipitation, drought, temperature, salinity, extreme events, earthquakes*	No
2.3	increases in vulnerability to climate change impacts or disaster risks now or in the future (also known as maladaptive or negative coping practices)? *For example, changes to land use planning may encourage further development of floodplains, potentially increasing the population's vulnerability to climate change, specifically flooding*	No
2.4	increases of greenhouse gas emissions, black carbon emissions or other drivers of climate change?	No
Standard 3: Community Health, Safety and Security		
Would the project potentially involve or lead to:		
3.1	construction and/or infrastructure development (e.g. roads, buildings, dams)? (Note: the GEF does not finance projects that would involve the construction or rehabilitation of large or complex dams)	No
3.2	air pollution, noise, vibration, traffic, injuries, physical hazards, poor surface water quality due to runoff, erosion, sanitation?	No
3.3	harm or losses due to failure of structural elements of the project (e.g. collapse of buildings or infrastructure)?	No
3.4	risks of water-borne or other vector-borne diseases (e.g. temporary breeding habitats), communicable and noncommunicable diseases, nutritional disorders, mental health?	No
3.5	transport, storage, and use and/or disposal of hazardous or dangerous materials (e.g. explosives, fuel and other chemicals during construction and operation)?	No
3.6	adverse impacts on ecosystems and ecosystem services relevant to communities' health (e.g. food, surface water purification, natural buffers from flooding)?	No
3.7	influx of project workers to project areas?	No
3.8	engagement of security personnel to protect facilities and property or to support project activities?	No
Standard 4: Cultural Heritage		
Would the project potentially involve or lead to:		
4.1	activities adjacent to or within a Cultural Heritage site?	No
4.2	significant excavations, demolitions, movement of earth, flooding or other environmental changes?	No
4.3	adverse impacts to sites, structures, or objects with historical, cultural, artistic, traditional or religious values or intangible forms of culture (e.g. knowledge, innovations, practices)? (Note: projects intended to protect and conserve Cultural Heritage may also have inadvertent adverse impacts)	No
4.4	alterations to landscapes and natural features with cultural significance?	No
4.5	utilization of tangible and/or intangible forms (e.g. practices, traditional knowledge) of Cultural Heritage for commercial or other purposes?	No
Standard 5: Displacement and Resettlement		
Would the project potentially involve or lead to:		
5.1	temporary or permanent and full or partial physical displacement (including people without legally recognizable claims to land)?	No

5.2	economic displacement (e.g. loss of assets or access to resources due to land acquisition or access restrictions – even in the absence of physical relocation)?	No
5.3	risk of forced evictions?[19]	No
5.4	impacts on or changes to land tenure arrangements and/or community based property rights/customary rights to land, territories and/or resources?	No
Standard 6: Indigenous Peoples		
Would the project potentially involve or lead to:		
6.1	areas where indigenous peoples are present (including project area of influence)?	No
6.2	activities located on lands and territories claimed by indigenous peoples?	No
6.3	impacts (positive or negative) to the human rights, lands, natural resources, territories, and traditional livelihoods of indigenous peoples (regardless of whether indigenous peoples possess the legal titles to such areas, whether the project is located within or outside of the lands and territories inhabited by the affected peoples, or whether the indigenous peoples are recognized as indigenous peoples by the country in question)? *If the answer to screening question 6.3 is "yes", then Standard 6 requirements apply, and the potential significance of risks related to impacts on indigenous peoples must be Moderate or above.* [*]	No
6.4	the absence of culturally appropriate consultations carried out with the objective of achieving FPIC on matters that may affect the rights and interests, lands, resources, territories and traditional livelihoods of the indigenous peoples concerned?	No
6.5	the utilization and/or commercial development of natural resources on lands and territories claimed by indigenous peoples?	No
6.6	forced eviction or the whole or partial physical or economic displacement of indigenous peoples, including through access restrictions to lands, territories, and resources? *Consider, and where appropriate ensure, consistency with the answers under Standard 5 above*	No
6.7	adverse impacts on the development priorities of indigenous peoples as defined by them?	No
6.8	risks to the physical and cultural survival of indigenous peoples?	No
6.9	impacts on the Cultural Heritage of indigenous peoples, including through the commercialization or use of their traditional knowledge and practices? *Consider, and where appropriate ensure, consistency with the answers under Standard 4 above.*	No
Standard 7: Labour and Working Conditions		
Would the project potentially involve or lead to: (note: applies to project and contractor workers)		
7.1	working conditions that do not meet national labour laws and international commitments?	No
7.2	working conditions that may deny freedom of association and collective bargaining?	No
7.3	use of child labour?	No
7.4	use of forced labour?	No
7.5	discriminatory working conditions and/or lack of equal opportunity?	No
7.6	occupational health and safety risks due to physical, chemical, biological and psychosocial hazards (including violence and harassment) throughout the project life-cycle?	No

[*] Note: revised July 2022 modifying presumption of risk significance from Substantial or higher to Moderate or higher.

[19] Forced eviction is defined here as the permanent or temporary removal against their will of individuals, families or communities from the homes and/or land which they occupy, without the provision of, and access to, appropriate forms of legal or other protection. Forced evictions constitute gross violations of a range of internationally recognized human rights.

Standard 8: Pollution Prevention and Resource Efficiency		
Would the project potentially involve or lead to:		
8.1	the release of pollutants to the environment due to routine or non-routine circumstances with the potential for adverse local, regional, and/or transboundary impacts?	No
8.2	the generation of waste (both hazardous and non-hazardous)?	No
8.3	the manufacture, trade, release, and/or use of hazardous materials and/or chemicals?	No
8.4	the use of chemicals or materials subject to international bans or phase-outs? *For example, DDT, PCBs and other chemicals listed in international conventions such as the Montreal Protocol, Minamata Convention, Basel Convention, Rotterdam Convention, Stockholm Convention*	No
8.5	the application of pesticides that may have a negative effect on the environment or human health?	No
8.6	significant consumption of raw materials, energy, and/or water?	No

PROJECT QUALITY ASSURANCE – DESIGN FOR FY2023 (VERSION 5)
GC7 (2024-2026)

☒	**PROJECT QA - DESIGN**
	1. STRATEGIC
	1. Does the project specify how it will contribute to higher level change through linkage to the programme's Theory of Change?
☒	• 3: The project is clearly linked to the programme's theory of change. It has an explicit change pathway that explains how the project will contribute to coverage, outcome and impact level change and why the project's strategy will likely lead to this change. This analysis is backed by credible evidence of what works effectively in this context and includes assumptions and risks.
☐	• 2: The project is clearly linked to the programme's theory of change. It has a change pathway that explains how the project will contribute to outcome-level change and why the project strategy will likely lead to this change.
☐	• 1: The project document may describe in generic terms how the project will contribute to development results, without an explicit link to the programme's theory of change. *Note: Projects not contributing to a programme must have a project-specific Theory of Change. See alternative question under the information icon for these cases.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The grant builds on the achievements of the New Funding Model (NFM3) HIV/TB ad Resilient and sustainable systems for health (RSSH) grants and provides integrated support to the two diseases and building resilient and sustainable systems for health for pandemic preparedness and response. The grant aims at providing comprehensive HIV and TB services across South Sudan, while creating resilient and sustainable systems for health to address any future pandemic. This is expected to be achieved through implementation of multiple modules, interventions and activities.
	2. Is the project aligned with the UNDP Strategic Plan?
☒	• 3: The project responds to at least one of the development settings as specified in the Strategic Plan[9] and adapts at least one Signature Solution[10]. The project's RRF includes all the relevant SP output indicators. (All must be true)
☐	• 2: The project responds to at least one of the development settings as specified in the Strategic Plan[11]. The project's RRF includes at least one SP output indicator, if relevant. (Both must be true)
☐	• 1: The project responds to a partner's identified need, but this need falls outside of the UNDP Strategic Plan. Also select this option if none of the relevant SP indicators are included in the RRF.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The project is aligned with the National Development Strategy objective on: Increase support to the social sector for human capital development and protect the vulnerable population, to leave no one behind; Strategic Plan Outcome 2: No one left behind centering on equitable access to opportunities and a rights-based approach to human agency and human development; UNSDCF Outcome 3: Children, women, and men in South Sudan, particularly youth and vulnerable groups, enjoy improved coverage of inclusive, responsive, quality social services and social protection.
	3.) Is the project linked to the programme outputs? (i.e., UNSDCF/CPD, RPD or Strategic Plan IRRF for strategic interventions not part of a programme
☒	• Yes
☐	• No (Project QA cannot be approved by the Project QA Approver)
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The project contributes to the achievement of: UNSDCF/UNDP Outcome 3: Children, women, and men in South Sudan, particularly youth and vulnerable groups, enjoy improved coverage of inclusive, responsive, quality social services and social protection. Output 3.1.: National health service delivery strengthened through scaling up HIV and tuberculosis services and building resilient health systems.

[9] The three development settings in UNDP's 2018-2021 Strategic Plan are: a) Eradicate poverty in all its forms and dimensions; b) Accelerate structural transformations for sustainable development; and c) Build resilience to shocks and crises

[10] The six Signature Solutions of UNDP's 2018-2021 Strategic Plan are: a) Keeping people out of poverty; b) Strengthen effective, inclusive and accountable governance; c) Enhance national prevention and recovery capacities for resilient societies; d) Promote nature based solutions for a sustainable planet; e) Close the energy gap; and f) Strengthen gender equality and the empowerment of women and girls.

[11] The three development settings in UNDP's 2018-2021 Strategic Plan are: a) Eradicate poverty in all its forms and dimensions; b) Accelerate structural transformations for sustainable development; and c) Build resilience to shocks and crises

☒	**PROJECT QA - DESIGN**
	2. RELEVANT
	4. Does the project identity target groups, and particularly those marginalized, vulnerable and left further behind (LNOB)? [12]
☒	• 3: The target groups are clearly specified, prioritizing discriminated, and marginalized groups left furthest behind, identified through a rigorous process based on evidence.
☐	• 2: The target groups are clearly specified, prioritizing groups left furthest behind.
☐	• 1: The target groups are not clearly specified.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The direct beneficiaries of the project are as follow: • Adults and children living with HIV/AIDS receiving ARV treatment. • TB patients on treatment; key and vulnerable populations including sex workers and their clients, IDPs, prisoners. • General population at risk of HIV/AIDS and TB; • Health sector overall (through improved coordination, human resources, and information systems)
	5. Have knowledge, good practices, and past lessons learned of UNDP and others informed the project design?
☒	• 3: Knowledge and lessons learned backed by credible evidence from sources such as evaluation, corporate policies/strategies, and/or monitoring have been explicitly used, with appropriate referencing, to justify the approach used by the project.
☐	• 2: The project design mentions knowledge and lessons learned backed by evidence/sources but have not been used to justify the approach selected.
☐	• 1: There is little, or no mention of knowledge and lessons learned informing the project design. Any references made are anecdotal and not backed by evidence.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): UNDP has a wealth of knowledge, good practices, and past lessons globally and locally, and as a PR of Global Fund grants in about 21 countries that can be used in the Project. UNDP also has a knowledge of local contexts in South Sudan which can provide valuable insights into local conditions, including cultural, social, economic, and political factors that may impact the success of this project.
	6. Does UNDP have a clear advantage to engage in the role envisioned by the project vis-à-vis national / regional / global partners and other actors?
☒	• 3: An analysis has been conducted on the role of other partners in the area where the project intends to work, and credible evidence supports the proposed engagement of UNDP and partners through the project, including identification of potential funding partners. It is clear how results achieved by partners will complement the project's intended results and a communication strategy is in place to communicate results and raise visibility vis-à-vis key partners. Options for south south and triangular cooperation have been considered, as appropriate. (all must be true)
☐	• 2: Some analysis has been conducted on the role of other partners in the area where the project intends to work, and relatively limited evidence supports the proposed engagement of and division of labour between UNDP and partners through the project, with unclear funding and communications strategies or plans.
☐	• 1: No clear analysis has been conducted on the role of other partners in the area that the project intends to work. There is risk that the project overlaps and/or does not coordinate with partners' interventions in this area. Options for south south and triangular cooperation have not been considered, despite its potential relevance.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): UNDP certainly has a clear advantage as it has a wealth of knowledge, good practices, and past lessons globally and locally, and as a PR of the Global Fund Grants in about 21 countries that can be used in the project. UNDP experience working with South Sudan government as PR is outstanding and can provide valuable insights into how to engage with government stakeholders and support them in implementing project initiatives. Network of partners: UNDP has a broad network of partners, including PEPFAR and other UN agencies such as UNFPA, WHO, UNICEF and CSOs and NGOs. This network can be leveraged to support the development of partnerships and collaborations that are critical to the success of the project initiatives.
	3. PRINCIPLED
	7. Does the project apply a human rights-based approach?
☒	• 3: The project is guided by human rights and incorporates the principles of accountability, meaningful participation, and non-discrimination in the project's strategy. The project upholds the relevant international and national laws and standards. Any potential adverse impacts on enjoyment of human rights were rigorously identified and assessed as relevant, with appropriate mitigation and management measures incorporated into project design and budget. (all must be true)

[12] *Operationalizing Leaving No One Behind good Practice Note for UNCT (https://unsdg.un.org/resources/leaving-no-one-behind-unsdg-operational-guide-un-country-teams)*

☒	**PROJECT QA - DESIGN**
☐	• 2: The project is guided by human rights by prioritizing accountability, meaningful participation and non-discrimination. Potential adverse impacts on enjoyment of human rights were identified and assessed as relevant, and appropriate mitigation and management measures incorporated into the project design and budget. (both must be true)
☐	• 1: No evidence that the project is guided by human rights. Limited or no evidence that potential adverse impacts on enjoyment of human rights were considered.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The project is one of the principal projects of UNDP in South Sudan aimed at establishment of an enabling legal and policy framework for reduction of human rights related barriers to HIV/TB services. Modules 1, 2, 3 4 and Module 15: (Reducing Human Rights-related Barriers to HIV and TB Services) are particularly designed in line with human rights-based approach.
	8. Does the project use gender analysis in the project design?
☒	• 3: A participatory gender analysis has been conducted and results from this gender analysis inform the development challenge, strategy and expected results sections of the project document. Outputs and indicators of the results framework include explicit references to gender equality, and specific indicators measure and monitor results to ensure women are fully benefitting from the project. (All must be true)
☐	• 2: A basic gender analysis has been carried out and results from this analysis are scattered (i.e., fragmented and not consistent) across the development challenge and strategy sections of the project document. The results framework may include some gender sensitive outputs and/or activities but gender inequalities are not consistently integrated across each output. (All must be true)
☐	• 1: The project design may or may not mention information and/or data on the differential impact of the project's development situation on gender relations, women, and men, but the gender inequalities have not been clearly identified and reflected in the project document.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The project uses dissagragated health data to to develop the funding request, with comprehensive strategies, modules, interventions and activities. The project ansures that both the planning, monitoring and evaluation of project actions maintain a gender equity approach, guaranteeing equal opportunities and participation between women and men, as well as guaranteeing that the results of this contribute to the commitment of the status in achieving the Sustainable Development Goals. Modules 1, 2,3,4 addresses reducing human rights related barriers to access to HIV/TB services for Females Sex Workers, People who Use Drugs, Men having Sex with Men and Transgenders. There is an intervention on Gender-based violence prevention and post violence care (COVID-19) in a complementary grant on C19 Response Mechanism Portfolio Optimization.
	9. Did the project support the resilience and sustainability of societies and/or ecosystems?
☒	• 3: Credible evidence that the project addresses sustainability and resilience dimensions of development challenges, which are integrated in the project strategy and design. The project reflects the interconnections between the social, economic and environmental dimensions of sustainable development. Relevant shocks, hazards and adverse social and environmental impacts have been identified and rigorously assessed with appropriate management and mitigation measures incorporated into project design and budget. (All must be true)
☐	• 2: The project design integrates sustainability and resilience dimensions of development challenges. Relevant shocks, hazards and adverse social and environmental impacts have been identified and assessed, and relevant management and mitigation measures incorporated into project design and budget. (Both must be true)
☐	• 1: Sustainability and resilience dimensions and impacts were not adequately considered.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The sustainability strategy of this project is based on an articulated work with 6 Modules addressing Resilient and Sustainable Systems for Health (RSSH). These include Module 16. RSSH: Health Sector Planning and Governance for Integrated People-centred Services; and 17. RSSH: Community Systems Strengthening; 18. RSSH: Health Products Management Systems; Module 19: RSSH/PP: Human Resources for Health (HRH) and Quality of Care; Module 20 RSSH: Monitoring and Evaluation Systems and Module 21: Laboratory Systems (including national and peripheral).
	10. Has the Social and Environmental Screening Procedure (SESP) been conducted to identify potential social and environmental impacts and risks? The SESP is not required for projects in which UNDP is Administrative Agent only and/or projects comprised solely of the preparation and dissemination of reports and communication materials; organization of events, workshops, or training; strengthening capacities of partners to participate in international negotiations and conferences; partnership coordination (including UN coordination) and management of networks; and global/regional projects with no country-level activities as well as Development Effectiveness projects and Institutional Effectiveness projects. [If SESP is not required, select all exemption criteria that apply.]
☒	• Yes
☐	• No (Project QA cannot be approved by the Project QA Approver)
☐	• SESP not required because project consists solely of (Select all exemption criteria that apply)

☒	**PROJECT QA - DESIGN**
	*Applicable only to option "SESP not required." ☐ 1: Preparation and dissemination of reports, documents, and communication materials ☐ 2: Organization of an event, workshop, training ☐ 3: Strengthening capacities of partners to participate in international negotiations and conferences ☐ 4: Partnership coordination (including UN coordination) and management of networks ☐ 5: Global/regional projects with no country-level activities (e.g., activities such as knowledge management, inter-governmental processes) ☐ 6: UNDP serves as Administrative Agent ☐ 7: Development Effectiveness projects and Institutional Effectiveness projects
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): SESP impact is considered durign project design. Health related activities dealing directly with populatons are governed by national policies and guidelines. Activities related to infructructure are governed by national regulations, plus terms and conditions of the contracts between contractors and UNDP. Activities related to harzadous waste management are governed by national policies and guidelines – the GF project has set up 3 Ultrahigh Temperature incinerators and is in the process of procuring 11 more.
	4. MANAGEMENT & MONITORING
	11. Does the project have a strong results framework?
☒	• 3: The project's selection of outputs and activities are at an appropriate level. Outputs are accompanied by SMART, results-oriented indicators that measure the key expected development changes, each with credible data sources and populated baselines and targets, including gender sensitive, target group focused, sex-disaggregated indicators where appropriate. (all must be true)
☐	• 2: The project's selection of outputs and activities are at an appropriate level. Outputs are accompanied by SMART, results-oriented indicators, but baselines, targets and data sources may not yet be fully specified. Some use of target group focused, sex-disaggregated indicators, as appropriate. (all must be true)
☐	• 1: The project's selection of outputs and activities are not at an appropriate level; outputs are not accompanied by SMART, results-oriented indicators that measure the expected change and have not been populated with baselines and targets; data sources are not specified, and/or no gender sensitive, sex-disaggregation of indicators. (if any is true)
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The the grant agreement and project document include coverage, outcome and impact indicators and targets for the project. The M&E system allows for a quarterly review in order to identify progress towards results and the implementation of corrective actions. The project's selection of outputs and activities are indicators are on appropriate level project has a strong result framework indicated in the project document. Refer PRODOC in Results Framework or the Grant Agreement Performance Framework.
	12. Is the project's governance mechanism clearly defined in the project document, including composition of the project board?
☒	• 3: The project's governance mechanism is fully defined. Individuals have been specified for each position in the governance mechanism (especially all members of the project board.) Project Board members have agreed on their roles and responsibilities as specified in the terms of reference. The ToR of the project board has been attached to the project document. (all must be true)
☐	• 2: The project's governance mechanism is defined; specific institutions are noted as holding key governance roles, but individuals may not have been specified yet. The project document lists the most important responsibilities of the project board, project director/manager and quality assurance roles. (all must be true)
☐	• 1: The project's governance mechanism is loosely defined in the project document, only mentioning key roles that will need to be filled at a later date. No information on the responsibilities of key positions in the governance mechanism is provided.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The project governance mechanism is in place and fully defined in the organigram of the project document, chapter VIII Governance and Management Arrangements.
	13. Have the project risks been identified using the risk assessment tools (Project Quality Assurance, Social and Environmental Screening Procedure, Partner Capacity Assessment Tool, Harmonized Approach to Cash Transfer, Private Sector Due Diligence, etc., if applicable), with clear plans stated to manage and mitigate each risk?
☒	• 3: Project risks related to the achievement of results are fully described in the project risk register, based on comprehensive analysis drawing on the programme's theory of change, Social and Environmental Standards and screening, situation analysis, capacity assessments and other analysis such as funding potential and reputational risk. Risks have been identified through a consultative process with key internal and external stakeholders, including consultation with the UNDP

☒	**PROJECT QA - DESIGN**
	Security Office as required. Clear and complete plan in place to manage and mitigate each risk, including security risks, reflected in project budgeting and monitoring plans. (both must be true)
☐	• 2: Project risks related to the achievement of results are identified in the initial project risk register based on a minimum level of analysis and consultation, with mitigation measures identified for each risk.
☐	• 1: Some risks may be identified in the initial project risk register, but no evidence of consultation or analysis and no clear risk mitigation measures identified. This option is also selected if risks are not clearly identified, no initial risk log is included with the project document and/or no security risk management process has taken place for the project.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The risk identification format was carried out, as well as the mitigation actions. See PRODOC Section X and Risk Log Annex 1.
	5. EFFICIENT
	14. Have specific measures for ensuring cost-efficient use of resources been explicitly mentioned as part of the project design? This can include, for example: **i) Using the theory of change analysis to explore different options of achieving the maximum results with the resources available.** **ii) Using a portfolio management approach to improve cost effectiveness through synergies with other interventions.** **iii) Through joint operations (e.g., monitoring or procurement) with other partners.** **iv) Sharing resources or coordinating delivery with other projects.** **v) Using innovative approaches and technologies to reduce the cost-of-service delivery or other types of interventions.**
☒	• Yes
☐	• No
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The project has identified the following elements to ensure efficiency and effectiveness in cost and resource management: conduct of value for money analysis for the hiring of the SRs; leveraging of existing mechanisms for delivery of HIV/TB services; integration of HIV/TB service delivery in the Health Facilities; exploring synergies with key partners such as PEPFAR to ensure complementarity and effectiveness.
	15. Is the budget justified and supported with valid estimates?
☒	• 3: The project's budget is at the activity level with funding sources and is specified for the duration of the project period in a multi-year budget. Realistic resource mobilization plans are in place to fill unfunded components. Costs are supported with valid estimates using benchmarks from similar projects or activities. Cost implications from inflation and foreign exchange exposure have been estimated and incorporated in the budget. Adequate costs for monitoring, evaluation, communications, and security have been incorporated.
☐	• 2: The project's budget is at the activity level with funding sources, when possible, and is specified for the duration of the project in a multi-year budget, but no funding plan is in place. Costs are supported with valid estimates based on prevailing rates.
☐	• 1: The project's budget is not specified at the activity level, and/or may not be captured in a multi-year budget.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The project budget has been defined for each of the defined outputs and the planned activities, planning it in the multi-year work plan format. See PRODOC Section VII- Multi Year Work Plan, plus the detailed workplan and budget for the grant agreement between UNDP and the Global Fund
	16. Is the Country Office / Regional / Global Project fully recovering the costs involved with project implementation?
☒	• 3: The budget fully covers all project costs that are attributable to the project, including programme management and development effectiveness services related to strategic country programme planning, quality assurance, pipeline development, policy advocacy services, finance, procurement, human resources, administration, issuance of contracts, security, travel, assets, general services, information and communications based on full costing in accordance with prevailing UNDP policies (i.e., UPL, LPL.)
☐	• 2: The budget covers significant project costs that are attributable to the project based on prevailing UNDP policies (i.e., UPL, LPL) as relevant.
☐	• 1: The budget does not adequately cover project costs that are attributable to the project, and UNDP is cross subsidizing the project.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The country office will recover the costs related to this Project. Project cost recovery is established in the Project Management section of the PRODOC.
	6. EFFECTIVE

☒	PROJECT QA - DESIGN
	17. Have targeted groups, and particularly those marginalized, vulnerable, and left further behind (LNOB), been engaged in the design of the project? [13]
☒	• 3: Credible evidence that all targeted groups, prioritizing discriminated, vulnerable, and marginalized populations that will be involved in or affected by the project, have been actively engaged in the design of the project. The project has an explicit strategy to identify, engage and ensure the meaningful participation of target groups as stakeholders throughout the project, including through monitoring and decision-making (e.g., representation on the project board, inclusion in samples for evaluations, etc.)
☐	• 2: Some evidence that key targeted groups have been consulted in the design of the project.
☐	• 1: No evidence of engagement with targeted groups during project design.
☐	• Not Applicable
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): Target groups (government employees, representatives from international and national partners, e.g., PEPFAR, CSOs, UN Agencies etc.) were fully engaged during the design stage.
	18. Does the project plan for adaptation and course correction if regular monitoring activities, evaluation, and lesson learned demonstrate there are better approaches to achieve the intended results and/or circumstances change during implementation?
☒	• Yes
☐	• No
	Evidence (Enter a short explanation and upload a document that provides evidence for your response): The project has a Results, Monitoring and Evaluation system, which will ensure the effective execution of the program, and whose process collects and analyzes the products and results of the project. This system is aligned with the planning, execution, and completion phases, where activities such as the preparation of work plans, risk management, baseline, follow-up and monitoring, reports, Measurement Follow-up and Evaluation committees, reports, and evaluation of the results.
	19. The gender marker for all project outputs are scored at GEN2 or GEN3, indicating that gender has been fully mainstreamed into all project outputs at a minimum.
☒	• Yes
☐	• No
	Evidence (Enter a short explanation and upload a document that provides evidence for your response): The gender marker is from GEN2 Gender equality as a significant objective. Some of the Outputs have GEN2 as gender marker.
	20. Have societal digital risks and opportunities been taken into account when designing the project's approach and have digital or data technology solutions been considered to enhance the efficiency, effectiveness and scalability of project results?[14]
☐	• 3: To the extent possible, societal digital risks and opportunities have been investigated when designing the strategy and Theory of Change, and the potential use of digital or data technologies in project activities has been considered in line with UNDP's digital standards[15] and data principles[16]. (All must be true)

[13] Operationalizing Leaving No One Behind Good Practice Note for UNCT (https://unsdg.un.org/resources/leaving-no-one-behind-unsdg-operational-guide-un-country-teams)

[14] For a checklist and evidence template, please see the Embedding Digital Thinking into Project Design Guidelines (https://rebrand.ly/DbDProjectGuideEN).

[15] The ten UNDP Digital Standards are: a) Start with the need; b) Bridge the digital divide; c) Test early and often; d) (Perhaps) Don't build it; e) Do no harm; f) Form the Right Team; g) Measure What Matters; h) Follow The UNDP Data Principles; i) Default to Open; and j) Plan for the Long Term (https://www.undp.org/digital/standards).

[16] The eight UNDP Digital Principles are: a) Safeguard personal data; b) Uphold the highest ethical standards; c) Manage Data Responsibly; d) Make data open by default; e) Plan for reusability and interoperability; f) Empower people to work with data; g) Expand frontiers of data; and h) Be aware of data limitations (https://data.undp.org/data-principles).

☒	**PROJECT QA - DESIGN**
☒	• 2: Only the potential use of digital or data solutions in project activities has been considered in line with UNDP's digital standards[17] and data principles[18], but there is no or limited evidence that aspects of inclusive digital societies have been considered in the design of the strategy or Theory of Change.
☐	• 1: Neither societal digital risks and opportunities, nor digital or data technology solutions were specifically considered in the project design or, UNDP's digital standards[19] and data principles[20] are not taken into account when intending to use digital or data technology solutions in project activities.
☐	• Digital considerations are not relevant to this project. *Applicable only to option "Digital considerations are not relevant" ☐ 1: Societal digital transformation is not a government or contextual priority ☐ 2: A non-digital approach yields higher effectiveness and efficiency ☐ 3: Other (specify in the "Evidence" section)
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): Module 20 RSSH: Monitoring and Evaluation Systems is entirely devoted to digitalization of HIV/TB data via DHIS2 and eTBr and eLMIS: The intervention areas include: 20.1. Routine reporting 20.2. Surveillance for HIV, tuberculosis, and malaria 20.3. Surveys 20.4. Data quality 20.5. Analyses, evaluations, reviews, and data use
	7. SUSTAINABILITY & NATIONAL OWNERSHIP
	21. Have national / regional / global partners led, or proactively engaged in, the design of the country / regional / global project, respectively?
☒	• 3: National / regional / global partners have full ownership of the country / regional / global project and led the process of the development of the project jointly with UNDP.
☐	• 2: The project has been developed by UNDP in close consultation with national / regional / global partners.
☐	• 1: The project has been developed by UNDP with limited or no engagement with national partners.
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): The multi-partner project management board, i.e the Country Cooordinating Mechanism (CCM), MOH, SSAC, National partners (PEPFAR, CSOs, UN Agencies etc were fully engaged during the design stage. Project team proactively collaborated with regional and regional partners in project design such as the UNDP-Global Fund Partnerships and Health Support Team and the GF CT, RSSH and CRG teams.
	22. Are key institutions and systems identified, and is there a strategy for strengthening specific / comprehensive capacities based on capacity assessments conducted?
☐	• 3: The project has a strategy for strengthening specific capacities of national institutions and/or actors based on a completed capacity assessment. This strategy includes an approach to regularly monitor national capacities using clear indicators and rigorous methods of data collection and adjust the strategy to strengthen national capacities accordingly.

[17] The ten UNDP Digital Standards are: a) Start with the need; b) Bridge the digital divide; c) Test early and often; d) (Perhaps) Don't build it; e) Do no harm; f) Form the Right Team; g) Measure What Matters; h) Follow The UNDP Data Principles; i) Default to Open; and j) Plan for the Long Term (https://www.undp.org/digital/standards).

[18] The eight UNDP Digital Principles are: a) Safeguard personal data; b) Uphold the highest ethical standards; c) Manage Data Responsibly; d) Make data open by default; e) Plan for reusability and interoperability; f) Empower people to work with data; g) Expand frontiers of data; and h) Be aware of data limitations (https://data.undp.org/data-principles).

[19] The ten UNDP Digital Standards are: a) Start with the need; b) Bridge the digital divide; c) Test early and often; d) (Perhaps) Don't build it; e) Do no harm; f) Form the Right Team; g) Measure What Matters; h) Follow The UNDP Data Principles; i) Default to Open; and j) Plan for the Long Term (https://www.undp.org/digital/standards).

[20] The eight UNDP Digital Principles are: a) Safeguard personal data; b) Uphold the highest ethical standards; c) Manage Data Responsibly; d) Make data open by default; e) Plan for reusability and interoperability; f) Empower people to work with data; g) Expand frontiers of data; and h) Be aware of data limitations (https://data.undp.org/data-principles).

☒	**PROJECT QA - DESIGN**
☐	• 2: A capacity assessment has been completed. There are plans to develop a strategy to strengthen specific capacities of national institutions and/or actors based on the results of the capacity assessment.
☒	• 1: Capacity assessments have not been carried out.
☐	• Not Applicable
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): As part of the design requirement, the project supported the conduct of capacity assessment of the potential SRs. There is an existing Capacity Development and transition plan for Government and CSOs. There is a specific Capcity Building Plan for the newly appointed CSO SR NEPWU. A new pragmatic approach to its implementation has been put in place.
	23. Is there is a clear strategy embedded in the project specifying how the project will use national systems (i.e., procurement, monitoring, evaluations, etc.,) to the extent possible?
☒	• Yes
☐	• No
☐	• Not Applicable
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): This will be made possible by consolidating and integrating HIV and TB services through differentiated service delivery strategy with dual emphasis on mixed facility-based and community-led interventions in estimated current <200 functional facilities. The interventions entail full integration of HIV, TB and other disease programmes; enhancing the roles of PLHIV, TB survivors and community networks including boma health workers in health facilities and communities; mobile TB/HIV services and community-led treatment services; taking full advantage of resilient and sustainable system funding to calibrate all aspects of health system strengthening (HRH, HMIS, PSCM, laboratory system and diagnostics), and ensuring that implementing partners are closely monitored and coordinated with the Ministry of Health.
	24. Is there a clear transition arrangement / phase-out plan developed with key stakeholders in order to sustain or scale up results (including resource mobilization and communications strategy)?
☒	• Yes
☐	• No
	Evidence (Enter a short explanation and attached a document that provides evidence for your response): There is an existing Capacity Development and transition plan for Government and the Health Sector. A new pragmatic approach to its implementation has been put in place.

Name and Title	*Signature and Date*	*Description*
QA Assessor David Ayoola OWOLABI M&E Specialist	Signature: Date:	The QA Assessor has to be accountable for project assurance, which is independent of the project manager. A UNDP programme or monitoring and evaluation officer typically holds the project assurance role on behalf of UNDP. For GEF- and GCF-financed projects, project assurance is undertaken as per the requirements of the vertical funds, and these services are covered by the fee provided by the vertical fund.
QA Approver Amit Arora M&E Specialist	Signature: Date:	The QA Approver is typically the Resident Representative, Deputy Resident Representative, or head of portfolio. The QA Approver must function at a higher level of accountability than the QA Assessor. The QA Approver cannot also be the QA Assessor.