UNITED NATIONS DEVELOPMENT PROGRAMME

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PROJECT DOCUMENT

Project Title: Integrating Services for Maximum Impact
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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 186 of the 189 countries on the Human Development Index in 2019 (UNDP, 2020) and it is rated third on the Fragile States Index.

The HIV epidemic in South Sudan is worrisome. By the end of 2019, the HIV epidemic was continuing to expand and remained generalised with estimated adult HIV prevalence of 2.5% (UNAIDS, 2020). Between 2010 and 2019, new HIV infections increased by 36%, which was far off the global Fast-Track goal of a 75% decline from 2010 rates by 2020. Weak health systems, along with persistently unmet funding needs for the TB response, have greatly impeded progress. Only 91 health facilities (HFs) provide TB diagnosis and treatment out of the country's 1,023 functional HFs. It is evident that the COVID-19 pandemic is straining national health systems globally due to the evolving needs and rapidly increasing demand on health facilities, supplies and healthcare workers. To mitigate the impact of the pandemic on HIV, TB, and malaria and support health and community systems in South Sudan, the Global Fund has granted USD 3,685,007 of additional investments for South Sudan's COVID-19 response.

The Global Fund project of the third new funding model (NFM3) has the following goals:

1. Reduction of new HIV infections by 50% by 2023 (from 2010 levels)

2. Reduction of deaths among people living with HV by 50% by 2023

3. Reduce TB incidence by at least 30% (relative to 2019)

This will be made possible by scaling up HIV and TB services through differentiated service delivery strategy with dual emphasis on mixed facility-based and community-led interventions in 20 new sites backed by test-and-start effectively increasing the number of facilities offering HIV/TB services from 80 to 100. 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; and ensuring that implementing partners are closely monitored and coordinated with the Ministry of Health.

Contributing Outcome (UNDAF/CPD, RPD or GPD): Outcome 5: More resilient communities Indicative Output(s) with gender marker[2]: GEN 2	

Total resources required:	USD 71, 726,259	
	UNDP TRAC:	USD 200,000
	Donor:	USD 71,526,259

Agreed by (signatures):

Government	UNDP
Hon. Athian Ding Athian Minister of Finance and Planning Republic of South Sudan	Mr Samuel Doe Resident Representative UNDP South Sudan
Date:	Date: 01-02-2021

MINISTRY OF FINANCE & PLANING ★ Minister's Office ★ REPUBLIC OF SOUTH SUDAN

United Nations Development Programme South Sudan

I. DEVELOPMENT CHALLENGE

Contextual Analysis

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 undermined most of the anticipated development gains since independence. This has worsened the humanitarian situation, leaving much of the population dependent on aid for their survival. While the formation of the Transitional Government of National Unity in February 2020, a major milestone of the Revitalised Agreement on the Resolution of the Conflict in South Sudan (R-ARCSS) signed in 2018, brought some optimism for a return to peace and security, the advent of the COVID-19 pandemic, and the resulting global economic shocks, particularly the sharp decline in oil values, has created new obstacles to progress. South Sudan is one of the poorest nations in the world, placed at 186 of the 189 countries on the Human Development Index in 2019 (UNDP, 2020) and it is rated third on the Fragile States Index.

Years of conflict and chronic underinvestment have resulted in a minimally functional public health system. There are significant challenges for the country to offer a minimal level of health services, with acute shortages of health workers and most health facilities unable to operate due to a lack of the necessary infrastructure or equipment. Recent services (health) availability and readiness assessment had found that only 44% of the country's largely rural population (83%) lived within a five-kilometre radius of a functioning facility (MoH, 2019). Availability of health workers per 10,000 population is merely 7.6 and that of health facilities 1.42. Only 1% of facilities have all the standard list of seven basic amenities (of sanitation, water, power, basic equipment etc.) and none of the facilities have available stock of all 20 essential medicines at time of assessment. On a positive note, two major projects have begun the process of restoring the public health system under the Health Pooled Fund initiative and the Provision of Essential Health Services to deliver basic public health and nutrition services.

Figure1: Map of South Sudan



Since South Sudan gained its independence, the country experienced several incidents of internal conflictsin December 2013, and more recently in July 2016. The renewed conflict, undermined the development gains achieved since independence and worsened the humanitarian situation. The conflict that erupted on 7th July 2016 resulted in more than 2.3 million people fleeing their homes, including 1.66 million internally displaced (with 53.4% estimated to be children) and nearly 644,900 refugees in neighbouring countries (Ethiopia, Kenya, Uganda, Democratic republic of Congo and Central African Republic). Approximately 185,000 internally displaced people (IDPs) have sought refuge in UN Protection of Civilians (PoC) sites.

These resurgence of internal conflict, insecurity and instability has had severe negative consequences for the people of South Sudan resulting in over 40% of the 12.4 million people (5.4 million people) in need humanitarian assistance. Furthermore, the conflict has contributed to severe food insecurity, affecting close to 1 million people.

The depreciating currency has impacted on the government as it is no longer able to procure medical supplies, recruit or increase the salary of health workers to match the inflation. Other challenges contributing to a weakening health system include: weak supply chain management systems resulting in frequent stock outs of health commodities; non-functional health facilities due to destruction of facilities, facilities that have closed down because many health workers fled from the insecure environment; shortages of health workers at functional facilities; inadequate mechanisms to reach pastoralist communities and displaced populations, and the under financing of the health system making universal access to health services difficult. The net result of the deteriorating situation is less than optimal delivery of health services.

To address the sub-optimal delivery of health services and alleviate treatment interruptions, the MoH with the support of its partners including humanitarian agencies (WHO, IOM, UNHCR, UNAIDS, ICAP) have defined a minimal package of services. The plan includes: conducting rapid assessment on functionality of facilities and needs, establishing where people have moved to, utilising existing community groups to reach out and re-supply medicines including Anti-retroviral drugs (ARVs), TB first and second line treatment to those affected for a longer duration, i.e. 3-9 months, negotiating passage or airlifting supplies for restocking facilities with emergency ARVs, OIs, first line and second line TB drugs; repositioning medicines to access points; broadcasting and transmission of key information to populations affected.

Rapid Response Teams (RRTs)/ mobile medical teams will be deployed in situations where populations are acutely displaced with limited or no health service providers available to provide the necessary services e.g. Kajokeji and Mayendit. The humanitarian contingency plans now include HIV and TB. Mobile Rapid Response Mission (1 – 3 months): at least one person trained on HIV and TB care and treatment, and is familiar with the South Sudan treatment guidelines; mobile lab services include both diagnostic and treatment monitoring e.g. using CD4 Point of Care instruments (PIMA); a supply of HIV and TB medications (both for intensive and continuation phases) to be distributed to patients already diagnosed and initiated on HIV and TB treatment (existing patients), but lack access to drugs due to displacement; health education and adherence counselling would be done before dispensing any medication; the team would have the monitoring tools e.g. registers for recording and reporting and ensuring treatment continuity after the RRT exits.

Epidemiological Context

By the end of 2019, the HIV epidemic was continuing to expand and remained generalised with estimated adult (15-49 years) HIV prevalence of 2.5% (UNAIDS, 2020). By the end of 2019, it was estimated that there were 194,000 PLHIV, of which 16,000 (8%) were children (0-14 years). Approximately 56% of all adult PLHIV were female. Between 2010 and 2019, new HIV infections increased by 36%, which was far off the global Fast-Track goal of a 75% decline from 2010 rates by 2020. In 2019, there were an estimated 19,000 new HIV infections (all ages), of which 2,700 (14%) were among children (0-14 years). Between 2010 and 2019, HIV incidence (all ages) increased from 1.51/1,000 population to 1.56/1,000 population. The annual rate of AIDS-related deaths has slowed over recent periods. Between 2010 and 2019, it declined by only 1%, however this is far from the Fast-Track Target of a 75% reduction from 2010 levels by 2020.

According to World Health Organisation (WHO) estimates, the incidence of all forms of drug-susceptible TB (DS-TB) was 227 per 100,000 population in 2019, while the incidence of drug-resistant TB (DR-TB) was 7.5 per 100,000 population (WHO, 2020). Among detected cases in 2019, the treatment success rate was 81% based on a coverage of 91% of expected cases. 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. Only 91 HFs provide TB diagnosis and treatment out of the country's 1,023 functional HFs.

It is evident that the COVID-19 pandemic is straining national health systems globally due to the evolving needs and rapidly increasing demand on health facilities, supplies and healthcare workers. To mitigate the impact of the pandemic on HIV, TB, and malaria and support health and community systems in South Sudan, the Global Fund has granted USD 3,685,007 of additional investments for South Sudan's COVID-19 response.

Gender and Human Rights Concerns

South Sudan has a very high incidence of sexual and gender-based violence (SGBV) and widespread impunity for SGBV offences. It is impossible to obtain national level estimates due to chronic under-reporting but it is accepted that rates of SGBV are very high. A 2017 study in Bentiu, Juba and Lakes States by the International Rescue Committee reported that 65% of women had experienced physical and/or sexual violence in their lifetime, and some 51% had suffered intimate partner violence (IPV). Thirty-three percent of women had experienced sexual violence from a non-partner, primarily during attacks or raids.[1]The GBV information management system reported 3,585 cases in 2017, 46% and 17% of which involved IPV and sexual violence respectively.[2]Moreover, only 68% of rape survivors received clinical management of rape (CMR) services within 72 hours of the violation.

The high prevalence of SGBV in the country heightens the risk of HIV for survivors.[3]Gender inequality, discriminatory and traditional/cultural practices such as girls being a source of family wealth (bride price) andunpaidlabour,poverty and the ongoing conflict, are drivers of GBV and child/forced marriage, and limit access to opportunities, resources and participation for women. Both child marriage (45%) and teenage pregnancy (300 per 1,000 adolescent girls) contribute to the lack of educational attainment: only 6% and 20% of enrolled girls complete primary and secondary education, respectively.[4]

Same-sex sexual acts, sex work and drug use are all criminalised.[5]Intentional HIV transmission is also criminalised. Additional penalties are included under provisions for defilement or sexual assault when the perpetrator is also HIV-positive. While sexual violence is criminalised under most circumstances, sexual violence between spouses is condoned. Although the Transitional Constitution of the Republic of South Sudan contains numerous provisions for the protection of human rights, the country is frequently cited by regional and international human rights bodies for systemic abuses of human rights, largely by military forces (both uniformed and non-uniformed armed men) and the police.[6]Access to justice is poor to non-existent for those who are the victims of such abuses, largely due to inaccessibility, weak functionality, political interference and financial barriers. Deeply held socio-cultural values and beliefs, coupled with widespread illiteracy, compound the unfavourable legal environment with high levels of stigma, discrimination and violence perpetuated against PLHIV, especially women and key populations (KPs). 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.[7]In a 2017 survey, among a sample of 698 sex workers (SWs), 49% had been beaten or hurt in the past 12 months, 48.6% had been forced to have sex or been raped, 40% had been refused protection by police or security forces when they requested it and 30% had been arrested. None of these women sought legal redress, either because they did not know it was available or for fear of further violence and abuse as a result of reprisals.

All of these country context challenges have detrimental consequences on the population's health, particularly in terms of increasing vulnerability to diseases such as HIV, TB and malaria.They also have important consequences for efforts to address and respond to these health challenges. It is reasonable to assume that poverty may bea leading cause of poor uptake of services;

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[1]https://www.rescue.org/report/no-safe-place. Accessed 21 April 2020.

[2]UNFPA (2018), *op. cit.*

[3]WHO (2017), *op. cit.*

[4]UNFPA (2018), *op. cit.*

[5]*Penal Code 2008.*

[6]United Nations Human Rights Council (2019). *Report of the Commission on Human Rights in South Sudan*.

[7]SSNeP+(2020). *The PLHIV Stigma Index Survey and Vulnerability Assessment.*

nonetheless, in South Sudan the lack of participatory social development and economic success is also clearly a major explanation. This implies that actions to ameliorate health concerns have to be grounded in a wider socioeconomic, multisectoral context.

COVID-19 in South Sudan

South Sudan confirmed its first COVID-19 case on 5 April 2020 and has since recorded a significant increase in notifications with 3,223 confirmed cumulative cases and 62 deaths as at 19 December 2020. For South Sudan with an already fragile and weak health system, the pandemic, if not well managed and controlled, will have an adverse effect on its health system resulting in increased morbidity and mortality from COVID-19 and other diseases or conditions.

Following the WHO recommendations to stop the human-to-human transmission of COVID-19, the Republic of South Sudan, developed a COVID-19 Preparedness and Response Plan. The goal of the plan is to scale up preparedness and response activities through enhancing surveillance; screening at designated points of entry and risk communication; while addressing critical gaps in case management, infection prevention and control and rapid response teams and harnessing the capacities to prevent and mitigate the risk COVID-19 to South Sudan.

II. STRATEGY

Integrating Services for Maximum Impact

The grant builds on the achievements of the New Funding Model (NFM2) 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 while mitigating the impact of COVID-19 pandemic. The grant aims at providing comprehensive HIV and TB services across South Sudan, while creating resilient and sustainable systems for health and mitigating the negative impact of COVID-19. This will be achieved through the following strategies:

1. ***Module 1: Treatment, Care and Support***

Intervention 1.1: differentiated antiretroviral therapy service delivery

Ensure continuity of services for those currently accessing treatment with additional 8,120 PLHIV receiving ART and totalling 40,600 PLHIV kept on anti-retroviral treatment (ART) during the grant period.

To achieve the proposed scale-up targets for HIV treatment and care, and to improve adherence, retention and viral suppression, an enhanced differentiated service deliverystrategywill be implemented with equal emphasis on facility-based and community-led components and backed by the ongoing implementation of test-and-start and multi-month dispensing (MMD). Starting in 2021, a mixed facility-community-based model will be rolled out at all sites offering HIV services (current and new) for optimal reach and retention in care for PLHIV including adults, children, adolescents and KPs. The mixed model will include the followingcomponents:

- EnhancedrolesforPLHIV,TBsurvivors,mentormothers,communityoutreachworkersand boma health teams asoutreach teams linked to facilitiesfor patient follow-up, treatment literacy, defaulter/loss-to-follow-up tracing, linkage/re-engagement in care, contact tracing and partners/familytesting.
- Enhanced roles of PLHIV networks, TB networks, civil society organizations (CSOs) and other community networks and associations in communitiesfor demand creation, stigma reduction, community-based HTS and referral, treatment literacy, patient support groups, positive health dignity and prevention for PLHIV, and adherence and retentionsupport.
- Scale up of community-based ART refill and other mobile refill strategies, prioritising key populations and priority populations (uniformed forces, mobilepopulations).

Existing national guidelines and standard operating procedures (SOPs) for the provision of HIV

treatment and care, HIV testing services (HTS) and routine monitoringwillbereviewedandrevisedtosupportallaspectsofthemixedmodelprovisionofservices to ensure programmequality.Technical assistance to facilities providing comprehensive HIV/ART services will be delivered through the Global Fund's sub-recipient (SR) and President's Emergency Plan for AIDS Relief (PEPFAR) implementing partners. UNDP has strategically selected a PEPFAR implementing partner to become SR for this particular module to promote synergy and leverage resources for maximum impact on quality of ART services delivery.

Intervention 1.2: treatment monitoring – viral load

In this grant, it is aimed to increase coverage of viral load (VL) monitoringto reach at least 80% of all PLHIV on ART by 2023. This includes support for consumables and sample transport to compliment both the Global Fund and PEPFAR support for the provision of a high-through-put PCR analyser to be located in Juba. In addition, the following activities will be implemented to improve the VL coverage: capacitate clinical mentors to regularly guide VL activities and mentorship to clinical providers; train laboratory staff on all aspects of VL cascade (VL test ordering, specimen collection and transport, results transmission and documentation and utilization of results for patient management);use an M&E framework including tools, registers and database to measure the progress and outcomes of routine VL monitoring; strengthen specimen transport system and results transmission.

Intervention 1.3: Treatment adherence

In this grant, it is proposed to improve 12-month retentionon ART from 57% in 2019 to 85% in 2023, and to achieve viral suppressionfor at least 80% of all PLHIV on ART using the following strategies:

- ImprovedcounsellingandconsistentapplicationofriskassessmentsfornewlydiagnosedPLHIV to be initiated on ART. This includes implementation of a revised training and supervision programmeforcounsellorsplacedinexistingandnewHIVsites.Italsoincludesrefreshertraining and enhanced supportive supervision for HCWs to implement risk assessments as stipulated in the national treatmentguidelines.
- Improved data collection and monitoring tools for all facilities, including the expansion of the electronic patient record to additional high-volume sites beyondJuba.
- Increased investments in community partnershipsto provide additional counselling andsupporttoPLHIVincommunities,includingmessagingontheroleoftreatmentadherencein VL suppression and how this prevents ongoing transmission to partners andchildren.
- Investments in PLHIV networks, TB networks, CSOs and other community networks and associations to implement interventions to address food security, transport needs, income generation, stigma reduction and mental health support, and other adherence and retention barriers.
- Annual cohort analysis covering at least 30% of ARTfacilities.

To improve coverage, uptake and retention in paediatric ART, the following interventions are prioritised:

- Improving the capacity of more health care workers (HCWs) to screen, diagnose and provide paediatric ART.
- Developing tools and protocols for the enhanced screening of children for TB and HIV disease as part malnutrition and other disease programmes and for referral of HIV-exposedinfants.
- Expanding access for timely early infant diagnosis (EID) through the decentralised GeneXpert platform
- Improving counselling and support for the parents of children onART.
- Including families with children on ART in community ART refill groups and other community-oriented strategies to improve access, uptake and retention in HIVcare.

To improve quality assurance and accountability, joint stakeholder supportive HIV/TB supervision missions, and quality assurance interventions will be maintained.

Module 2: HIV Prevention

The grant is set for tailored intervention packages to address female sex workers (FSWs), their clients and children, members of the uniformed services (specifically the military), adolescent and populations of humanitarian concern. Funding is also requested to improve the range and quality of information to guide prevention programming, to update guidelines, and to strengthen linkages and integration with sexual and reproductive health (SRH), adolescent- and youth-friendly services (AYFS) and STI services.

Intervention 2.1. Behavior Change Interventions

Female Sex Workers:

The HIV prevention package will focus on: (a) improving HIV, TB and SRH information and services; (b) promoting condoms, lubricants and dual protection where appropriate; (c) demand creation and accompanied referral for HIV testing services (HTS), TB screening, STI and other SRH needs; (d) improving awareness and supporting referrals for comprehensive sexual and gender based violence (SGBV) services, including legal support; and (e) interventions to support FSWs' children. Specific efforts will be made to include young FSWs through training and mentoring as peer outreach workers, and using older peers for ongoing guidance and support. The project will provide performance-based support for peer counsellors, support to conduct a peer-to-peer outreach services to reach sex workers and their clients, and peer-led BCC to the networks of sex workers in 7 locations. Peer educators will be trained to conduct both venue-based and community outreach activities to also reach out to IDPs. The project will source for a TA provider to facilitate the production of a technical guidance for HIV integration in humanitarian response.

These interventions will complement programming included under PEPFAR's Country Operational Plan (COP) 20 and aim to bring the proportion of FSWs reached with combination HIV prevention interventions from less than 50% in 2019 to 70% by 2023.Global Fund investments will support scale-up in Kapoeta, Maban, Malakal, Nzara, Tambura, Torit and Yei.

Populations of Humanitarian Concern:

The grant will sustain activities funded under the NFM2 supporting the integration of combination HIV prevention interventions within health programmesprovided in IDPs camps in and out of host communities. Activities will include: (a) increasing general knowledge and awareness about HIV; (b) SRH and sexual behaviour change; (c) condom and lubricant promotion, and dual protection where appropriate; (d) demand creation for SRH, HTS, prevention of mother to child transmission of HIV (PMTCT), sexually transmitted infections (STI) screening, TB screening; (e) stigma and discrimination reduction; and (f) awareness, prevention and responses to GBV.

In addition, the grant will support the production of country-specific technical guidanceto ensure that agencies working as part of the broader humanitarian response integrate HIV prevention and SRH programming in their strategies.

Intervention 2.2. Interventions for Young Key populations

Aset of interlinked interventions to provide combination HIV prevention programming to prioritised sub-groups of adolescent and young people (AYP) will be provided**:**:

(a) Undertake and support mentoring and coaching sessions between senior FSW peer educators and or young FSW peer educators in 10 target towns of the country.
(b) Design and roll-out country specific technical guidance to fully integrate combination HIV prevention and Adolescent Sexual and Reproductive Health and Rights (ASRHR) through a technical assistance sourced internationally. The technical assistance (TA) provider will lead the development of job aids and SOPs for the ASRHR integration to guide implementers.
(c) Monitoring and evaluation of the HIV integration within ASRHR will be supported by the project to ensure smooth implementation and ensure results are properly evaluated.

These interventions will complement activities planned under the legal and human rights literacy intervention.

Intervention 2.3. Gender-based violence (GBV) prevention and post violence care

The project will support population specific capacity building workshops targeting FSWs, AYPs, PLHIVs on HIV and GBV including rights, post rape care, post-exposure prophylaxis (PEP) and

documentation and reporting all incidents of stigma, discrimination, and violence including reporting systems for GBV.

Intervention 2.4. Community Empowerment

The grant will provide support to peer counsellors through activity-based performance incentives. The peer counsellors will conduct outreaches to sex workers, motor bike riders, truck drivers and the general population. In addition, community mobilization and sensitization on HIV and AIDS in IDP camps will be conducted.

Module 3: Differentiated HIV Testing Services

Intervention: Facility-based testing

Key activities under this intervention include the training and re-training of HIV testing Counsellors and health care workers at new HTS sites. The grant will also support the procurement of HIV rapid testing to ensure that the targets for HIV testing are met. The grant will oversee intensified testing at health facilities and among key populations including sex workers and their clients and other vulnerable populations such as IDPs.

Module 4: Prevention mother-to-child transmission of HIV (PMTCT)

Intervention: Preventing vertical HIV transmission

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.

Module 5: Reducing human rights-related barriers to HIV/TB services

Intervention 5.1: Legal Literacy ('Know Your Rights')

The grant proposes to design and implement legal literacy interventions to address low levels of knowledge and awareness regarding legal redress for legal and human rights challenges. This will involve developing legal literacy training package and material, undertaking legal literacy training for lead peer educators of FSWs and AYPs to enable them navigate basic legal aid support. This will focus on priority counties to build capacity for PLHIV, TB survivors, AYP, FSW and outreach workers, as well as women and girls in organised networks and clubs at the community level.

Intervention 5.2.: Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity

The project will support the reduction of HIV-related gender discrimination, harmful gender norms and violence against women and girls by engaging in research dissemination and outreach activities.

Intervention 5.3.: Stigma and discrimination reduction (HIV/TB)

In order to reduce stigma and discrimination against people infected or affected by HIV or TB, the project will undertake targeted sensitization and engagement meetings bringing together county and Payam level leadership, traditional chiefs, PLHIVs, FSWs, and refugees and IDPs in targeted towns on stigma and discrimination, and violence impacts and mitigation. There will also be annual community awareness and sensitization outreach meetings to counter myths and misconceptions on how HIV is transmitted, address fears and change attitudes in 10 counties. In partnership with local media, the project will support the development of short films that enhance awareness about HIV and TB. Implementers of the project will also undertake radio shows and have paid radio adverts on anti-stigma and discrimination messaging, social media campaigns.

Module 6: TB/HIV

Intervention: TB/HIV collaborative interventions

Under the TB/HIV collaborative module, there will be support to the TB and HIV programmes to conduct joing planning and M&E activities including integrated supportive supervision, mentorships and data reviews. There will be training of health workers in the major prisons in each state for them to be able to carry out TB and HIV diagnosis and treatment.

Module 7: TB Care and Prevention

Intervention 7.1.: TB case detection and diagnosis

In a bid to markedly improve TB case detection in South Sudan, the following key activities are planned for implementation: (i) Scale up light emitting diode (LED) microscopy services from 62 facilities to 122 facilities by 2024 by training 1 lab personnel per facility with LED microscopy services (ii) Train at least two lab staff per health facility on external quality assurance (EQA) (microscopy and GeneXpert) (iii) Conduct quarterly EQA support supervisory visits from State to peripheral laboratories with TB services and (iv) Conduct quarterly EQA support supervisory visits from State to peripheral laboratories with TB services

Intervention 7.2.: TB Treatment

TB treatment interventions will be enhanced by building the capacity of health facility health workers on TB care and treatment by training 3 per primary health care centre (PHCC) and 1 per primary health care unit (PHCU) health workers on TB treatment and care. In addition, the project will continue supporting facilities TB care by ensuring that HCWs are regularly incentivized. Importantly, the project will support the procurement of first line anti-TB drugs and other consumables to ensure that all TB patients diagnosed are treated.

Module 8: MDR-TB

Intervention 8.1: MDR-TB case detection and diagnosis

The project will support the efforts by the National TB Programme to enhance MDR-TB case detection in the country by building the capacity of programme staff and health workers. There will be a training of 90 frontline health workers on DR-TB detection and management. There will be interventions that aim at optimizing the utilization of GeneXpert in the country.

Intervention 8.2: MDR-TB treatment

The quality of MDR-TB treatment and care will be improved by implementing the following key activities at various levels in the MDR-TB management tier: (i) provision of enablers (e.g., transport, nutrition) to all DR-TB patients during care; (ii) establishing monthly follow-up clinics of DR-TB patients and track adverse events; (iii) updating and supplying treatment sites guidelines, SOPs and job-aids for management of DR-TB; (iv) training at least one specialised equipment user per center on equipment operation and interpretation of results (X-Ray, ECG and audiometer); (v) conducting quarterly cohort review /performance review meeting at the state level; (vi) forming 7 multi-disciplinary teams from the 42 trained National Master trainers to conduct quarterly facility coaching and mentorship of State TB/HIV coordinators and Frontline health workers on DR-TB; (vii) training health workers on use of the tools and conduct periodic data quality audits as well as integrate DR-TB reporting to district health information system (DHIS2); (viii) conducting cohort review /performance review meeting at the National level once a year (ix) developing, printing, and disseminating TB guidelines (algorithms, SOPs, job aids) for culture, drug susceptibility testing (DST), Mycrobial growth inihibituion tube (MGIT), and line probe assay (LPA); and (x) providing TA for LPA, culture and DST test methods, laboratory information management system (LIMS) including the relevant guidelines and SOPs.

Module 9: Building Resilient and Sustainable Systems for Health (RSSH)

Intervention 9.1: Community Systems Strengthening

The project will undertake organizational capacity assessment of 3 networks and will develop organization specific capacity development plan. There will be a 3-day capacity building training of the board members of the Networks and core staff will be recruited and maintained by the project. In addition, the Networks will be supported in terms of office set up and motor bikes will be procured to support community-based ART deliveries. The project will also support institutional capacity building, planning and leadership development by mobilizing AYPs living with HIVs to form support groups. There will be planning retreat for youg PLHIV and undertaking treatment literacy workshops for PLHIVs including AYPs and FSWs.

Intervention 9.2: Laboratory Systems Strengthening

The laboratory systems in the country will be strengthened through the project beginning with strengthening the information systems and integrated specimen transport networks through a technical assistance provided by an international expert. For smooth and uninturrepted HIV and TB specimen transportation, courier companies will be sourced to facilitate smooth specimen transportation. The project will be supporting the smooth operation of the National Public Health Laboratory by ensuring that the laboratory equipments are properly maintained and that the power system (generators) are 24-hours operational. In order to facilitate prompt GeneXpert result delivery and monitor the functionality of the machines, LMIS software (GxAlert) will be installed in 35 GeneXpert machines.

Intervention 9.3: Health products management systems

In order to maintain robust procurement and supply chain management of Global Fund health products, the operations of the warehouse and distribution of health products will continue to be supported.

COVID-19 Response Mechanism

In July 2020, the Global Fund made a decision to provide additional investment of USD 3,685,007 to support the country's capacity to mitigate the impact of the COVID-19 pandemic on HIV, TB, and malaria and support health and community systems in the country. The following three interventions were included uder the response mechanism that was incorporated into the NFM 2 HIV grant. The funding is to be used up until the end of June 2021.

Intervention 10.1: Mitigating COVID-19 impact on HIV, TB and malaria programmes

The key activities approved for implementation under this intervention are: (i) ToT orientation of COVID-19 social mobilisers and facilitation of peer-to-peer sensitization of PLHIV, TB peer educators/contact tracers, iCCM Boma Health Promoters and mentor mothers to integrate relevant COVID-19 messaging and (ii) support to peer educators by supplying them with airtime communication vouchers to undertake mobile-based adherence support, lost-to-follow up, COVID-19 preventive, and promotive health education.

Intervention 10.2: Reinforcing National COVID-19 Response

The COVID-19 response mechanism has set out to reinforce the national COVID-19 response by implementing the following: (i) procurement of SARS-CoV-2 tests in compliance with the GF quality assurance(QA) requirements; (ii) laboratory trainings of the national and state rapid response teams on COVID-19 sample collection and outbreak investigation; (iii) procurement of laboratory consumables; (iv) procurement of 2 GeneXpert machines after the country confirms the operationalization of existing GeneXpert machines; (iv) GeneXpert maintenance; and (v) contact tracing by supporting airtime and transportation

Intervention 10.3: Urgent improvements in health and community systems

The response mechanism supports the strengthening of the DHIS2 by sourcing consultancy to facilitate the implementation of electronic integrated disease surveillance and response (e-IDSR) information system and the procurement of tablets to strengthen the DHIS2 e-IDSR information system.

Target for Resource Assignment from the Core (TRAC) system

The TRAC fund from the core UNDP fund to support the Global Fund will focus around leveraging partnership and resource mobilization. UNDP will use the Global Fund platform to advance partnership with the Government of South Sudan and resource mobilization efforts by supporting the Country Coordination Mechanism (CCM) South Sudan. The following are the interventions intended for implementation under the TRAC funding.

Intervention 1. Country Coordination Mechanism (CCM) support

The CCM is a national multi-sectoral body established to coordinate and facilitate the Global Fund activities to Fight HIV/AIDS, Tuberculosis and Malaria Programmes in South Sudan. Currently CCM is represented by 17 constituencies which includes Government, NGOs, Faith-based organizations, Private Sector, People Living with the Disease, Key Affected Population, Women, Youth, Media Bilateral & Multilateral Agencies.

South Sudan CCM is the only multi-sectoral coordination body in the country that brings together Government and non-government sectors such as civil society organizations including women, youthsand FBOs as well as people infected and or affected by the three diseases, to coordinate resources mobilization and provide oversight in partnership with bilateral and multilateral development. The TRAC is crucial to provide support that is required for the CCM to strengthen its role in resources mobilization, governance and oversight of the national response against HIV, TB and Malaria in South Sudan

The main objective for the request for the TRAC 1 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. 2021 is a critical year for the Global Fund programme in South Sudan because it is the first year of implementation of the NFM3 HIV/RSSH/TB grant, and the implementation of the NFM3 Malaria grant under a new PR yet to be announced by the Global Fund since PSI is no longer continuing as PR for malaria. The CCM has quite a full calendar in 2021 and therefore requires additional resources to oversee all these critical activities.

The following are the key activities for implementation for the CCM South Sudan to become a fully functional and capacitated body to discharge its duties in the coming years:

1. CCM induction for new members and alternates
2. Re-installation of CCM website
3. Design and share materials for effective information sharing with stakeholders – annual activity
4. Regional meetings and workshops (Leadership, Governance and Oversight)
5. CCM engagements at national and State levels with the Parliamentarians and senior Government Officials to understand CCM processes and solicit their participation and contribution to institutional development of CCM processes in South Sudan (States not visited in 2020).
6. Support the Youth & Women groups to share info on implementation and delivery of Services funded by GF
7. Support training and Installation of PR Dashboard for strengthening CCM Oversight role (Phase 2 not implemented in 2020)
8. Support facilitation of consultancy (TA to the CCM) and Volunteers services
9. Operations support and office administration costs to the CCM office

2: Technical support to MoH for health programmes coordination and integration

Effective collaboration and coordination among country partners is essential in order to improve the scale and reach of health sector investments and to avoid inefficiencies and increased costs.Currently, the HIV, TB and malaria programmes operate largely as vertical interventions alongside numerous other similar health programme arrangements. The scale and reach of these programmes are dependent on the amount of resources available to support them. Efforts to improve coordination and to achieve integration have not succeeded, for example, HIV or TB services operate only where there are specific resources to support them; and not as an integrated component of the BPHNS. Accordingly, the Ministry of Health Directorate of Public Health and Coordination needs strong technical support to improve the its capacity to require effective coordination from partners, and to improve PHC integration with an emphasis on TB, HIV/AIDS, RMNCH and SRH services. UNDP in collaboration with UNFPA will source provision of Technical Assistance to the Directorate to forge the health programmes integration and benefit the health programmes and ensure efficient use of health investments.

Therefore, the Global Fund Unit requests allocation of $50,000 from TRAC 1 to provide TA to the MOH to support the Directorate of Public Health and Coordination,to strengthen Coordination and Integration of HealthProgrammes. The TA shall be provided jointly by UNDP and UNFPA.

South Sudan health services are supported by various partners including the HPF3, Rapid results for health fund (RRHF), the Global Fund, WHO, UNICEF, UNFPA and others. These investments are improving health service delivery for many communities. However, the lack of effective coordination amongst health system partners limits integration and consistency. For example, while malaria is included within the package of services supported by HPF3 at facility and community levels, HIV and TB are not. These programmes remain largely donor-funded, vertical interventions within the health sector despite their inclusion within the BPHNS.

There is poor coordination and alignment between donor-funded interventions and the broader policies, goalsandstandardsforthepublichealthsystem.Effortstoaddressthis,throughtheHealth Sector Technical Working Group, for example, have not been successful. A clearerpolicy framework is needed along with stronger regulatory and oversight mechanisms. The TA to be provided shall be the starting point to strengthen coordination and integration of health programmes.

Coordination and integration are very crucial to the implementation of the Global Fund NFM3 HIV/RSSH/TB grant. Expansion and quality of clinical and community level HIV and TB services highly depends on the effective coordination and integration amongst health service delivery partners.

3: Facilitation of the implementation of NFM3

Part of TRAC funds will be utilized to facilitate the implementation of the NFM by identifying bottlenecks in the implementation of the project, ensuring that activities are implemented timely by addressing the bottlenecks. In addition, technical support to the UNDP PMU will be provided through TRAC funding to ensure smooth implementation of the grant activities, implementing partners are adequately monitored and resources are properly utilized during the course of the project implementaiton.

Therefore, the Global Fund programme requests an allocation of $90,000 from TRAC 1 to facilitate the implementation of the NFM3 HIV/RSSH/TB grant during 2021. In December 2021; UNDP signed the Grant Confirmation for the NFM3 HIV/RSSH/TB grant worth $71 million. The NFM3 grant shall be implemented from 1 January 2021 to 31 December 2023.

It is crucial that UNDP positions itself to be able to fully support the implementation of the NFM3 grant especially during the start-up period in 2021. Although the NFM3 budget appears to be high, 47% of the budget is allocated to health products (pharmaceuticals and non-pharmaceuticals).

There is a need to set aside a budget to facilitate the implementation of the grant, including consultancies that will be identified during the course of grant implementation.

III. RESULTS AND PARTNERSHIPS

Expected Results

In line with the revised National Strategic Plan for HIV and AIDS, the progectaims at reducing new HIV infections per 1000 uninfected population from 1.51 to 0.75, reduce AIDS-related deaths from 62 per 100,000 population to 34, reduce TB mortality rate from 8.4 per 100,000 to 0.5, and proportion of new TB cases with MDR-TB from 2.4% by half.
The project's expected outcomes are: to increase retention on ART from 75% in 2019 to 85% by 2023 and thus reduce the high attrition; to attain a viral suppression of 90% by end of the project from 47% in 2019, to improve the percentage of PLHIV who know their HIV status from 27% in 2019 to 39% by 2023; improve notified MDR-TB cases three-fold; and improve treatment success rate of MDR-TB patients from 65% in 2019 to 80% by 2023.

The project has a performance framework (PF), with key impact, outcome and output undicators and targets reported to the Global Fudn 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 USD USD 71, 526,259 by the Global Fund for the period 2021-2023 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$ 200,000 to support the CCM functions, the coordination and integration of health programmes by the Ministry of Health and the facilitation of the NFM3 implementation. Below is the summary budget by intervention:

Module	Year 1	Year 2	Year 3	Year 4
Differentiated HIV Testing Services	$1,455,073.95	$1,921,733.62	$2,039,113.39	$5,415,920.96
MDR-TB	$1,136,790.41	$628,853.43	$327,159.91	$2,092,803.75
PMTCT	$370,920.00	$329,400.00	$329,400.00	$1,029,720.00
Prevention	$405,978.29	$327,938.30	$372,884.46	$1,106,801.06
Reducing human rights-related barriers to HIV/TB services	$224,827.00	$85,240.00	$83,240.00	$393,307.00
RSSH: Community systems strengthening	$295,924.77	$289,726.10	$231,697.50	$817,348.37
RSSH: Health management information systems and M&E	$993,923.33	$261,963.33	$261,963.33	$1,517,850.00
RSSH: Health products management systems	$1,026,587.99	$926,876.00	$934,807.99	$2,888,271.97
RSSH: Human resources for health, including community health workers	$128,400.00	$0.00	$0.00	$128,400.00
RSSH: Laboratory systems	$615,984.90	$435,500.90	$435,500.90	$1,486,986.69
TB care and prevention	$3,092,210.39	$3,252,159.45	$2,825,817.36	$9,170,187.20
TB/HIV	$85,600.00	$85,600.00	$85,600.00	$256,800.00

Treatment, care and support	$9,446,873.72	$9,709,213.89	$9,850,895.48	$29,006,983.10
Program management	$5,468,151.26	$5,421,386.22	$5,325,341.41	$16,214,878.90
Grand Total	$24,747,246.01	$23,675,591.25	$23,103,421.74	$71,526,259.00

TRAC Fund Requested

No.	Activity	Output ID, Activity	Period Covered	Total Amount Requested
1	Facilitation of Implementation of NFM3 Activities	TBD	1 Jan – 31 Dec 2021	$90,000
2	Support MOH for health system strenghtening	TBD	1 Jan – 31 Dec 2021	$50,000
3	Support to CCM activities in 2020	TBD	1 Jan – 31 Dec 2021	$60,000
	GRAND TOTAL			**$200,000**

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

Continuous and deliberate adoption of strategies aimed at achieving budget efficiencies will be the responsibility of the Principal Recipient (PR), UNDP while working with its key implementing partners identified in the implementation map with the aim of achieving Value for Money (VfM). 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: the Global Fund project will continue to collaborate with PEPFAR and continually interface with PEPFAR partners. There is geographic division of HIV facilities between PEPFAR and the Global Fund. Accordingly, the support provided in terms of personnel, operations costs, administration and technical support will be provided by each with minimal overlap in these investments. However, the Global Fund project will procure and distribute all commodities and drugs required for the programmes to support all sites. There is no more support/contribution provided by PEPFAR for anti-retrovirals and commodities. PEPFAR will rather focus on the following activities (table) which the Global Fund will also implement but in facilities distinct from PEPFAR sites:

PEPFAR support	GF support and collaboration
Facility-level technical support through its implementing partners.The technical support to facilities includes trainings, filling staff gaps, mentorship, supporting of data collection and reporting, help with guidelines/protocols, DHIS rollout, strengthening PLHIV networks/CSOs.	Similar facility-level technical support; The same implementing partner (ICAP) proposed enabling the leverage of PEPFAR technical resources for the GF sites as well
HIV testing services that includes supporting VCT centers and PITC in facilities where PEPFAR's IPs support HTS, as well as PLHIV engagement, stigma reduction training, etc.	Similar HTS technical support to be provided by the GF; The same implementing partner (ICAP) proposed enabling the leverage of PEPFAR technical resources for the GF sites as well
Laboratory support that includes integrated specimen transport and scale up of multi-disease point of care diagnostic platforms	The same implementing partner (ICAP) selected to support the integrated specimen transport in GF sites The national Public Health Laboratory will be collaboratively supported through contribution by both to complement each other
HIV prevention activities among sex workers in 8 towns (Juba, Yambio, Ezo, Nimule, Yei, Maridi, Torit, Wau).	HIV prevention activities among similar key populations in the remaining major towns of the country (Malakal, Maban, Kapoeta, Tambura, Rumbek, Bor)

2. Collaborative Partnership in Supply Chain Management: UNDP will continue to partner with the proposed Principal Recipient for the Malaria Grant (once determined) in the following:
   Load consolidation: UNDP will ensure synchronized last mile deliveries of pharmaceuticals with the UNDP, thereby benefitting on the cost effectiveness of consolidation.
   *Warehousing:*UNDP is currently managing the Central Warehouse Store on behalf of the Ministry of Health. The combined HIV, TB and malaria commodities warehousing has created cost efficiencies.
   Pre-positioning of HIV Commodities and Pharmaceuticals: UNDP under the RSSH Component is supporting the establishment of Regional Warehouses that are strategically located to optimally serve the various states across the country. By using the regional hubs, it will become easier and more cost effective to deliver commodities to implementing sites by cutting down the transport costs currently being incurred through the frequent air transportation of commodities across the country. Delivery to the regional hubs will provide efficiencies through bulk transportation and strengthening the last mile delivery system.
3. 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 present and delivering services in various parts of the country. For example, UNDP is partnering with UNFPA to continue supporting HIV services in IDP sites in Bentiue, Malakal and Wau where they have presence supporting SRH. UNDP will continue exploring more of these opportunities and enhance the provision of integrated TB and HIV services.
4. Collaboration with partners managing grants for the Basic Packackage for Health Services: UNDP will continue collaboration with HPF3, RRF, 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.

In terms of implementation, under the Additional Sefeguards Policy (ASP), UNDP 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 be able to reach effectively. Accountability, transparency and effectiveness are key. For this grant, UNDP will contract the SRs that performed well under the NFM2 grant implemented from 2018 to 2020 (Ministry of Health, South Sudan AIDS Comission, AAA and Cordaid) and bring on board new SRs (UNFPA and ICAP) for HIV prevention, treatment and care, and PMTCT modules.

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. Capacity of national NGOs/CBOs such as Network of Positive Women United (NEPWU) and South Sudan Newtwork of People living with HIV (SSNEP) will be strengthened in order to take on more responsibilities and strengthen their community networks. UN agencies such as WHO and UNICEF are no longer selected as SRs due to implementation challenges these agencies have faced in the previous grants. UNFPA has been selected as SR of last resort mainly to because of its comparative advantage of its presence in sites of the project's interest and its engagement in related programmes such as SRH and AYPs programmes.

Risksand Assumptions

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

i. Worsening of COVID-19 within the country can derail the provision of services in health facilities and within the communities because of restricted movements.
ii. 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.
iii. 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.
iv. 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

v. Loss of health sector assets due to theft and looting: There has been a loss of assets such as vehicles, infrastructure, equipment and health commodities due to theft and looting. The ongoing conflict continues to pose a risk to the security of key health sector assets.

vi. Inadequate integration of TB and HIV services by former implementing partners (e.g. AAA) will 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.

vii. 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

viii. 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 revision of the South Sudan Health Policy - 2016-2026, 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 EID and Viral Load Strategy, Integrated Specimen Transportation Strategy, and multi-disease Points of Care strategy using lessons learned from the EID and Viral Load services implementation, multi-disease point of care (geneXpert) expansion. A robust programmeevaluation 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 and facility level, and soon 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 exepmtions 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 2021-2023 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 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 2018-2020 NFM grant, the government will continue supporting human resources for the HIV and TB programs in the2021-2023 funding request. The human resources component for the 2021-2023 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 the yet to be determined 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 present and delivering services in various parts of the country. UNDP is partnering with UNFPA to sustain HIV services in IDP sites. UNDP will continue exploring more of these opportunities and enhance the provision of integrated TB and HIV services.
5. Collaboration with partners managing grants for the Basic Package for Health Seervices: UNDP will continue collaboration with HPF, RRF, and other partners to ensure intergrration 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 (2021-2023) 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.

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 HSS 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 cooperation framework (UNCF) 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 UNCF/CPD output 2.3 that speaks to strengthened capacities at national and sub-national levels to deliver HIV and related services to reduce vulnerability and enhance productivity. The project's ouputs also align with the Results and Resources Framework (IRRF)'s Output 3.2 HIV: Population in South Sudan particularly yout, key population and people living with HIV have increased access to and utilization of quality HIV services. Through scaled up HIV, TB and other primary health services across South Sudan, the project aligns with the NDS outcome of 'Population has access to basic services'.

V. RESULTS FRAMEWORK[8]

EXPECTED OUTPUTS	OUTPUT INDICATORS[9]	DATA SOURCE	BASELINE		TARGETS			DATA COLLECTION METHODS & RISKS
			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*	16,323	2019	22,637	22,637	22,637	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*	81%	2019	85%	86%	87%	DHIS2, Quarterly Programme reports from MOH and SRs
	3. Percentage of laboratories showing adequate performance in external quality assurance for smear microscopy among the total number of laboratories that undertake	*Facility Reports*	153/187 (82%)	2019	95%	95%	95%	DHIS2, Quarterly Programme reports from MOH and SRs
Output 2: Improved MDR-TB cases detection and quality of MDR-TB care	1.Number and proportion of MDR-TB cases notified	*Facility Reports*	68	*2019*	100	145	202	DHIS2, Quarterly Programme reports from MOH and SRs
	2. MDR TB-3(M) Number of cases with RR-TB and/or MDR-TB that began second-line treatment	*Facility Reports*	61	*2019*	100	145	202	DHIS2, Quarterly Programme reports from MOH and SRs
	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*	65.50%	*2019*	80%	80%	80%	DHIS2, Quarterly Programme reports from MOH and SRs
Output 3: HIV Prevention programmes,	KP-1c(M) Percentage of sex workers reached with HIV prevention programs - defined package of services	*SR Reports*	13,592/22,550 (60%)	*2019*	65%	70%	75%	SR/SSR reports

[8]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.

[9]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.

differentiated HIV testing services scaled up	HTS-3c(M) Percentage of sex workers that have received an HIV test during the reporting period and know their results	*SR Reports*	33%	*2019*	40%	45%	50%	SR/SSR reports
	HTS-3e Percentage of other vulnerable populations that have received an HIV test during the reporting period and know their results	*SR Reports*	3.50%	*2019*	4.3%	6.2%	7.4%	SR reports
Output 4: Human rights-related barriers to HIV/TB services are reduced	Percentage of PLHIV who report experiences of HIV related discrimination in health care settings	*IBBS report*	13%	*2019*			5%	IBBS report
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*	18%	*2019*	21%	24%	36%	DHIS2, Routine HMIS HIV quarterly reports and programme reports
	TB/HIV-6(M) Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	*Facility Reports*	88%	*2019*	90%	90%	90%	DHIS2, Routine HMIS HIV quarterly reports and programme reports
	TB/HIV-5 Percentage of registered new and relapse TB patients with documented HIV status	*Facility Reports*	93%	*2019*	93%	93%	93%	DHIS2, Routine HMIS HIV quarterly reports and programme reports
Output 6: Prevention of mother-to-child transmsion of HIV enhanced	PMTCT-2.1 Percentage of HIV-positive women who received ART during pregnancy and/or labour and delivery	*Facility Reports*	42%	*2019*	50%	60%	70%	DHIS2, Routine HMIS HIV quarterly reports and programme reports
	PMTCT-3.1 Percentage of HIV-exposed infants receiving a virological test for HIV within 2 months of birth	*Facility Reports*	12%	*2019*	30%	40%	60%	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*	94%	*2019*	95%	95%	95%	DHIS2, Routine HMIS HIV quarterly reports and programme reports

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	Quarterly, Annually, and at the end of the		MoH, WHO, CCM Implementing	

	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.	project (final report)		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[10]

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 Evaluation	MOH and SSAC	**Output 1.2.** Vulnerable population groups have access to tuberculosis, HIV and AIDS prevention, care, and treatment	**Outcome No.1** More resilient communities	March 2022	MoH, WHO, Implementating Partners, donors, beneficiaries	GFATM
End-Term Evaluation	MOH and SSAC	**Output 1.2.** Vulnerable population groups have access to tuberculosis, HIV and AIDS prevention, care, and treatment	**Outcome No.1** More resilient communities	March 2022	MoH, WHO, Implementating Partners, donors, beneficiaries	GFATM

[10] Optional, if needed

VII. MULTI-YEARWORK PLAN [11][12]

By Module	Year 1 (US$)	Year 2 (US$)	Year 3 (US$)	Total (US$)	%
Differentiated HIV Testing Services	1,441,028.21	1,905,094.89	2,022,644.20	5,368,767.31	8%
Treatment, care and support	9,186,905.72	9,449,245.89	11,366,492.48	30,002,644.10	42%
PMTCT	370,920.00	329,400.00	329,400.00	1,029,720.00	1%
TB care and prevention	3,092,210.39	3,252,159.45	2,825,817.36	9,170,187.20	13%
MDR-TB	1,136,790.41	628,853.43	327,159.91	2,092,803.75	3%
Prevention	405,976.47	327,936.48	372,882.64	1,106,795.59	2%
TB/HIV	85,600.00	85,600.00	85,600.00	256,800.00	0%
Reducing human rights-related barriers to HIV/TB services	224,827.00	85,240.00	83,240.00	393,307.00	1%
RSSH: Community systems strengthening	249,327.27	241,886.00	185,100.00	676,313.27	1%
RSSH: Human resources for health, including community health workers	128,400.00	-	-	128,400.00	0%
RSSH: Health management information systems and M&E	939,323.33	207,363.33	207,363.33	1,354,050.00	2%
RSSH: Health products management systems	1,026,587.99	926,876.00	934,807.99	2,888,271.97	4%
RSSH: Laboratory systems	615,984.90	435,500.90	435,500.90	1,486,986.69	2%
Program management	5,255,309.82	5,201,859.90	5,114,042.34	15,571,212.06	22%
Total	**24,159,191.51**	**23,077,016.27**	**24,290,051.15**	**71,526,258.93**	**100%**

[11] 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

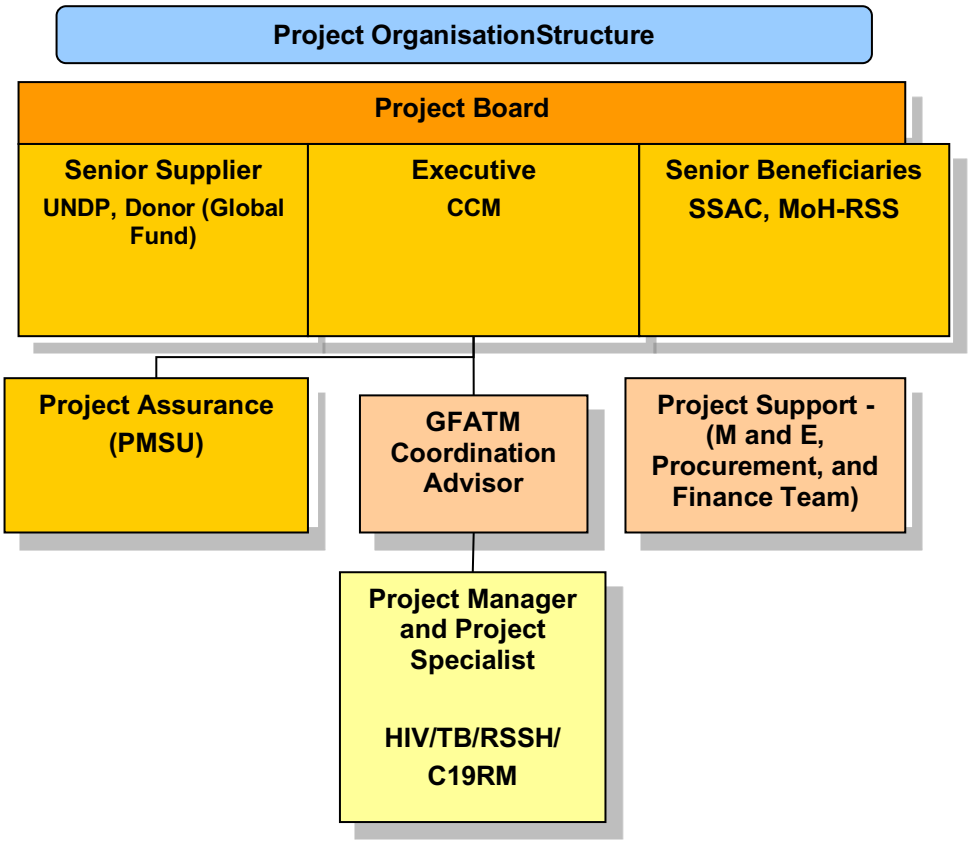
[12]Changes to a project budget affecting the scope (outputs), completion date, or total estimated project costs require a formal budget revision that must be signed by the project board. In other cases, the UNDP programme manager alone may sign the revision provided the other signatories have no objection. 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 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 the Principal Recipient (PR) of last resort 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, 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.

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 an Analyst 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, 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[13].

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.

[13] 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: RISK MATRIX

CPD Outcome: Output 1.1. Output 2.3. Capacities at national and subnational levels strengthened to deliver HIV and related services to reduce vulnerability and enhance productivity.

Outputs and Key Results	Description of Risk Event	Type of Risk	Risk Source Category	Impact of Risk	Impact Risk Rating	Mitigation Measures	Indicator to Monitor	Risk Owner	Status
Output 1:Improved TB case notification and enhanced quality of TB programme	Contiued presence of COVID-19 pandemic or increased morbidity and fatality from it	Strategic	1.a. Contextual Risks/Safety & Security Situation	block/delay the delivery of results	Moderate	i)Closely monitor the situation ii)Customization of SOP HIV and TB service continuity plans iii)HIV/TB-COVID-19 integration	Proportion of health facilities implementing HIV/TB/Covid-19 integrated surveillance	Project Managers	new
Output 2: Improved MDR-TB cases detection and quality of MDR-TB care	Continued inaccessibility of HFs due to insecurity	Environmental	1.a. Contextual Risks/Safety & Security Situation	block/delay the delivery of results	Moderate	Coordination with humanitarian agencies/actors & local NGOs	incremental humanitarian organizations coordination meeting with agenda on service delivery in insecure areas	Project Managers	new
	Limited budget/cash to IPs might lower incentives for expansion of services and enhanced identification of TB among suspects	Financial	3.a. UNDP/Unclear/ overambitious objectives in relation to available financial and human resources	Scale up of services will be hindered, thus reducing the positive impact the project might have had.	Moderate	Reprogramming i.e. redesign activities to incentivize the new SRs (i.e. activties may be arranged in collaboration with IPs as an event partner to allow them receive payment for their services	ratio of participation of CSO, NGO in the project activites	Project Managers	new
Output 3: HIV Prevention programmes, differentiated HIV testing services scaled up	Challenges in implementating activities among sex workers- may face issues of human rights violations	Environmental	2.d Stakeholder Risks/Other stakeholders	Some of the project initiatives will either be delayed or not undertaken	Moderate	TA from the regional office, support from in-country partners	monitor selected SRs delivery through agreed performance framework	Project Managers	new

	Delay in signing of SR agreements due to misunderstanding on the terms and conditions	Strategic	2.a Stakeholder Risks/Implementing Partners / Responsible Parties	Block/delay the delivery. Decreases the rating of the grant.	Significant	Fastrack the signing of SR agreements and follow-up to ensure activities are implemented.	Monitor selected SRs delivery through agreed performance framework	Project Managers	new
	Challenges in implementating activities among sex workers and MSM in the current context - may face issues of human rights violations	Environmental	2.d Stakeholder Risks/Other stakeholders	Some of the project initiatives will either be delayed or not undertaken	Significant	Implementation of the KELIN Consultant Recommendations, TA from the regional office, support from in-country partners	monitor selected SRs delivery through agreed performance framework	Project Managers	new
Output 5: High quality HIV treatment, care and support provided to PLHIV	Delay in signing of SR agreements due to misunderstanding on the terms and conditions and budget allocations	Strategic	2.a Stakeholder Risks/Implementing Partners / Responsible Parties	Block/delay the delivery. Decreases the rating of the grant.	Significant	Fastrack the signing of SR agreements and follow-up to ensure activities are implemented.	Monitor selected SRs delivery through agreed performance framework	Project Managers	resolved
	Expansion of ART sites may be a challenge in conflict affected areas	Environmental	1.a. Contextual Risks/Safety & Security Situation	block/delay the delivery. Decreases the rating of the grant.	Significant	Coordination with humanitarian agencies/actors, WHO and PEPFAR working in insecure areas	incremental coordination meeting with agenda on service delivery in insecure areas	Project Managers	reducing
Output 6: Prevention of mother-to-child transmsion of HIV enhanced	Delays in recruitment of MOH staff to support the implementation of project activities.	Operational	2.a Stakeholder Risks/Implementing Partners / Responsible Parties	Delay in implementation of project activities	Significant	Support the recruitment process for the Ministry staff; provide analysis to the GF on the budgeteryimpications	Monitor selected SRs delivery through agreed performance framework	Project Managers	reducing
	Expansion of PMTCT sites may be a challenge in conflict affected areas	Environmental	1.a. Contextual Risks/Safety & Security Situation	block/delay the delivery. Decreases the rating of the grant.	Significant	Coordination with humanitarian agencies working in insecure areas to implement basic services,	incremental humanitarian organizations coordination meeting	Project Managers	reducing
Output 7: Resilient and sustainable systems for health established	High turnover of M&E officers at counties and states poses a risk in data management and reporting	Strategic	2.a Stakeholder Risks/Implementing Partners / Responsible Parties	Grant rating negatively affected because of low quality data and incomplete data	Significant	Ensure the realization of performance-based incentives to the officers and mentoring and logistics support	Percentage of monthly report from health facilities	Project Managers	new

ANNEX 2: SOCIAL AND ENVIRONMENTAL SCREENING

Project Information

Project Information	
1. Project Title	Integrating Services for Maximum Impact
2. Project Number (i.e. Atlas project ID, PIMS+)	00132701
3. Location (Global/Region/Country)	South Sudan
4. Project stage (Design or Implementation)	Approval for Implementation
5. Date	22/01/2021

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
The project will design and roll-out country specific technical guidance to fully integrate human rights with HIV prevention and Adolescent Sexual and Reproductive Health and Rights (ASRHR) through a technical assistance sourced internationally. The technical assistance (TA) provider will lead the development of job aids and SOPs for the ASRHR integration to guide implementers.
Briefly describe in the space below how the project is likely to improve gender equality and women's empowerment
The project will support the reduction of HIV-related gender discrimination, harmful gender norms and violence against women and girls by engaging in research dissemination and outreach activities.
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 at primary health care level; (ii) supporting the government to initiate domestic resources mobilization; (iii) Building the capacity of national NGOs and CSOs in resource mobilization to support the maintenance of provision of health services.
Briefly describe in the space below how the projectstrengthensaccountability to stakeholders
UNDP will contract the SRs that performed well under the NFM2 grant implemented from 2018 to 2020 (Ministry of Health, South Sudan AIDS Comission, AAA and Cordaid) and bring on board new SRs (UNFPA and ICAP) for HIV prevention, treatment and care,

and PMTCT modules. 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. Capacity of national NGOs/CBOs such as NEPWU and SSNEP will be strengthened in order to 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 5below 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, ModerateSubstantial, High)***	***Comments (optional)***	***Description of assessment and management measures for risks rated as Moderate, Substantial or High***
Risk 1: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	I = 3 L = 3	Substantial		-UNDP will work with humanitarian agencies in early asessement, 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: High cost of providing	I = 3	Moderate	In addition, this	-Ensuring that TB/HIV/public health programmes

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.	L = 3		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.	are integrated -Pooling of services and activities to gain cost efficiencies -Regular review of budget and expenses and finding cost efficiency measures -Prioritization of high impact, high yield interventions and create savings (periodic stock take of activities/interventions in collaboration with the MoH and SSAC)
Risk 3: Suboptimal programming (not achieving targets/impact) because of rapid changes in operating environment mostly due to: Migration of intended beneficiaries outside South Sudan where they cannot access services through current grants / changes in beneficiary needs and locations :Limited access of implementers and partners to key areas due to insecurity -Implementation of activities delayed or postponed or cancelled	I=2 L=2		This risk also undermines scale up plans to increase coverage	-Ensure cross-border collaboration with neighboring countries -Mechanisms put in place for easy tracking of patients and other beneficiaries
[add additional rows as needed]				
	QUESTION 4: What is the overall project risk categorization?			
	Low Risk	☐		

	Moderate Risk	x			
	Substantial Risk	☐			
	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")	☐			***Status? (completed, planned)***
	if yes, indicate overall type and status		☐	Targeted assessment(s)	
			☐	ESIA (Environmental and Social Impact Assessment)	
			☐	SESA (Strategic Environmental and Social Assessment)	
	Are managementplans required? (check if "yes)	☐			
	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 risks, which Principles/Project-level Standards triggered?		**Comments (not required)**		
	Overarching Principle: Leave No One				

	Behind		
	Human Rights	☐	
	Gender Equality and Women's Empowerment	☐	
	Accountability	☐	
	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	***Date***	***Description***
QA Assessor		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		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		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	
INSTRUCTIONS: The risk screening checklist will assist in answering Questions 2-6 of the Screening Template. Answers to the checklist questions help to (1) identify potential risks, (2) determine the overall risk categorization of the project, and (3) determine required level of assessment and management measures. Refer to theSEStoolkitfor further guidance on addressing screening questions.	
Overarching Principle: Leave No One Behind **Human Rights**	**Answer (Yes/No)**
P.1 Have local communities or individualsraised human rights concerns regarding the project (e.g. during the stakeholder engagement process, grievance processes, public statements)?	*No*
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?	*No*
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 projectpotentially 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?[14]	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)?	No
Would the projectpotentially 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

[14] 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.

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
Sustainability and Resilience: Screeningquestions regarding risks associated with sustainability and resilience are encompassed by the Standard-specific questions below		
Accountability		
Would the projectpotentially 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 projectpotentially 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*	
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	significantagricultural 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	
1.12	handling or utilization of genetically modified organisms/living modified organisms?[15]	No
1.13	utilization of genetic resources? (e.g. collection and/or harvesting, commercial development)[16]	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:		
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 invulnerability to climate changeimpacts 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

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

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

Standard 4: Cultural Heritage		
Would the projectpotentiallyinvolve 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 projectpotentially 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?[17]	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 the potential risk impacts are considered significant and the project would be categorized as either Substantial Risk or High Risk*	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

[17] 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.

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
Standard 8: Pollution Prevention and Resource Efficiency		
Would the projectpotentiallyinvolve or lead to:		*No*
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