



**Southern Sudan  
Basic Service Fund – Interim Arrangement  
Mid-Term Review 14 March-1 April 2011**

**Final Report**

**17 May 2011**



## Basic Services Fund – Interim Arrangement

### Mid-Term Review

### Final Report

Name	Basic Services Fund – Interim Arrangement
Duration	July 2010 to December 2011
Key Stakeholders	Service Users, GoSS, States and County; NGO, FBO, and CBOs; BSF Secretariat and Steering Committee, Development Partners (Netherlands, Norway, Sweden, UK, European Union)
Purpose	Expand coverage and use of basic services in (South) Sudan
Results	Strengthened Education Services, Strengthen Health Services; Strengthened Water and Sanitation Services; Strengthen GoSS Capacity to plan and monitor basic service activity
Location	Southern Sudan
Management Consultant	BMB Mott MacDonald
Value	GBP 37,529,543 (excluding management fee)

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## Acronyms

ANC	Ante-natal care
BEmONC	Basic Emergency Obstetric and Neonatal Care
BPHS	Basic Package of Health Services
BSF	Basic Services Fund
BSF-IA	Basic Services Fund Interim Arrangement
CBO	Community Based Organisation
CED	County Education Department
CHD	County Health Department
CHW	Community Health Worker
CLTS	Community-Led Total Sanitation
CPA	Comprehensive Peace Agreement
DFID	Department for International Development
DP	Development Partner
ECHO	(the former) European Community Humanitarian Aid Office
EMIS	Education Management Information System
FBO	Faith-based Organisation
GBP	Great Britain pound
GoSS	Government of South Sudan
HMIS	Health Management Information System
INSET	In Service Training
MCHW	Mother and Child Health Worker
MTDF	Medium Term Development Fund
MoE	Ministry of Education
MoFEP	Ministry of Finance and Economic Planning
MoH	Ministry of Health
MWRI	Ministry of Water Resources & Irrigation
NGO	Non-Governmental Organisation (generally including Faith-Based Organisation in this context)
O&M	Operation and maintenance
OFDA	Office of U.S Foreign Disaster Assistance
PHAST	Participatory Hygiene and Sanitation Transformation
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PPP	Purchasing Power Parity
PRESET	Pre-Service Training
PTA	Parent Teacher Association
QPR	Quarterly Progress Report
RWSS	Rural Water Supply and Sanitation
SDG	Sudanese pounds
SMoH	State Ministry of Health
SSCCSE	South Sudan Centre for Census, Statistics and Evaluation
SSWICH	Southern Sudan Water Information Clearing House
TBA	Traditional Birth Attendant
TTI	Teacher Training Institute
UNICEF	United Nations Children Fund
UNOPS	United Nations Operations for Project Services
USAID	United States Agency for International Development
USD	United States Dollar
VfM	Value for money
VLOM	Village Level Operation & Maintenance
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
WMC	Water Management Committee

## Summary

The purpose of the Basic Service's Fund Interim Arrangement (BSF-IA) is to increase the coverage, access and use of the population of Southern Sudan to Basic Services in primary education, primary health and water and sanitation in a sustainable way, including the strengthening of the Government of southern Sudan's (GOSS) capacity to plan, monitor and co-ordinate this service delivery by non-state actors. BSF-IA builds on previous phases of the BSF to ensure basic services continue to be delivered, allowing GoSS time to develop its plans and capacity for an enhanced leadership and management role after independence in July 2011. BSF-IA runs from July 2010 to December 2011.

This Mid-Term Review was conducted from 14 March to 1 April 2011 by Mr Richard Johnson (Primary Health), Mr Tom Power (Primary Education), Mr Jeremy Ockelford (Watsan and team leader) and Mr Charles Chol (Goss MoFEP, Deputy Director Aid Coordination). It consisted of meetings with Ministries, DFID, BSF-Secretariat, NGO groups and field visits to several states, including meetings with State, County and Payam authorities.

**Programme design and management:** BSF-IA is a short extension of the previous phase of BSF pending the outcome of the referendum in January this year. As such it had a short term-perspective. Future funding for basic services will now need to have a much longer-term perspective. BSF-IA is managed by a service provider, BMB Mott MacDonald, selected through international tender. In the logframe for BSF-IA set by DFID, the purpose level indicators tend to be output oriented, rather than outcome oriented. BSF is felt by NGOs to be exemplary in collaborative working, cash flow and achieving outputs. They have found BSF to be flexible and responsive and very prompt in managing disbursement.

Except for certain indicators in health which are difficult to measure, BSF-IA is likely to largely achieve the targets set. BSF is increasing basic health service coverage, and expects to support 20-30% of primary care facilities that open regularly by December 2011. Without BSF, these facilities would probably function very much less, if at all. These views are based on past performance of the BSF program as well as interviews, field observations and reports on current progress.

On reporting and monitoring by the BSF Secretariat, reporting is not consistent between documents; whilst reporting is extensive, reporting against log-frame indicators and targets is not always clear.

Overall governance of BSF is still evolving. While the Steering Committee has an important role in project selection, there is a now a need for a strategic overview of the future of support for basic services, after the end of BSF-IA.

Key issues in **Health** include:

- BSF still focuses more on facilities than on County-wide needs. Despite attempts to reduce overlap between the 5 major funders of basic health services<sup>2</sup>, 17 counties and 9 states had operations supported by more than one of these funders in 2010.
- The breadth of the Basic Package of Health Service makes it hard to prioritise the use of scarce human and material resources to deliver the most essential health services.
- Staffing and supplies are major constraints on quality. Many PHCUs depend almost exclusively on CHWs and TBAs. MOH drug supplies have been inadequate and erratic. It is unclear whether recent improvements will be sustained. Despite these problems, BSF

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<sup>2</sup> (BSF, OFDA, USAID, ECHO, MDTF)

facilities appear far better off than other MOH facilities, which suffer from non-payment of salaries, inadequate supervision and supplies, and poor facilities.

- Although BSF demonstrates strong consultation rates, these are not sufficient to ensure that BSF fulfils its purpose of improving health and working towards the MDG goals.

Key issues in **Education** include:

- South Sudan has approximately two million children of primary school age, and 26,000 primary teachers, including volunteers. To reach a ratio of one teacher to fifty students, 14,000 additional teachers need to be trained. Current rates of training are barely above replacement, and insufficient to begin to close this gap within the foreseeable future.
- The new schools are designed to accommodate 400 students. Current data on enrolment and attendance is unreliable, but it seems that many more children may be using the schools than they were designed to accommodate. The resulting overcrowding is likely to substantially impact the quality of teaching and learning.
- Although INSET and PRESET follows a common GOSS curriculum, the teachers participating in each kind of training are very different in terms of educational attainment and experience. It appears that the current teacher training curriculum and delivery does not adequately provide for the different needs of these two groups of trainees.
- Teaching-training strategies appear to be presented separately from subject knowledge. Although trainers say they teach 'how to teach', very limited observation indicates a predominance of subject knowledge over classroom practice.

Key issues in **water, sanitation and hygiene promotion** include:

- Planning for new coverage of water supply is based on 500 users per water-point. Actual coverage is not known – NGOs generally do not assess the number of households using the water-points; observation indicates substantially higher numbers of users.
- Although water supply service has clearly improved in terms of water quality and access, it is likely to be undermined by the over-use, causing long queuing times, arguments and excessive wear and tear on the pumps leading to higher maintenance needs and more frequent breakdown. The long queuing times also have implications for women's workloads and girls' ability to go to school.
- There is no standard approach for the process of introducing and developing a water supply in a village, a critical factor for sustainability – the more limited approaches are unlikely to achieve this.
- Approaches to hygiene promotion vary. The more limited approaches may increase knowledge slightly but are very unlikely to result change in hygiene practices.

On **government engagement and capacity building**, all NGOs and BSF engage with the authorities at their respective levels. Capacity building, however, needs a more systematic and longer term approach than is offered by BSF-IA.

**Sustainability** of health services is dependent on continued funding after the end of BSF-IA. In education, sustainability of infrastructure depends on funding in the short-term from communities, which varies from place to place. On-going teacher training will need continuing funding. In the short-term, water supplies will continue, but more work needs to be done on maintenance support systems and supplies chains for long-term sustainability. Changes in sanitation and hygiene behaviour are unlikely to be sustained without further reinforcement of promotion.

On **value for money**, health costs of the BSF programme are low in proportion to typical health expenditure within low-income countries. However, the value of the health outcomes achieved by BSF is not clear. Well-chosen interventions in basic health are very cost

effective<sup>3</sup>. There is therefore likely to be scope for increasing investment, where this is clearly linked to improvements in health outcomes. The unit costs of school construction and teacher training are competitive compared to other projects in South Sudan. In an international economic study, investment in water and sanitation has been shown to have a cost-benefit ratio of 12.5 for countries in the region. Such investment will, however, be lost if sustainability is not improved by sufficient funding for the software of water and hygiene behaviour change and other key aspects such as supply chains for replacement parts for pumps.

## Summary of output results

The results for each targeted output are taken from the BSF-IA Quarterly Progress Report 1 – 2011, version 23 March 2011. This reports results up to December 2010. It should be noted that outputs, in particular construction outputs, were constrained in this period because of the rainy season.

### Output 1: Strengthened [primary] education services

- 2 schools completed (16 classrooms); construction started on 30 out of 32 schools
- Just over half (1,170) of the targeted (1,996) teachers have begun or completed training

### Output 2: Strengthen primary health services

- 0 out of 13 of PHCC/PHCUs built/reconstructed
- 45 PHCC and 112 PHCUs supported with medical services only
- 274,229 patient consultations held

### Output 3: Strengthened water and sanitation services

- 6 out of 185 new tubewells constructed
- 42 out of 222 tubewells rehabilitated
- 59 out of 141 other waterpoints constructed
- 498 out of 9,376 household toilets constructed
- 43 out of 566 institutional toilets (stances) constructed
- 1,463 out of 37,623 people, of whom 850 were women, have received training on various water, sanitation and hygiene topics
- 401 out of 5,000 people, of whom 202 were women, have received training on maintenance and monitoring of water supply and sanitation systems

### Output 4: Strengthen GOSS capacity to plan and monitor basic service delivery

- Target and achievement figures not available

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<sup>3</sup> See WHO-CHOICE choosing cost effective interventions in Health:

## Recommendations

Ref	Recommendation	Priority and approximate dates	BSF Secretariat	DFID /DPs	Govt	Other
G1	For future funding, develop clear and measurable targets for the purpose and outputs in capacity development, and include basic services within GOSS budgets (GOSS, DFID and DPs)	April to Dec 2011 Design process		X	X	
G2	Consider allocating part of the funding to support specialist operational inputs that would facilitate the work of NGOs in the field	April to Dec 2011 Design process		X	X	
G3	Build upon BSF strengths of the Steering Committee, the NGO contracting process, responsiveness and support in future funding arrangements	April to Dec 2011 Design process		X	X	
G6	Ensure Steering Committee has full opportunities to consider strategy for completion of BSF and for development of future support (DFID, BSF)	April to Dec 2011 Design process	X	X	X	
H1	Build on BSF success in future support for basic health services, by maximising coverage with cost-effective services provided by NGO providers in specified counties,	April to Dec 2011 Design process		X	X	
H2	Shift from providing grants for specific facilities, to County-based services or contracts under CHD control. To do this, support preparation of a SMOH/CHD capacity development plan, drawing key elements from existing health policy and draft CHD guidance; use this to support CHDs and implementation partners in developing County service plans or contracts	April to Dec 2011 Design process		X	X	
H3	Shift from present focus on number of attendances and facilities, to a new focus on delivering results for health, by agreeing key interventions within BPHS, and setting County-level targets for these.	April to Dec 11 Design process		X	X	
H4	Facilitate adoption of MoH HMIS and LQAS tools at County and facility level; use these to show performance against targets in a redesigned Annex 10 of QPR; use these also to provide baselines for future support	April to Dec 11 BSF completion	X			
H5	Ensure that there is a complete strategy to provide qualified, trained staff for basic services	April to Dec 11 Design process		X	X	
H6	Agree responsibilities for staff payment within new funding arrangements and provide regular reports	April to Dec 11 Design process		X	X	
H7	Agree responsibilities for distribution of drugs and supplies and provide regular reports	April to Dec 11 Design process		X	X	
H8	Stop using BPHS norms of calculating number of beneficiaries	Mar to Jun 2011		X		

Ref	Recommendation	Priority and approximate dates	BSF Secretariat	DFID /DPs	Govt	Other
H9	Ensure that Government and DP develop plans to ensure continuity of support to health services after BSF-IA (BSF, DP, Steering Committee)	April to Dec 11 Design process		X	X	
H10	Provide strong technical support within DFID, as well as technical assistance in the design and implementation of future support to basic health services. Technical assistance should include a full-time technical adviser to support the design process for basic health service, alongside BSF, and increased availability of TA to government and NGOs within future health support	Apr 11 to Feb 12 Design / inception process		X		
G4	DFID and BSF should confirm a definitive logframe for the programme	0-3 months Corrective	X	X		
G5	BSF should confirm completeness and accuracy of progress and completion reports, including <ul style="list-style-type: none"> <li>– Distinguish cumulative and non-cumulative totals</li> <li>– Identify period reported in all tables</li> <li>– Clarify status of all documents – draft, final</li> <li>– Ensure accuracy of all reports is confirmed</li> <li>– Report achievement against all logframe targets – repeated</li> <li>– Provide consistent reporting across BSF1, BSF2, BSF-IA – repeated</li> </ul>	0-3 months Corrective	X			
E6	Ensure structured process of development for CEDs and States, to ensure capacity for planning, supervision, supply and accountability	0-9 months Design process		X	X	
E7	PTAs need training and capacity building, to enable them to meet the on-going costs of the schools. This includes estimating the extent of those costs, planning how to raise the capital required, and managing the funds and their disbursement. This should ideally be done in collaboration with the CED. This should be part of a wider capacity building process to increase community participation and management from pre-construction onwards.	0-9 months Design process	X	X	X	
E8	GOSS should explore whether there may be hybrid architectures, with greater emphasis on locally sourced permanent materials and construction techniques, that might provide school buildings at lower initial cost, and with lower on-going costs for communities, representing a more sustainable architecture for development in education	0-9 months Design process		X	X	
E9	Explore potential savings by increasing use of locally sourced building materials	0-9 months Design process		X	X	
E10	Future funding should include indicators tracking quality of outcome, to inform value for money	0-9 months Design process		X	X	

Ref	Recommendation	Priority and approximate dates	BSF Secretariat	DFID /DPs	Govt	Other
E1	Model the numbers of additional teachers required (PRESET), the numbers of current teachers requiring up-skilling through In-Service Training (INSET). Explore appropriate training methodologies to reach such scale within realistic time period (e.g. <a href="http://www.tessafrica.net">www.tessafrica.net</a> )	0-9 months Design process		X	X	
E2	Provision and on-going management of school infrastructure should be informed by robust, verified data on enrolment and attendance, and an understanding of how these typically change after construction of new schools	0-3 months Corrective	X		X	
E3	The purpose, content and approaches to PRESET and INSET training should be revised, to better match teacher training needs of the different trainee groups	0-9 months Design process		X	X	
E4	Teacher training provision should be revised to emphasise practice, through activities for work-based learning	0-9 months Design process		X	X	
E5	English language training for teachers should move towards more communicative language teaching approaches	0-9 months Design process		X	X	
W1	NGOs should make and report an accurate assessment of the number of households using a waterpoint, involving the WMC and using techniques such as community mapping (BSF/GoSS)	0-9 months BSF corrective	X			
W10	Develop minimum standards for approaches for hygiene promotion with community, based on best practice in Southern Sudan and internationally (MWRI/BSF)	0-9 months Design process	X	X	X	
W11	Explore potential for alternative water sources (hand-dug wells, traditional sources, etc.) (MWRI/Donors)	0-9 months Design process		X	X	
W12	Consider conducting a formal standardisation process for handpumps with a view to adopting true VLOM handpumps as standard (MWRI/Donors)	0-9 months Design process		X	X	
W13	Provide more funding to software processes to achieve sustainable water supplies and hygiene behaviour change – otherwise the value of infrastructure will be lost (GoSS/Donors)	0-9 months Design process		X	X	
W2	The scale of sanitation promotion should be increased, including capacity development of local small-scale private sector (GoSS/Donors)	0-9 months Design process		X	X	
W3	NGOs should train village masons in the construction of latrine slabs so that it is possible for households to get slabs after the end of the project	0-9 months BSF completion	X			
W4	A strategic action plan needs to be developed and implemented to address how to rapidly but sustainably increase rural people's access to water supplies	0-9 months Design process		X	X	

Ref	Recommendation	Priority and approximate dates	BSF Secretariat	DFID /DPs	Govt	Other
W5	Develop minimum standards for approaches for hygiene promotion with community, based on best practice in Southern Sudan and internationally, inclusive of both men and women.	0-9 months Design process	X	X	X	
W6	Introduce as hygiene behaviour change as a subject in its own right from Year 1 in the primary education curriculum	0-9 months Design process		X	X	
W7	Increase the number of latrines in primary schools to two per classroom, one for girls and one for boys	0-9 months Design process		X	X	
W8	Develop a common approach for the process of developing water supply with community, based on best practice (including gender) in Southern Sudan and internationally and (MWRI/BSF)	0-9 months Design process		X	X	
W9	Support piloting of alternative approaches to sanitation	0-9 months Design process		X	X	

Comments on the BSF-IA Mid-Term Review Report

<p><u>Recommendations</u></p> <p>A. 51 recommendations - rather a lot to take forward, need prioritising by using some kind of rating system: critical to the continuing success, need action immediately - RED; important to the continuing success, need to be actioned in next 6 months- AMBER; important but not so key to the continuing success - GREEN.</p>	<p><i>Total recommendations now reduced to 38, which we do not consider excessive for a review of 3 sectors and the programme management. WE consider the timing and process gives sufficient indication of process.</i></p> <p><i>Health – Total recommendations reduced to 10. All are top priority as essential either for project correction, completion or design of future support</i></p> <p><i>Education: total recommendations are reduced to 10.</i></p>
<p>B. Recommendations need to be discussed with the project management team to categorise in terms of immediate actions and medium term actions.</p>	<p><i>This should be a discussion between DFID and the BSF-Secretariat.</i></p> <p><i>Health – Further discussion with Project Management Team would be useful. It may take the view that design of future support lie outside its remit. The proposal for additional TA support needs full discussion</i></p> <p><i>Education – as per health.</i></p>
<p>C. Some recommendations may require additional resources to implement-is that feasible?</p>	<p><i>The MTR Team are not in a position to advise on the feasibility of additional resources.</i></p> <p><i>TA is recommended for health, both to support design phase and implementation of future support. DFID needs to discuss this further with project management.</i></p> <p><i>Education – as per health.</i></p>
<p><u>Introduction</u></p> <p>A. The introduction needs to say something about why a Basic Services Fund was thought to be the right aid instrument/ mechanism of delivery? What were the alternatives - perhaps there were none? What are the efficiencies of a BSF - presumably greater coordination and harmonisation of delivery, better effectiveness?</p>	<p><i>Some more background has been added to the introduction. The question of appropriateness, however, was not set as a priority and with the limited time available it was not possible to explore it, or the alternatives. The efficiencies of BSF are covered in different aspects in the report.</i></p>
<p><u>2.1.2 Quality</u></p> <p>A. Mott should focus on delivering three changes before the end of the year:</p> <ol style="list-style-type: none"> <li>1. Pro-actively facilitate NGOs to start using</li> </ol>	<p><i>Agreed. This is reinforcing something that is underway. However, this needs to include adoption of LQAS, in order to provide a baseline of County service coverage for future funding.</i></p>

the HMIS systems of the MoH and track progress (recommendation H4a).	<i>(Both now form recommendation H4)</i>
2. Redesign annex 10 of the QPR to use rates/percentages/comparisons with local targets and report cumulatively (H6 and H7)	<i>This is also included in Recommendation H4. It may be hard to track performance against targets if these have not been clearly stated by NGOs, but important to establish this discipline for the future.</i>
3. Assist the MoH develop a County Health Department (CHD) Guideline outlining roles/responsibilities etc and disseminate it to NGOs (H8 revised)	<i>Now included in a more comprehensive recommendation on the role of counties (Recommendation H2)</i>
B. Other recommendations which are lower priority and would depend on technical secretariat TA resources;	
4. Start requesting feedback from counties on drug distributions and salary payments. Share this information in the QPR to provide the MoH with management information (H4d/e)	<i>The recommendation is to get clear agreements on drug supply and staff payment, as a condition for future funding. It would be a major improvement in accountability to start getting that feedback now, but we did not sound out the feasibility of that idea.</i>
5. Support NGOs to assist the CHDs they work with to write a basic County Health Plan for the remainder of 2010 (where not in place). BSF support could entail for example a presentation to brief NGOs e.g. in an NGO health forum meeting and disseminating a basic template (from the CHD guidelines). (H3 revised)	<i>Health – This is now all included within Recommendation H2.</i>
<a href="#">2.2 Education</a>	
<a href="#">2.2.2 Quality</a>	
A. More could be said about how to prioritise activities that are effective and delivering value for money in terms of effectiveness. Training, construction, English language skills have their own costs and benefits. It would be good if the project can devise a mechanism to identify VfM of those activities	<i>Agreed. Further TA is recommended for education, both to support design phase and implementation of future support.</i>
B. It would be good to know how best to encourage partners to initiate learning assessment activities. Technical assistance for developing appropriate tools and mechanisms should be provided by the management team	<i>Agreed. Further TA is recommended for education, in relation to assessment of outcomes.</i>
C. More could be said about community involvement at the school level in construction and management of schools. It would be good to know if there is a model that works in the country	<i>Agreed. There was extremely limited opportunity during fieldwork to engage with communities to understand their perspective on current participation. Would recommend this is considered 'as a piece' in the process from</i>

	<p><i>school construction, management and maintenance.</i></p> <p><i>Now included in recommendation E7.</i></p>
<p><a href="#">3 Government engagement and capacity building</a></p> <p><a href="#">3.1 Education</a></p> <p>A. More information would be useful on the role the local county and state authorities play in the BSF committees - are they invited or is this just a NGO implementing partner forum? The issue of Government engagement also has a political/ governance dimension linked to public financial management (increasing the development budget over the recurrent budget) and GOSS development planning.</p>	<p><i>These points have been added.</i></p>
<p><a href="#">3.2 WASH</a></p> <p>A. Issues around sustainability and capacity building which has been partially reflected in the report. The missing part is the lack of government structures present at county level to actually to capacity building with and the under laying causes for this such as the absent of financial / logistical support from the line ministries down from national to state to county level.</p>	<p><i>These points have been added</i></p>
<p><a href="#">4 Sustainability</a></p> <p><a href="#">4.1 Health</a></p> <p>A. <u>Main implications for future DFID health programming</u> In the proposed new mechanism to support basic health services there should be;</p> <p>C. A shift away from ‘grants for specific clinics’ to <u>county contracts</u> providing coverage for the whole county population</p>	<p><i>Included within recommendation H2</i></p>
<p>D. A focus on delivering results by emphasising <u>key interventions</u> and setting locally appropriate targets - a shift away from measuring out patient attendances/number of clinics built.</p>	<p><i>Included within recommendation H3</i></p>
<p>E. Greater focus on system strengthening/<u>capacity building for both SMOH and CHDs</u></p>	<p><i>Included within Recommendation H2</i></p>
<p>F. Any <u>technical secretariat needs more TA resources</u> to be able to provide TA to NGOs, do better analysis of data to manage contracts and support the MoH to develop policy where there are gaps which negatively affect service delivery</p>	<p><i>Included within Recommendation H10</i></p>

G. <u>More technical input from DFID</u> to steer better performance from the technical secretariat and to work with the MoH to unblock policy issues to facilitate this.	<i>Included within Recommendation H10</i>
H. A <u>baseline survey/LQAS</u> at the start of the proposed new health mechanism with annual updates.	<i>included within Recommendation H4</i>
<p><u>6.2 Programme Management</u>      <b>Error!</b>  <b>Bookmark not defined.</b></p> <p>A. the remarks on cash flow and finance management seems largely based on positive remarks from the education-partners (the smallest group amongst the BSF_ IA recipients). During the consultation with WASH partners a considerable time was spent on areas that need improvement with regards to the financial reporting requirements and other constraints.</p>	<i>This was raised but did not come across strongly in the groups meeting with NGO. It was discussed with individual NGOs during the field work, and was not apparent as a major problem. A point has been added in the report.</i>
<p><u>Appendix 1: Project Logframe</u>      <b>Error! Bookmark not defined.</b></p> <p>A. the revised log frame needs to include some demand-side indicators that give a better sense of systems being strengthened - e.g. community budgeting for health facilities increases - each output should have a theory of change underpinning it. Increasing supply as the project appears to be doing is necessary but not sufficient to lead to sustained change.</p>	<i>The weakness of the logframe has been identified in the Review, as well as the repeated changes to it. Adding yet more indicators to make another version appears to be moving the goalposts, with contractual implications between DFID and the BSF Secretariat in having additional monitoring. We consider this should be resolved directly between DFID and BMBMM.</i>
<p><u>Appendix 2: Summary of Achievements</u></p> <p>A. The results reporting is very extractive and as the report admits very output oriented - we don't get a sense of what the beneficiaries think of the interventions, how have their lives improved or changed – it would be good to see some case studies included - if it's not too late.</p>	<i>We did not collect case studies – it would have needed more time in the field, as well as more space allowed in the report to include these.</i>
<p>B. It would be good to see the results under each output at the front of the report before the recommendations, and the results presented as a narrative , e.g.  Strengthened Education Services (July 2010 - Dec 2010):</p> <ul style="list-style-type: none"> <li>• 3513 teachers were trained, of which X were women</li> <li>• 352 new classrooms, holding a capacity of X pupils, were built and 6 schools (how many pupils)</li> </ul>	<i>Added</i>

rehabilitated, etc... (at what level of education primary?). This can be extracted from the table, Appendix 2, at the back.	
<p><u>Other Comments:</u></p> <p>A. In the draft report there is no mention in the narrative of any issues relating to gender (in) equality. I would expect to see consideration of gender equality especially in the service delivery sections on quality and particularly usage of services. Although Appendix 2, Summary of achievements, includes sex disaggregated data I am no clearer after reading the draft report whether there are any issues that need to be addressed in the remainder of the implementation period. I consider this a major weakness that needs to be addressed in the next draft. Stronger analysis on this from the BSF will help us identify issues to consider as we develop our programmes on health and education.</p>	<p><i>Health – now reflected in service delivery section, and as a requirement for future design. MOH Indicators are much more gender-specific, and should therefore be used to provide the baseline and performance tools for the future. WASH – some points have been added, including addressing gender in development of standards approaches to community water supply and hygiene promotion</i></p>
<u>Suggested amendments/errata;</u>	
A. Revise wording in H3 and H8 (as outlined in section A)	<i>H3 now reworded as H9, H8 reworded</i>
B. H7 – revise to “set NGO programme targets” (County/state target are not possible where NGOs are only accountable for supporting specific facilities).	<i>H7 revised and incorporated in new H3</i>
C. Health findings need a caveat, e.g. “Due to time constraints we were only able to review x facilities in y counties in EES. The findings from clinic visits may not therefore be generalisable across all counties”.	<i>Health – noted in text. May need noting in intro too</i>
D. 2.1.1 para 3 – error re PHCCs and PHCUs	<i>Corrected</i>
E. P4 consultations per annum – SSDP suggests baseline is 0.2 pa (Source HMIS)	<i>reference included</i>
F. P11 – CHD guidelines are an unfinished draft which was never approved or circulated. The MoH should be offered TA to draft these	<i>included within recommendation H2</i>
G. P14 – Comparator on cost per capita could be improved e.g. using SHTP/MDTF rather than total annual health expenditure	<i>Comparable data was not found on overall service coverage/cost.</i>
H. Page 17 – Main issue on performance based contracting is the lack of data, its poor quality, lack of roll out of the HMIS and the need for robust verification.	<i>Agreed – amended.</i>

## 1 Introduction

Following the signing of the Comprehensive Peace Agreement (CPA), DFID Sudan established the Basic Services Fund (BSF Phase I) in 2006 to deliver basic services to war-affected communities in Southern Sudan as a temporary measure to ensure delivery while the Multi-Donor Trust Fund-South (MDTF-S) established capacity. The BSF was extended until August 2010 (Phase II) because the MDTF-S continued to face delays and the Sudan Recovery Fund (SRF) was not then fully operational. A further continuation, the BSF-IA, was considered necessary because of the urgency of expanding the delivery of a peace dividend during the period of elections in 2010 and the referendum in the South in 2011. The MDTF-S and SRF will not be in a position to scale up delivery of basic services post August 2010. GOSS capacity to deliver basic services remains low: 85% of all basic services in Southern Sudan continue to be delivered by NGOs.<sup>4</sup>

The purpose of the Basic Service's Fund Interim Arrangement (BSF-IA) is to increase the coverage, access and use of the population of Southern Sudan to Basic Services in primary education, primary health and water and sanitation in a sustainable way, including the strengthening of the Government of southern Sudan's (GOSS) capacity to plan, monitor and co-ordinate this service delivery by non-state actors. BSF-IA builds on previous phases of the BSF to ensure basic services continue to be delivered, allowing GoSS time to develop its plans and capacity for an enhanced leadership and management role after independence in July 2011. BSF-IA runs from July 2010 to December 2011. It is managed by a service provider, BMB Mott MacDonald, selected through international tender.

This Mid-Term Review was conducted from 14 March to 1 April 2011 by Mr Richard Johnson (Primary Health), Mr Tom Power (Primary Education), Mr Jeremy Ockelford (Watsan and team leader) and Mr Charles Chol (Goss MoFEP, Deputy Director Aid Coordination). It consisted of meetings with Ministries, DFID, BSF-Secretariat, NGO groups and field visits to several states, including meetings with State, County and Payam authorities.

## 2 Service delivery

### 2.1 Health

#### 2.1.1 Coverage

BSF-IA demonstrates that BSF can maintain and increase basic health service coverage, by achieving its targets for support to a growing number of functioning facilities across South Sudan.

By December 2011, BSF-IA will be supporting approximately 58 PHCCs out of a national total of 310 PHCCs and 154 PHCUs out of 1,100 PHCUs<sup>5</sup>. All BSF-supported facilities appear to be open at least 5 days a week<sup>6</sup>, mainly because staff are paid and supervised,

<sup>4</sup> Project Memorandum: Basic Services Fund Interim Activities (BSFIA)

<sup>5</sup> MOH Health Facilities Mapping exercise, quoted in draft MOH Health Sector Development Plan. Total number of facilities adjusted for missing data, Jonglei state.

<sup>6</sup> Based on observation of the facilities visited during the Review – due to time and security constraints we were only able to attend 10 facilities in 5 counties in Eastern and Central Equatoria. The findings from clinic visits may not therefore be generalisable across all counties”.

and facilities are reasonably equipped and supplied. By contrast, less than 80% of all facilities nationally were reported to be functional in a national mapping exercise<sup>7</sup>; anecdotally, CHDs reported that as few as 50% of all facilities are attended 5 days a week, and that generally these are the facilities supported by an NGO or FBO. BSF therefore supports approximately 20-30% of primary care facilities that open regularly. Without BSF, these facilities would probably function very much less, if at all.

BSF-IA represents a big step up in the number of facilities that BSF supports. Between July 2010 and December 2011, BSF can be expected to have increased the number of PHCUs supported from 30 to 58 (76% growth) and PHCCs from 94 to 154 (64% growth).<sup>8</sup>

### **(Recommendation H1)**

BSF-IA project Application Guidelines and selection process emphasised under-served or neglected geographical areas. In those under-served areas where projects were not selected, it was at least partly due to a shortage of providers. BSF's selection of Returnee Reintegration projects is informed by up-to-date information on areas of need. As a longer term development tool, rather than a relief tool, BSF-IA criteria favour services in home areas, more than arrival areas.

In regard to gender, BSF records gender-specific indicators for health service utilization, showing that 54% of clients were female in July to December 2011. BSF's design also reflects gender-specific needs, particular in reproductive health. Quality issues<sup>9</sup> result in incomplete service, notably in family planning and mother and child health. This in turn reflects shortages of skilled female staff. While 48% of the staff trained with BSF-IA funding have been female, the volume and nature of training provided is far less than needed to make up the current deficit. Later recommendations on service quality and training address these concerns.

Although BSF has supported county-wide applications, its support still focuses on facilities rather than on a County-wide requirement. In some cases a facility may serve a Payam, or be one of several facilities within a town. Although only providing 20-30% of facilities, BSF-IA support is spread across 35 out of 79 Counties (44%). Despite attempts to reduce overlap between the 5 major funders of basic health services<sup>10</sup>, 17 counties and 9 states had operations supported by more than one funder in 2010. This entails extra administrative burden on funders, Counties and States. **(Recommendation H2)**

#### **2.1.2 Quality**

The BPHS is the basis for service delivery and staffing norms. In practice, delivery falls short of this. A Peer Review conducted during BSF2<sup>11</sup> showed that a sample of PHCUs and

<sup>7</sup> Draft Final Health Facilities Mapping Exercise, MOHS 2009, p.v

<sup>8</sup> The use of "cumulative" data across 3 BSF phases sometimes makes it difficult to elucidate progress. Cumulative data in the logframe which adds the number of facilities providing continuous service under BSF-IA to those under earlier contracts is not a useful indicator, as many facilities have been supported under both BSF-IA and earlier contracts. See Inception Report Logframe Output 2: PHCC/PHCUs supported with medical services; QPR 01:2011, Annex 5 CUM target

<sup>9</sup> See 2.1.2 Quality below for findings on service quality and staffing

<sup>10</sup> (BSF, OFDA, USAID, ECHO, MDTF)

<sup>11</sup> Consolidated Report on Peer Review of BSF Grant Recipients in Primary Health, January 2011, BSF

PHCCs covered an average 51% of the standards of BPHS 2006<sup>12</sup>, with highest scores in ante-natal care, and lowest in TB, HIV/AIDS and public health. We found significant gaps in some facilities, particularly immunisation, and family planning. Some facilities had decided, in conjunction with CHD, not to provide delivery in facilities close to hospitals. Referral was severely limited by poor roads, transport and telecoms.

Attainment and measurement of quality standards is made more difficult by MoH's replacement of the 2006 draft BPHS, by its much more widely scoped 2009 BPHS, also in draft. The scope and lack of clarity has made it difficult for its partners and for MOH itself to prioritise the use of scarce human and material resources to deliver the most essential health services. SHTP-II notably focuses services on a sub-set of BPHS, reflected in three key indicators and seven high impact services<sup>13</sup>. **(Recommendation H3)**

While tools for measuring and improving have been weak, MOH has developed, and is now implementing a range of tools measuring quality at the facility and at the community level including Health Facility Assessment, HMIS, a supervision checklist and Lot Quality Assurance Sampling LQAS)<sup>14</sup>. These MOH tools are essential for establishing the baseline and measuring the performance of future health services, to ensure that they address the specific health needs of people according to gender, age and circumstances.

**(Recommendation H4)**

We found strong evidence of the expert commitment of BSF and its partners to quality, despite all the difficulties. This included clinical process, hygiene, supplies, stock control, structures and security. Several NGOs had introduced variants of MOH supervision checklists, using inspection, clinical observation and exit interviews to inform supervision and training.

Most facilities were using MOH registers where available, and some partners were supporting CHDs in introducing Health Management Information Systems, based on indicators agreed between BSF and MOH. While HMIS data is now reported to BSF it is not widely reported. Thus a failure to deliver immunisation may go unresolved for months.

The biggest constraint to quality is facility staffing. Although overall staff numbers may approach or exceed 2009 BPHS staff norms (8 PHCU, 21 PHCC), technical staff were in short supply. At PHCC level, about half clinical officer, nurse and midwife posts could be filled, but many PHCU services depend almost exclusively on CHWs and illiterate TBAs. This seriously weakens essential services such as ANC and safe delivery, and has resulted in BSF's very limited progress in increasing the number of deliveries supported by skilled staff.

By December 2011 facilities supported by BSF will require 1,192<sup>15</sup> technically trained staff above CHW level to meet BPHS standards<sup>16</sup>. There are currently only 702, a shortfall of 490,

<sup>12</sup> Basic Package of Health Services for Southern Sudan, second draft WHO, March 14<sup>th</sup> 2006

<sup>13</sup> % of children <1 who received DPT3; % of deliveries with a skilled birth attendant; % of health facilities that provide at least 5–7 high impact services (child health, nutrition, malaria, hygiene and sanitation, maternal health, family planning and prevention of HIV/AIDS)

<sup>14</sup> LQAS provides a cost-effective method of assessing and prioritising community needs and service coverage.

<sup>15</sup> 13X 68 per PHCC = 884; 2X 154 per PHCU = 308. Total trained staff required 1,192.

but BSF-IA only provides for 43 staff to receive long term training. Reasons for training so few included the short term of the contract, and the doubt that trainees would return to local facilities. Some projects were, however, finding innovative local solutions, using skilled refugees and school leavers, and placements in local facilities. **(Recommendation H5)**

Despite these problems, BSF facilities appear far better off than other MOH facilities. Non-payment (over a year in Eastern Equatoria), inadequate supervision, supplies and support, are widely acknowledged to lead to non-attendance and non-performance. NGO cash incentives may not be standardised or equitable, but provide a predictable income. When an NGO stops paying, even for a few months, a facility may lose its entire technical staff. **(Recommendation H6)**

MOH drug supplies have been inadequate and erratic. However, most facilities had received one or more deliveries in the last half year, reported good drug stocks, and were consequently spending less BSF funds on drugs. Some PHCUs had large stocks of injectables that staff are not qualified to deliver, as well as excess supplies of expired drugs. It is unclear whether drug supplies will be sustained. . **(Recommendation H7)**

The standard of structures was variable, but far better than most other MOH facilities. Most facilities had basic facilities for consulting and delivery, secure storage, latrines, waste disposal, water, and fencing. Some had radios. The cold chain was only partly effective. Transport was usually inadequate. There are no blue-prints for facilities, and perhaps should not be any, given the varied geography and life styles. As with many recent buildings, the longevity of the physical structure is a concern. Some were severely degraded, even after 2-5 years. With poor maintenance budgets, quality of design and construction is essential.

### 2.1.3 Usage

BSF calculates the number of "Beneficiaries" in two different ways for BSF-IA.

The first definition is the "catchment" population theoretically served by PHCCs and PHCUs: 10,000 and 50,000<sup>17</sup> respectively. On this basis BSF-IA targeted facilities will serve 4,525,000 beneficiaries<sup>18</sup>. BSF staff agree that this figure is unrealistic. On the same basis, South Sudan would have enough PHCCs to serve 15.5 million, and PHCUs to serve 16.5 million.

BSF also uses a second definition of beneficiaries. It calculates the official population, adjusted for growth, of the payams or county it seeks to serve. BSF then calculates the total number of consultations it should achieve, based on 0.7<sup>19</sup> consultations per person per year, thereby deriving a measurable target for consultations in the project period.

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<sup>16</sup> Basic Package of Health Services, Final Draft MOH January 2009, pp37, 38

<sup>17</sup> The catchment served by a "BEmONC-PHCC", ie one unable to provide comprehensive emergency obstetric care, such as caesarean section, is reduced to 25,000 in BPHS 2009. There are few if any PHCCs able to provide such a service in South Sudan.

<sup>18</sup> QPR 1:2011 Annex 4, p20.

<sup>19</sup> 0.5 for newly opened facilities

This second definition is a reasonable, if crude, basis for calculating beneficiaries. The population calculation is a more realistic approximation to the real population served by a facility, which is determined by local circumstances, including geography, inter-ethnic and intra-ethnic rivalries, proximity to other facilities, immigration, and other factors. 0.7 consultations per person per year is a considerable target in difficult circumstances, and likely to be very much higher than the national average<sup>20</sup>. On this second basis, BSF-IA is likely to achieve its target of 1,142,499 consultations, after allowing for seasonal variations and the expected increase in functioning facilities<sup>21</sup>. **(Recommendation H8)**

Focusing on attendance alone, however, is inadequate for showing the fulfilment of project purpose or its contribution to wider MDG goals. Although providers now regularly report ANC visits, deliveries, under-5 consultations and other data, only a selection of the agreed MOH indicators is reported, and there are no targets for these to that reflect how many ANC visits, completed DPTs or referrals would be required to achieve the project purpose and goal. **(See Recommendation H4)**

## 2.2 Education

### 2.2.1 Coverage (potential users)

Students & Schools:

- In output 1, BSF-IA is likely to meet, or nearly meet the numbers of classrooms built (indicator 1) in the revised logframe (2010)

Teacher training:

- In output 1, BSF-IA is likely to meet, or nearly meet the numbers of teachers trained (indicator 2) in the revised logframe (2010)

*How many more trained teachers does South Sudan require?*

2010 data from EMIS shows that South Sudan has approximately two million children of primary school age, and twenty-six thousand primary teachers<sup>22</sup>, including volunteers. To reach a ratio of one teacher to fifty students (the ratio assumed in school construction), South Sudan would need to train fourteen thousand additional teachers, to serve the 2010 primary school age population. Current rates of Pre-Service Training (PRESET) are likely to be barely above replacement, and insufficient to begin to close this gap within the foreseeable future. **(Recommendation E1)**

### 2.2.2 Quality

School construction

Schools are being constructed to a standard pattern, similar to many school constructions across Sub-Saharan Africa; if well built, they can provide an acceptable quality of infrastructure for delivering basic education. NGOs, together with BSF, and with some involvement of State and County MoE representatives, are taking reasonable steps to ensure quality construction. It may be that members of the local communities see such new school buildings as a totemic representation of the peace dividend, and a solid step towards development.

<sup>20</sup> Compared e.g. with national baseline of 0.2 consultations per annum (source: attributed to HMIS)

<sup>21</sup> This assumes a satisfactory explanation for the lower Total Consultation figures shown in QPR 1:2011 Annex 10, page 39,

<sup>22</sup> Based on personal communication with EMIS, 28/3/11

The standard pattern of construction has 8 classrooms, each designed for up to 50 children (school population ~ 400). Current data on enrolment and attendance is unreliable, but suggests enrolment of 108 children per classroom, and attendance of 17 children per classroom<sup>23</sup>; neither figure is dependable, but either would suggest significant issues to address. In reality, and from teacher testimony during fieldwork, it seems likely that many more children may be using the schools than they were designed to accommodate. If this is the case, overcrowding is likely to substantially impact the quality of teaching and learning. There are several possible responses to this, but there are only early signs of pro-active planning and engagement on the issue, either between BSF and NGOs, or between NGOs and PTAs. There is a lack of hard data, and little use of data in planning and management. **(Recommendation E2)**

Whilst BSF is providing some stationary, and UNICEF is providing exercise books, it seems there are issues around the provision of text books or other learning materials. Coupled with the low level of education and training of many (particularly 'volunteer') teachers, this may represent a severe impediment to providing opportunities for learning.

#### Teacher training

NGOs and Teacher Training Institutes (TTIs) are working hard to deliver quality education and training to teachers. The training provided appears to be highly valued by teachers, who are often making significant investment in time, effort and opportunity costs (e.g. forsaking other activities, such as second income generation or domestic duties) to attend and complete the training. There are some innovations, such as the use of small portable digital audio players in school.

Although INSET and PRESET follows a common GOSS curriculum, the teachers participating in each kind of training are very different, in that PRESET teachers are typically young secondary school leavers, whilst INSET teachers typically have only (often partial) primary education; however, the latter tend to have more classroom experience. The INSET teachers, despite having significantly lower levels of education to begin with, receive significantly less training and support than the PRESET teachers. It seems unlikely that the current teacher training curriculum and delivery adequately provides for the different needs of these two groups of trainees. **(Recommendation E3)**

There are some training materials produced to match the GOSS teacher-training curriculum; in the very limited sample of materials seen, teaching strategies appear to be presented separately from subject knowledge. The availability of, or access to materials appears partial. A wide variety of responses have been observed, including using post-16 student materials from the UK, using primary classroom materials from East Africa, and using no materials at all. Although trainers say they teach 'how to teach', very limited observation indicates a predominance of subject knowledge over classroom practice. Trainees generally had difficulty identifying anything they would do differently in the classroom, as a result of their training. **(Recommendation E4)**

From very limited observation, English language training seems to emphasise grammar translation, rather than communicative approaches. **(Recommendation E5)**

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<sup>23</sup> Based on figures in BSF QPR 1-2011, Annex 7, taking data only from NGOs reporting enrolment and attendance

## 2.3 WASH

### 2.3.1 Coverage

Although construction had not started in earnest until the start of the current dry season in December and January, past performance suggests that the achievement of the targets for new and rehabilitated waterpoints set in the logframe is likely to be largely achieved.

The targeted expansion in coverage is based on an assumption that each water point serves 500 people, which is reasonable for planning purposes. The actual coverage is not possible to determine, because NGOs generally do not make an assessment of the number of households that will use the waterpoints. From discussions it is apparent that the actual numbers of users in several places is much higher than the 500 assumption, sometimes more than 1,000. This may improve the coverage figures, but it means that waterpoints are overused, with implications for higher wear and tear, and it was reported that such high usage generates arguments and conflict. **(Recommendation W1)**

From the approved grant applications for water supply the planned coverage was estimated at 129,770 beneficiaries, assuming 420 people per waterpoint, from 94 new and 135 rehabilitated boreholes<sup>24</sup>. Estimated sanitation coverage from the approved grants was 19,350 beneficiaries from 2,000 household toilets<sup>25</sup>. The sanitation coverage represents 15% of the coverage of the water supply, despite the requirement of GOSS that water supply and sanitation are done together. The scale of sanitation implementation clearly needs to be increased substantially. **(Recommendation W2)**

For the sanitation components of some NGO projects concrete slabs are provided. In some cases these are made in the NGO's compound and transported to the village. It would be better to train masons in the village to make these, so that there is a possibility for other people to get a latrine after the NGO project. **(Recommendation W4)**

The Water Policy states that "investment in RWSS shall be targeted firstly to those areas which are currently unserved and/or experiencing acute water shortage"<sup>26</sup>. The report on Poverty in South Sudan gives information on poverty for urban and rural areas and in each state<sup>27</sup>. From discussions, however, it is considered that all areas are underserved, and for political reasons all areas were treated equitably in selection of projects under BSF. In allocation of projects for services, the Steering Committee operates a policy of no distinction between areas or types of population to be served.

There are returnee populations in most places, but because the WASH NGOs do not gather basic information on the number of households served by a waterpoint, it is not possible to determine the numbers of displaced or returnee populations served. Some NGOs do try to target vulnerable groups.

<sup>24</sup> The Table gives totals including institutional supplies, which is actually double counting

<sup>25</sup> excluding one grant for sanitation only, which proposed 32,500 beneficiaries from 6,500 latrines. BSF-IA (2010). Fund Management of the Basic Services Fund Interim Arrangement: Inception Report

<sup>26</sup> GOSS (2007). Water Policy. Southern Sudan Water Sector Steering Committee and Ministry of Water Resources and Irrigation

<sup>27</sup> SSCSE (2010). Poverty in South Sudan: Estimates from the NBHS 2009, Southern Sudan Centre for Census, Statistics and Evaluation

### 2.3.2 Quality of service

The quality of the water supply service has clearly improved compared with people's previous sources in terms of water quality and access. It is not possible to comment in terms of quantity of water as baseline data is not available. The improvement in quality of service is, however, undermined by the too few water-points resulting in substantial over-use. The reason is because of the general lack of improved water points, and the policy of trying to provide them equitably. In the sites visited, well in excess of the specified 500 people are getting water from the water-point – causing long queuing times, arguments and excessive wear and tear on the pumps. The last of these will lead to higher maintenance needs and more frequent breakdown. The long queuing times also have implications for women's workloads and girls' ability to go to school. **(Recommendation W4)**

Another cause for concern is that at one of the water-points seen, the well has recently started to run dry by the end of the day due to insufficient recharge. Obviously more water-points are needed as soon as possible. Alternatives could include small piped schemes with motorised pumps that could serve more people (though with higher running costs); provision of new hand dug wells and lining of existing wells; and improvement of traditional sources. The last two could be done at lower cost than drilled wells fitted with handpumps.

The quality of construction of the water-points seen was generally satisfactory. In part this has been due to the technical training provided by BSF on drilling supervision and water quality, and the posting of technical guidelines on the BSF website.

The construction and use of latrines by households is clearly an improvement compared with open defecation. In most projects, however, sanitation has not been promoted sufficiently to achieve full coverage in a village, so the full public health benefit cannot be achieved. **(Recommendation W2).**

The quality of hygiene promotion varies from full application of the PHAST approach to relatively short hygiene promotion sessions held with small numbers of villagers who are then expected to pass the messages on to the several hundred other people living in the area. The latter may increase knowledge slightly but is extremely unlikely to result in change in hygiene practice. In some cases seen the messages appear to be unrealistic – telling people to build latrines but without any support on what and how to build. **(Recommendation W5)**

In schools, hygiene promotion is part of the science curriculum. It would be better to have it as a separate, practical based subject that is taught from Year 1. **(Recommendation W6)**

### 2.3.3 Usage

Data on actual usage of water-points – the number of users and the amount of water taken, is not collected by the programme. From observation during the field trip, the water-points are certainly used heavily, mainly by women and girls. From brief conversations with some of the women users, it appears they are managing to take about 12-15 litres per family member per day. This is close to the interim target level set in the Policy.

It was not possible to observe use household in most places as promotion and construction are still on-going. School latrines are also under construction and schools were in a vacation period. In the few existing schools seen, some latrines are used but in one or two cases there is evidence of open defecation behind the latrines.

For schools of 400 students, 8 stances are provided – 4 for girls and 4 for boys. This means that 50 children<sup>28</sup> are expected to use each toilet, which is not possible during a short mid-morning break. Children are likely to resort to open defecation. Increasing the number of stances to two per classroom would reduce this problem, with the advantage that each class would have its own toilet and be responsible for looking after it. **(Recommendation W7)**

#### 2.3.4 Common Standards and Shared Approaches

In water supply, MWRI with support from the BSF Secretariat, UNICEF and others has set standards for the hardware components such as drilled wells and technical processes such as drilling. In general, these appear to be followed by NGOs. NGOs also follow the national Policy of establishing Water Management Committees with 7 members, 3 of whom are women.

For the process of introducing and developing a water supply in a village there is no standard approach. Practice ranges: at one extreme – limited discussion with village leaders and elders (who are usually men) followed by drilling, appointment and training of a WMC; at the other extreme – a full participatory process of mass meetings with villagers, decision-making inclusive of women and minorities, agreements specifying obligations of all parties, s/election and training of a WMC for construction and subsequent O&M. This process is a critical factor for sustainability – the first extreme is unlikely to achieve this. A step-by-step approach as described in the other extreme should be developed as a minimum standard approach. **(Recommendation W8)**

Common and standard approaches should not exclude innovation and piloting of new approaches, in particular for sanitation. These include CLTS (already producing impressive results in a project support in BSF-IA); social marketing of sanitation; development of the capacity of local private sector capacity for making and selling latrine products; and informed choice giving a range of technical options from the very cheap to the expensive for householders to choose from. **(Recommendation W9)**

Similarly, approaches to hygiene promotion vary. At one extreme, there is short training sessions over two or three visits to a relatively small number of villagers who are expected to pass on the messages to the several hundred other villagers. This may increase knowledge slightly but is very unlikely to result change in hygiene practices. At the other extreme, some organisations are using the full PHAST process or CLTS, which are likely to achieve much better results. There is a need develop common minimum standards for the approaches to hygiene promotion with the objective of getting changes in practice, not just transmission of knowledge. Donors need to recognise that this will need more resources.

**(Recommendation W10)**

Most NGOs have opted for construction of new boreholes fitted with handpumps and rehabilitation of existing boreholes and handpumps. With a few exceptions, there appears to have been little consideration of alternatives such as improved hand-dug wells and traditional sources. These have the advantage of being cheaper and easier to maintain, albeit at some cost to the reliability of the water quality. The other advantage would be that more of the construction cost would be put into the local village economy. To achieve full coverage of rural areas with drilled wells and handpumps will cost something in the order of

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<sup>28</sup> From assumed enrolment numbers – actual enrolment is much higher, exacerbating the problem

US\$100 million for the hardware<sup>29</sup>. Financially, coverage may be more achievable using lower cost alternatives. **(Recommendation W11)**

The handpump of choice in South Sudan has become the India MkII and is effectively the MWRI policy. This is not a VLOM pump, so the provision of it makes achievement of village maintenance more difficult. It would be worth reconsidering the types of pumps to select ones that are more suitable for VLOM, such as the India MkIII or the Afridev<sup>30</sup>. This would need to take account of different groundwater levels. The older India MkII pumps could be retrofitted with the VLOM pump when they reach the end of their life. **(Recommendation W12)**

### 3 Government engagement and capacity building

The strategy and targets for development of government capacity, and engaging with that were unclear.

As BSF is engaged in delivery of services at the most local level, working towards appropriate engagement of Government requires engagement at all levels from Boma to GOSS.

Overall, our visits found significant attempts in health, education and WASH to strengthening capacity at County and State level, by providing equipment, materials and training, and by including officials on visits. Such supply-side interventions did not, however, address the central issue of how Government could lead and supervise local development and hold NGOs and other local providers to account. **(Recommendation G1)**

#### 3.1 Education

The MoE representatives at state and county level, report that they only have salary budgets; they have no financial line for construction, maintenance or materials costs for schools within their areas. In effect, this places state MoEs and CEDs in dependence upon the activities of donors, as mediated through NGOs.

State and County level education officials do not have a sense of responsibility for, or the means of ensuring, ongoing maintenance and quality of service. In the absence of central or regional funding (for example, for textbooks or school maintenance), CEDs and NGOs see the ongoing costs of educational provision being met by local communities, through community contributions, raised and managed by PTAs. This may not be an unreasonable position, but it is perhaps somewhat at odds with the stated national policy of 'universal free primary education'. **(Recommendation E6)**

There is some indication of community at county level, in the planning of school locations (e.g. conversation with NGO staff from HARD). Communities and CEDs appear to be actively involved, at least in some instances, in determining school locations, but their ability to inform / influence other factors appears limited.

<sup>29</sup> Data from SSCSE (2010), Key Indicators for Southern Sudan, based on 2008 Census data and other *National Baseline Household Survey (2009)*: 8.26 million population, 83% rural = 6.86 million; water supply coverage 53%; therefore required new waterpoints = ~6,500 (@1/500 people) @US\$12,500 average cost +overhead = ~US\$100 million.

<sup>30</sup> Technical advisers for BSF have raised the desirability of alternatives. UNICEF's role of as main advisor will be critical for moving this forward.

### 3.2 WASH

The county water offices are generally weak, with unpaid volunteers working in the post in anticipation of getting the official position when it is established as a salaried post. There is a lack of funding from national and state level for staff, logistics and other activities. This makes it difficult for the NGOs, which are expected to undertake capacity building of payam and county water offices in the areas in which they are working.

Capacity building generally consists of involvement of the local government staff in the selection of project villages, field visits, monitoring and short-term training, and in some cases, provision of equipment. Capacity building should, however, be much more than this. The BSF-IA Programme's expectation of NGOs is unrealistic in this respect, particularly given the short-term nature of the program – NGOs are not in a position to address the structural, procedural and regulatory aspects of capacity development. Capacity building needs a much more systematic, long-term approach, addressing the different components of capacity: human resource development, organizational development and institutional and legal framework development.

Without having a full picture of the needs in this respect, it appears that it may have been useful to provide specialist operational inputs to facilitate aspects of NGOs' work in the field. This would require some of the funding to be reserved for such commissioned inputs.

#### **(Recommendation G1)**

The BSF Secretariat has developed good working relationships with the MWRI, and has contributed to some important training. MWRI officials are always provided with the opportunity to accompany BSF on field trips. Again, however, the Secretariat is not in a position or resourced to provide the systematic capacity development that may be necessary. Other donor partners are involved in this at national and sub-national levels.

MWRI is currently preparing a national strategy for water resources, water supply and sanitation. This is still in draft form and was not available to this Review.

The Southern Sudan Water Information Clearing House (SSWICH) was established in 2008 as a database of water and sanitation related information. It has received support from Unicef in its development, but is still not fully functional. This in part appears to be due to the added requirements to manage many more aspects of water information than originally envisaged, resulting in a much more complex computer database. It has just started a third phase of development, mainly focussing on capacity building.

## 4 Sustainability

### 4.1 Health

Basic health services require a lot of ongoing support from outside the immediate community for sustainability, as well as local support. Key factors for sustainability were found to be strong working relationships with village structures, government leadership of public health, and continuity of support.

BSF partners have built strong *working relationships with village structures*, including Health Committees, Bomas, CBOs and local faith groups. These are essential to sustainability in many ways: identifying requirements and planning services, identifying home health promoters and other volunteers or staff, providing accommodation for facilities and staff,

generating community contributions, generating demand for services, receiving and communicating health education messages, and holding service providers to account. The continuity of these relationships by service providers is essential.

*Government leadership of public health* ensures that action at the local level is fostered, supported and directed by policy, standards and support at all levels up to GOSS. The County Health Department is the key focus for both the coordination and implementation of plans that benefit the whole population, and is discussed further below. **(Recommendation H8)**

*Continuity of support* ensures reliable supplies, staff payment, and supervision of staff within the framework of service quality discussed above. Uncertainty of ownership, funding, failures in drug supply or in staff payment can quickly destroy a facility. Regular supervision, often on a weekly or fortnightly basis is essential, particularly where technical skills within the facility team are weak. Clear ownership and handover of services is vital for sustainability. CHDs have frequently felt unable to predict or control changes in service ownership. Although BSF facilities are required to draw up exit strategies, these can only be achieved if the CHD has funds, staffing and skills to take on the responsibility. There therefore needs to be a realistic plan to ensure immediate continuity of support after BSF-IA, within the context of a longer term plan for sustainability. **(Recommendation H9)**

### **County Health Departments**

CHDs have lengthy draft guidance<sup>31</sup> on their functions, but not the skills or resources to fulfil them: some only had 1 member of staff, little transport or recurrent budget. A big problem is holding local NGO providers to account. Many felt powerless to control the arrival, location, functioning, reporting and departure of NGOs, though we heard no direct criticisms of BSF partners. CHDs need to match their functions to the resources available to them, focusing development on the key functions required to coordinate, plan, support, monitor and hold to account health services.

All NGO partners we visited wanted to work with and support CHDs. They provided equipment and training, consulted CHDs on siting and staffing, took CHD staff on supervision visits, provided activity reports, supported county HMIS, and agreed memoranda of understanding with CHDs.

Designing and implementing support to basic health services with systematic engagement with Government and local partners requires a significant investment in technical resources. Technical assistance will be needed during the design phase. Key tasks will include development of county plans, key interventions and baselines. **(Recommendation H10)**

## **4.2 Education**

### **School construction**

When NGOs hand over a school, it effectively becomes jointly owned by the MoE (who pay teachers' wages, and a contribution 'volunteer teachers' from the war), and the local community (who, through the PTA, agree, collect and manage 'contributions' to the ongoing costs of the school, including contributions to volunteer teachers).

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<sup>31</sup> *County Health Department Function Guidelines*, undated draft, c 2009

School construction typically involves the use of a number of materials that have to be transported at significant expense (especially concrete breeze-blocks and cement). A complete school costs approximately \$100,000, making an individual classroom around \$10,000 to construct. Both the nature of materials and construction skills used in school building, and the overall costs of construction, raise questions about the capacity of local communities to maintain, sustain or extend this infrastructure, once NGO contributions cease.

During fieldwork, site visits were carried out at a number of schools previously funded under BSF-II, in order to assess how well the schools were enduring or being maintained. One such school was heavily over-subscribed, expecting to enrol approximately 1,200 students in the 2011 academic year. To cope with the additional student numbers, this school had already self-funded the construction of four further classrooms, in addition to those built through BSF-II. The BSF funded buildings appeared to be in good repair, as did the classroom furniture. A storeroom had sacks of exercise and textbooks ready for the new school year, which was imminently due to start. This school had set community contributions at an average of around 20 SDG per student, per annum. With an anticipated 1,200 students, this amounts to a potential income of 24,000 SDG for the PTA to meet recurring costs. Such a scenario seems likely to be sustainable; however, in relation to recommendation E5, it should be noted that even with the extra four classrooms constructed, there would still be an average class size of 100 enrolled students at this school. **(Recommendation E7) (Recommendation E8)**

Fieldwork has shown other schools, with lower enrolment and community contributions, to be less well maintained and repaired.

There is particular concern relating to school furniture supplied via GOSS; in one school (opened 2010) this had become largely beyond use after a single year; of the 400 seats provided, less than half remained in use. Elsewhere, classroom furniture that had been constructed locally (out of wood or steel) seemed significantly more robust and durable.

#### Teacher training

The short-course training in English Language for Teachers, for PTAs and CEDs should be completed for all current participants, within the funding envelope and time frame of BSF-IA.

The longer-term teacher training courses will take 2 years for PRESET teachers to complete, and 4 years for INSET teachers to complete. It is not clear whether funding arrangements are in place to enable teachers participating in longer-term training to complete this training, where it extends beyond the time frame of BSF-IA.

### 4.3 WASH

Key factors for the sustainability of rural water supplies are:

- Community management from start
- Technology – appropriateness and choices
- Maintenance system
  - Community management of O&M
  - Government support
  - Supply chains
  - Private sector
- Finance
  - Community
  - Recurrent costs of local government

As already discussed, involvement of communities in management from the start has been variable. In the cases where it is inadequate, this provides a weak foundation on which to build sustainability. For technology, in most cases people have not been involved in choosing between alternatives.

On the maintenance system, Water Management Committees are established for the new water-points and are being given some training, together with pump mechanics. However, from the field work, villagers reported a lack of tools, and they do not have access to the lifting tackle needed to safely extract the heavy below-ground parts of the India MkII pumps. In general, they do know where to obtain replacement parts.

From discussions with some state and county water authorities, it appears that a centralised maintenance system<sup>32</sup> has been adopted by assumption, even though the authority lacks the resources to operate such a system. Such systems have been difficult and expensive to operate in other countries, and particularly when villages are remote and scattered. The assumption that villagers can maintain pumps having established a water committee and received some training has been widely discredited in recent years. It is clear that some form of government run support system is required, not to do the repairs, but to visit on a regular basis to ensure the WMCs is functioning and maintenance workers are still capable of making repairs. Part of such a support system should include refresher training as necessary.

The system currently relies on the provision of replacement parts free of charge by Unicef. Until such time as Unicef stops this practice, it will be very difficult to establish supply chains in the local markets so that people can buy parts from the local private sector traders as and when they need them. The provision of a stock of spare parts to communities after construction also undermines this long-term solution. There has not been much effort to establish the other part of the private sector in maintenance – local mechanics could be supported to make a small business out of repairing pumps, being paid by the community.

From visits to a small number of villages, it appears that some communities are prepared to pay for such operating costs. In one case villagers were paying SDG1 per household per month; in another the users at the water-point said that would pay SDG5 per household when the pump needs to be repaired. The recurrent costs of the government support system would need to be paid, either from central or local revenues.

The overall impression from the short time and limited visits to the field of this MTR is that currently the water supplies systems installed under the BSF program will not be sustainable after the NGOs stop working in the areas.

Sustainability of sanitation is more difficult to assess, mainly due to the few numbers of household toilets seen during the field visits. Such sustainability will depend to a large extent on the quality of the hygiene and sanitation promotion process. In the CLTS project, the toilets will clearly be sustainable – people are constructing substantial latrines that are likely to last for generations.

## 5 Finance

BSF budgets are not currently included within GOSS budgets. A quick analysis of the GoSS budget estimates for 2011 compared with BSF funding is given in Table 1. This indicates

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<sup>32</sup> A team of trained technicians travel out from a depot to inspect and repair facilities. Communities have little if any input. It is most common for the public sector to provide this service, although the private sector may be involved

that the BSF funding is a substantial addition to GoSS's own funding. As such, the funding makes a significant contribution to GoSS's financial capacity to implement its policies in basic services.

**Table 1: Comparison of GoSS Budget Estimates with BSF-IA funding**

	GoSS 2011 Budget Estimates <sup>33</sup>								BSF funding <sup>34</sup>		
	Salaries		Operating		Capital		Total		UK£	SDG <sup>35</sup> ('000s)	As % of National budget
	SDG ('000s)	% of all.	SDG ('000s)	% of all.	SDG ('000s)	% of all.	SDG ('000s)	% of total			
Education (excl. higher education etc.)	240,190	75.3	53,104	16.7	25,526	8.0	318,820	5.9	18,571,796	82,830	26
Health - health (excl. HIV/AIDS Commission)	117,788	54.5	56,544	26.1	41,928	19.4	216,260	3.8	9,897,362	44,142	20
Infrastructure – water resources and irrigation	12,091	22.9	11,259	21.3	29,441	55.8	52,792	0.9	9,060,38	40,409	77
Total Budget (all sectors)	2,432,166	42.5	2,107,831	36.9	1,178,510	20.6	5,718,508	100.0	37,529,544	167,382	3

## 5.1 Health

Both recurrent and capital costs of the BSF programme are low in proportion to typical health expenditure within low-income countries. However, the value of the health outcomes achieved by BSF is not clear. Well-chosen interventions in basic health are very cost effective<sup>36</sup>. There is therefore likely to be scope for increasing investment, where this is clearly linked to improvements in health outcomes. **(See Recommendation H1)**

Total BSF-IA planned expenditure on primary health, including the lead contractor's technical secretarial cost<sup>37</sup> is GBP 8,921,570.

### BSF-IA Planned Costs July 2010 to December 2011<sup>38</sup>

	Unit cost	GBP	
Recurrent costs		6,890,593	77.2%
Construction & Rehabilitation			
- 42 PHCUs	21,200	890,400	10.0%
- 13 PHCCs	44,906	583,778	6.5%
Technical Secretariat		556,799	6.2%
Total		8,921,570	100%
Recurrent cost per consultation		GBP 6.0	USD 9.0
Recurrent cost per person per year		GBP 4.2	USD 6.3

Recurrent costs by BSF for primary care are estimated to be in the range of 9 USD per consultation, or 6 USD per person per year.

<sup>33</sup> Figures from GOVERNMENT OF SOUTHERN SUDAN, DRAFT BUDGET 2011; Ministry of Finance & Economic Planning; Draft to Southern Sudan Legislative Assembly; December 2010

<sup>34</sup> Although this funding is for 18 months, most of it is being spent in one dry season, so it can be taken as annual funding for simple comparative purposes

<sup>35</sup> Exchange rate from [http://coinmill.com/GBP\\_SDG.html#GBP=1](http://coinmill.com/GBP_SDG.html#GBP=1) on 2 May 2011

<sup>36</sup> See WHO-CHOICE choosing cost effective interventions in Health

<sup>37</sup> Apportioned from a total overhead secretariat cost declared by the contractor of GBP 2,676,292.

<sup>38</sup> Sources: BSF Inception Report 2010, BSF study on unit costs and contractor

There is no clear information about costs incurred by other parties in delivering BSF-supported services. MOH and other contributors provide variable quantities of staffing, drugs and other supplies. Community contributions include labour and materials for construction. Service user costs are expected to be lower than in other facilities because of BSF compliance with MOH policies on free supply of services and drugs. Overall these costs are unlikely to exceed BSF expenditure. The maximum recurrent cost for BSF primary care is therefore estimated as **USD 12 per person per year**.

It is hard to make a direct comparison with MOH or other provider costs in South Sudan, as available expenditure and utilisation data are limited. However, BSF's recurrent annual cost of USD 12 per person on primary care is compatible with WHO's estimate of total annual health expenditure of USD 67 per person per year for low income countries<sup>39</sup>.

BSF construction costs are 16.5% of total expenditure.

### **BSF-IA Rehabilitation and Construction Costs (GBP)**

	BSF Total	BSF Average	BSF Highest	BSF Lowest	UNOPS <sup>40</sup>
PHCU	445,200	21,200	41,804	10,000	40,000
PHCC	583,778	44,906	83,623	30,809	426,000

There is some variation in BSF-funded rehabilitation and construction costs, but this is less than in earlier phases. Variation is explained by a number of variables, including material costs, transport, logistics and soil conditions, the extent of community contributions of labour materials (such as burnt bricks, aggregate and sand), the extent of rehabilitation, and finally specification of building. The last of these depended on the specification of service to be delivered, which varied according to local demand and the capacity of provider staff to meet the wider scope of the BPHS. Costs are markedly lower than the comparable costs provided by UNOPS for facilities constructed locally.

Just as important as any concern for over-expenditure, is to consider whether there could be too little capital investment in facilities for long term development. Buildings are easily subject to damage from subsidence, harsh weather, and infestation. This could have a major impact quality of service, sustainability by providers and local communities, and on replacement costs.

## **5.2 Education**

The unit costs of school construction and teacher training have already been demonstrated to be competitive, by the standards of other projects in South Sudan.<sup>41</sup>

In relation to school construction and furnishing, E8 may offer the potential to further lower unit costs, and the on-going costs subsequently born by communities. **(Recommendation E9)**

<sup>39</sup> WHO World Health Statistics 2010. PPP expenditure per capita Sudan 2007.

<sup>40</sup> Data provided by UNOPS for draft South Sudan Health Strategic Plan 2010. Converted from USD at 1.5 USD=1GBP

<sup>41</sup> Completion report, BSF2

The indicators for BSF track outputs, not outcomes, so whilst it is possible to comment on unit costs, and the comparative VfM of these, it is not possible to say whether the investment represents good VfM, in terms of achieving quality educational outcomes for the beneficiaries. **(Recommendation E10)**

### 5.3 WASH

#### 5.3.1 Value for money

As Hutton and Haller state in their seminal study, *Evaluation of the Costs and Benefits of Water and Sanitation Improvements at the Global Level*, conducted on behalf of the World Health Organisation, “the potential productivity and income effects of improved access is a significant argument to support further resource allocations to water and sanitation”. The benefits of the interventions included time savings associated with better access to water and sanitation facilities, the gain in productive time due to less time spent ill, health sector and patients costs saved due to less treatment of diarrhoeal diseases, and the value of prevented deaths. From the information given in the Appendices to the Report, South Sudan fits into a regional grouping for Africa. The cost-benefit ratio for water supply alone is estimated at 11.50. For water supply and sanitation combined it is 12.54.<sup>42</sup> This means that for every dollar invested, the economic benefit would be \$11.5 and \$12.5 respectively. In short, investment in sustainable water supply and sanitation represents considerable value for money in Southern Sudan.

It is difficult to assess the value for money of individual components of water supply due to the wide variation in geographical and hydrogeological conditions. There is, however, some indication that NGOs using their own drilling rigs may offer better value than commercial companies. As suggested earlier, improved alternative water may offer better value for money than boreholes fitted with handpump, although at the cost of reliability of water quality. The additional value in development terms would be the contribution of substantially more of the construction costs to the local economy.

One of the most critical parts of value for money is sustainability. More funding is required to ensure basic minimum standards in the software process for development of water supplies and hygiene behaviour change as a foundation for sustainability. Otherwise the value of the infrastructure will be lost. **(Recommendation W13)**

#### 5.3.2 Recurrent costs

At present officials at County and Payam levels are working as unpaid volunteers in anticipation of being offered the permanent position when they become available. When these posts are established, the costs of salaries will add to the recurrent costs of water supply and sanitation in the government system. In addition, the development of an O&M support service will need to be funded, either from national or state revenues.

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<sup>42</sup> Hutton, G., and Haller, L. (2004). *Evaluation of the Costs and Benefits of Water and Sanitation Improvements at the Global Level*, World Health Organization, Geneva

## 6 Design and Management of BSF-IA Programme

### 6.1 Programme design

The BSF-IA Programme was designed by DFID on behalf of the donor group. It was intended as a relatively short extension of the previous phase of BSF pending the outcome of the referendum on national unity with or separation from North Sudan, held in January this year. As such it had a short term-perspective. Future funding for basic services will now need to have a much longer-term perspective.

Although intended to provide a “peace dividend” through basic service, the design did not include an analysis of conflict, and the changes in this over the period since the CPA. The broad view of this is that conflict has changed from being a north-south conformation, to local conflict with Southern Sudan, due to locally generated tension. Any future programme preparation should carry out a conflict analysis.

In the logframe for BSF-IA, the purpose level indicators tend to be output oriented, rather than outcome oriented. On DFID’s request, the logframe itself has been changed a number of times, seemingly without agreement on the various amendments<sup>43</sup>. This has made it confusing to analyse achievements against the project logframe. **(Recommendation G4)**

### 6.2 Programme Management

BSF is felt by NGOs to be exemplary in collaborative working, cash flow and achieving outputs. In particular, education NGOs report that BSF has created genuine partnerships with them, with shared framing of problems, and shared working towards solutions. They have found BSF to be flexible and responsive (for example, in being able to shift funding to NGOs capable of additional output), and very prompt in managing disbursement. Several education NGOs observed that they have been able to achieve far more in terms of output, working with BSF, than they had previously been able to achieve in working with other donors or funding mechanisms. Some WASH NGOs were concerned about the detailed financial reporting required, and the staff time needed for this.

In relation to reporting and monitoring, BSF-IA has extended monitoring in line with the broader range of activities being engaged in (for example, there are now many more forms of short training, for a much wider range of participants, addressing school management from PTA level through to County level). However, reporting is not consistent between documents; whilst reporting is extensive, reporting against log-frame indicators and targets is not always clear. **(Recommendation G5)**

Overall governance of BSF is still evolving. The Steering Committee has an important role in project selection. There is a need for a strategic overview of the future of support for basic services, after the end of BSF-IA. There are Sub-committees of the Steering Committee, but the Health sub-committee, representing the largest area of investment, does not meet. There are also sectoral NGO fora. **(Recommendation G6)**

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<sup>43</sup> most recently in Jan 2011 to bring it in line with DFID’s new logframe guide, which has changed the terminology : Goal has been replaced by Impact; Purpose is now called Outcome; and Output is what often also is referred to as result

Overall accountability for BSF and BSF-IA is weakened by unevenness in the quality of information. Generally, however, the secretariat appears willing to make information available, and has a large amount of data on its website.

There is a need for clear reporting against fixed logframe indicators. Reports need to be consistent in their reporting of data, between and within reports, and across the phases of BSF's operations. **(Recommendation G5)**

There is limited independent verification of BSF's interim and final reports, apart from financial audits. A mid-term review of BSF1 was carried out in February 2008 and an annual review of BSF2 was done in September 2009, both with relatively a relatively short time for field work; there have been no final evaluations.

### 6.3 Performance-based contracting

Future funding mechanisms will need to consider how they will best ensure performance.

Performance-based contracting provides potential mechanisms for this, but depends on reliable and appropriate measures of performance. Current data is not sufficiently complete, robust or verifiable to provide a basis for performance-based contracting.

Under BSF, outputs have not been adequately linked to performance, because of the weakness of HMIS and other performance systems. Attaching excess weight to outputs such as construction of classrooms, boreholes and health service attendances, could skew performance towards high outputs without achieving the project purpose.

Data also needs to be reported to a higher standard of accuracy and consistency than at present.

However, improvements in programme design, and improvements in indicators developed in conjunction with government increase the scope for modest performance-based incentives, where these are consistent with project purpose and administratively feasible.

**Recommendations** for design of performance-based incentives (GOSS, DFID, NGOs):

- Ensure that performance indicators support both the purpose and outputs of any future funding programme
- Identify or develop indicators that can be regularly reported through established and reliable information systems (e.g. MOH monitoring and evaluation framework)
- Devise simple incentives to support performance at different levels, such as County offices, providers and facilities
- Consider modest incentives for both teams (e.g. increased recurrent budgets) and individuals (bonuses)

## Appendix 1: Project Logframe

This is the original Project Logframe accompanying the Project Memorandum (file name BSFIA - Logframe\_P1.xls dated August 2009). It has been modified several times during the course of implementation, although an agreed version is still pending.

<b>PROJECT NAME</b>	<b>Basic Services Fund for South Sudan</b>					
<b>GOAL</b>	<b>Indicator</b>	<b>Baseline (1999/2000)</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target ( Dec 2011)</b>	
Expand education, health and water and sanitation to communities recovering from conflict	MDG 2: Gross enrolment in primary education	20%	n/a	n/a	52%	
		<b>Source</b>				
	JAM Vol 1, P20, GoSS statistics					
	<b>Indicator</b>	<b>Baseline (2001)</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target ( Dec 2011)</b>	
	MDG 3: Ratio of girls to boys in primary education	36% of pupils are female	n/a	n/a	40% of pupils are female	
		<b>Source</b>				
	JAM Vol 1, P20, GoSS statistics					
	<b>Indicator</b>	<b>Baseline (2001)</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target ( Dec 2011)</b>	
	MDG 4: Under-5 mortality per 1,000 live births	250	n/a	n/a	188 (GoSS target 25% reduction)	
		<b>Source</b>				
	JAM Vol 1, P20, GoSS statistics					
	<b>Indicator</b>	<b>Baseline (1999/2000)</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target ( Dec 2011)</b>	
MDG 5: Maternal mortality per 1,000 live births	150	n/a	n/a	113 (GoSS target 25% reduction)		
	<b>Source</b>					
JAM Vol 1, P20, GoSS statistics						
<b>Indicator</b>	<b>Baseline (1999/2000)</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target ( Dec 2011)</b>		

	MDG 7: Proportion of population with sustainable access to improved water sources and sanitation	27%, 15%	n/a	n/a	38% 21% (GoSS target +40%)	
		<b>Source</b>				
		JAM Vol 1, P20, GoSS statistics				
<b>PURPOSE</b>						
	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	<b>Assumptions</b>
Expand coverage and use of basic services in Southern Sudan	Number of people with new/improved drinking water sources	0	176,494	318,994	393,994	1. CPA holds and transitions to a stable situation post-2011.
		<b>Source</b>				
		BSF reports. Milestone 1 is actual achievement.				2. GOSS is able to steadily increase budget allocations to basic service provision.
	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	
	Number of people with access to improved sanitation facilities	0	12,030	19,365	23,865	3. GOSS is able to recruit and retain qualified basic services staff.
		<b>Source</b>				
		BSF reports. Milestone 1 is actual achievement.				4. Continued and effective donor support to enable a phased and manageable transition to GOSS.
	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	
	No. of children in school	0	15536 boys, 7864 girls	17580 boys, 8719 girls	31,980 boys, 18,319 females	4. We are targetting attendance atthis stage rather than enrolment
		<b>Source</b>				
	BSF reports. Milestone 1 is actual achievement.					

	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	
	Proportion of births attended by skilled health personnel	5.0%			7%	
		<b>Source</b>				
		JAM Vol 1, P20, , GoSS statistics				
	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	
	BSFIA supports delivery of central and state targets	n/a	n/a	BSFIA contributes to improved state and central level indicators for service delivery	All BSFIA projects integrated into GoSS state-level planning	
		<b>Source</b>				
<b>INPUTS (£)</b>	<b>DFID (£)</b>	<b>Govt (£)</b>	<b>Other (£)</b>	<b>Total (£)</b>	<b>DFID SHARE (%)</b>	
	39,525,437	(£7.5 million)	£33.3 million	£72,325,437.00	51.9% (excluding indicative GoSS share)	
<b>INPUTS (HR)</b>	<b>DFID (FTEs)</b>					
<b>OUTPUT 1</b>	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	<b>Assumptions</b>
Strengthened education services	No. of classrooms constructed or rehabilitated	0	100	249	729/210	1. Dec 2011 target figures based on minimum GoSS targets in priority paper
		<b>Source</b>				
		BSF reports. Milestone 1 is actual achievement.				
		3. Teacher's salaries paid.				
<b>IMPACT WEIGHTING</b>	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	4. State governments able to manage education service effectively.

<b>20%</b>	No. of teachers trained/AES trained	0	852 teachers, [0] AES	2,856 teachers, 0 AES	5,856, 100	5. Communities are willing to provide reasonable support.
	<b>Source</b>					<b>RISK RATING</b>
	BSF reports. Milestone 1 is actual achievement.					<b>Medium</b>
<b>INPUTS (£)</b>	<b>DFID (£)</b>	<b>Govt (£)</b>	<b>Other (£)</b>	<b>Total (£)</b>	<b>DFID SHARE (%)</b>	
	<b>£9.65 million</b>	<b>(£3 million)</b>	<b>£8.175 million</b>	<b>£16.95 million</b>	51.8% (excluding indicative GoSS share @ 20%)	
<b>INPUTS (HR)</b>	<b>DFID (FTEs)</b>					
<b>OUTPUT 2</b>	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	<b>Assumptions</b>
Strengthen primary health services.	No. of PHCC/PHCUs built/reconstructed	0	13 PHCC/23 PHCU	18 PHCC/36 PHCU	tbd after call for proposals	1. BSF implementing partners deliver to plan.
	<b>Source</b>					2. GOSS and/or donor partners agree plans to sustain services post BSF.
	BSF reports. Milestone 1 is actual achievement.					
	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	
	No. of PHCC/PHCUs supported with medical services	0	19 PHCC/44 PHCU	45 PHCC/132 PHCU	tbd after call for proposals	3. State governments develop capacity to maintain services for the long term.
	<b>Source</b>					4. Communities are willing to provide reasonable support.
BSF reports. Milestone 1 is actual achievement.						
<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>		
No. of health professionals trained (Nurses & midwives/TBA'	0	Nurses 40F/55M, Midwives/TBA's 19M/472F	tbd	tbd after call for proposals		
<b>Source</b>						

	s)	BSF reports. Milestone 1 is actual achievement.					
<b>IMPACT WEIGHTING</b>	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>		
50%	Number of patient consultations	0	783,958	1,567,916	tbd		
		<b>Source</b>				<b>RISK RATING</b>	
		BSF reports. Milestone 1 is actual achievement.				<b>High</b>	
<b>INPUTS (£)</b>	<b>DFID (£)</b>	<b>Govt (£)</b>	<b>Other (£)</b>	<b>Total (£)</b>	<b>DFID SHARE (%)</b>		
	£18.4 million	£4 million	£15.95 million	£32.6 million	51.07% (Excluding indicative GoSS share at 20%)		
<b>INPUTS (HR)</b>	<b>DFID (FTEs)</b>						
<b>OUTPUT 3</b>	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	<b>Assumptions</b>	
Strengthened water and sanitation services.	No. of new/improved water points provided	0	219 (1 gravity scheme)	477 (16 gravity scheme/other source)	777 (16 gravity scheme/other sources)	1. BSF implementing partners deliver to plan.	
		<b>Source</b>				2. Dec 2011 target figures based on minimum GoSS targets in priority paper	
		BSF reports. Milestone 1 is actual achievement.				3. Workable models for community management.	
		<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	
		No. of new/improved sanitation facilities provided	0	1203	2,670	3,570	4. Secure spare supplies.
			<b>Source</b>				5. Hygiene training includes - hygiene & sanitation, public basic hygiene and sanitation, school hygiene and sanitation clubs, village health motivators & water quality.
		BSF reports. Milestone 1 is actual achievement.					
		<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	
	No. of people trained in	0	1,348	25,326	50,000		
		<b>Source</b>					

	hygiene/sanitation or environmental awareness	BSF reports. Milestone 1 is actual achievements.				
<b>IMPACT WEIGHTING</b>	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	
<b>20%</b>	No. of staff and community members trained to maintain and monitor water and sanitation systems	0	64 staff, 1,124 community members	151, 2,387	300 - 800, [5,000]	
		<b>Source</b>				<b>RISK RATING</b>
		BSF reports. Milestone 1 is actual achievement.				<b>Medium</b>
<b>INPUTS (£)</b>	<b>DFID (£)</b>	<b>Govt (£)</b>	<b>Other (£)</b>	<b>Total (£)</b>	<b>DFID SHARE (%)</b>	
	<b>£8.75 million</b>		<b>£7.775 million</b>	<b>£15.65 million</b>	50.3% (Excluding indicative GoSS share at 20%)	
<b>INPUTS (HR)</b>	<b>DFID (FTEs)</b>					
<b>OUTPUT 4</b>	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	<b>Assumptions</b>
Strengthen GoSS capacity to plan and monitor basic service delivery	Number of State-level line ministry staff trained as part of NGO projects	0	0	0	500	
		<b>Source</b>				
	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	
	% of BSFIA projects planned and monitored jointly with state-level line	0	0	0	100%	
	<b>Source</b>					

	ministries					
<b>IMPACT WEIGHTING</b>	<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>	
10%						
		<b>Source</b>				<b>RISK RATING</b>
						<b>Medium</b>
<b>INPUTS (£)</b>	<b>DFID (£)</b>	<b>Govt (£)</b>	<b>Other (£)</b>	<b>Total (£)</b>	<b>DFID SHARE (%)</b>	
<b>INPUTS (HR)</b>	<b>DFID (FTEs)</b>					

## Appendix 2: Summary of Achievements

Logical Framework accompanying Project Memorandum<sup>44</sup>

*Additions and amendments from the Inception Report<sup>45</sup> are shown in italics.*

Indicator	Baseline	Achievement JUN 2010 <sup>46</sup>	Target DEC 2011	Achievement DEC 2010	Rating <sup>47</sup>	Comment
<b>Goal:</b> Expand education, health and water and sanitation to communities recovering from conflict						
MDG 2: Net enrolment in primary education	(1999,2000) 20%	48% <sup>48</sup>	52%	48% <sup>49</sup>	2	Rating based on reported figures; suspect may be contentious. However, same figure now used by UNDP for 2010 MDG report <sup>50</sup> .
MDG 3: Ratio of girls to boys in primary education	(2001) 36% of pupils are female <i>0.56</i>	(39% of pupils are female) <sup>51</sup>	40% of pupils are female <i>0.67</i>	(39% of pupils are female) <sup>52</sup>	1	2009 figures show total enrollment of 917k children aged 6-13, of whom, 355k are girls. It is likely that the 2010 figures (shortly to be published) will reach 40% female enrollment.

<sup>44</sup> Basic Services Fund for South Sudan Revised Logical Framework August 2009

<sup>45</sup> BSF-IA Inception Report September 2010, with additional material from accompanying spreadsheet

<sup>46</sup> BSF Phase 2 Completion Report September 2010

<sup>47</sup> 1. = Likely to be completely achieved.

2. = Likely to be largely achieved.

3. = Likely to be partly achieved.

4. = Only likely to be achieved to a very limited extent.

5. = Unlikely to be achieved.

0= unable to score

<sup>48</sup> EDUCATION STATISTICS FOR SOUTHERN SUDAN 2009, NATIONAL STATISTICAL BOOKLET v. 2.0

Published 13 October 2010 by the Government of Southern Sudan Ministry of Education, p 26

<sup>49</sup> As June 2010

<sup>50</sup> [http://www.sd.undp.org/mdg\\_fact.htm#2](http://www.sd.undp.org/mdg_fact.htm#2)

<sup>51</sup> based on figures in table 6.1.3, from i) above.

<sup>52</sup> As June 2010

MDG 4: Under-5 mortality per 1,000 live births	(2001) 250 <sup>53</sup>	Not available	188 (GoSS target 35% reduction)  <i>MDG target in 2015: 66% reduction</i>	Not available	0	Not reported in Abridged SHHS 2010.
MDG 5: Maternal mortality per 100,000 live births	(1999/2000) 150/1,000 1,700 <sup>54</sup>	Not available	113 (GoSS target 25% reduction) <i>Is there a GoSS target?</i>	Not available	0	Not reported in Abridged SHHS 2010.
MDG 7: Proportion of population with sustainable access to improved water sources and sanitation	(1999,2000) 27%, 15%		38% 21% (GoSS target + 40%) <i>&gt; 40%, GoSS target for sanitation?</i>			
<b>Purpose:</b> Expand coverage and use of basic services in Sudan						
Number of people with new/ improved drinking water sources	(2006) 0	273,000	393,994 482,500	331,000	2	June and December 2010 achievement estimated from 500 users per waterpoint
Number of people with access to improved sanitation facilities	(2006) 0	33,135	23,865 97,725	35,650	2	June and December 2010 achievement figure includes double counting of beneficiaries using institutional latrines (40/stanza) as well as household latrines (5/latrine). Full achievement and hence the rating depends on success in the CLTS pilot project by PSI
No. of children in school	(2006) 0	52,400	31,980 boys, 18,319 females 63,000			
Proportion of births attended by skilled health personnel	(2006) 5%  [10.0% SHHS] <sup>55</sup>		7% 30%	10% provisional <sup>56 57</sup>	4	BSF achievement of 10% births assisted by skilled staff falls well below 30% target, largely due to lack of skilled staff to assist delivery: a further 10% of births are assisted by TBAs.

<sup>53</sup> 135 in Household Survey 2006, Table CM.1, p21

<sup>54</sup> 2,054 in Household Survey 2006, p. xviii

<sup>55</sup> Household Survey 2006, p. xviii

<sup>56</sup> Births recorded by BSF-supported facilities, assisted by staff trained as community midwives and above, both in facility and in community. Trained and untrained TBAs assist delivery of a further 10% (provisional) of all births.

BSF-IA supports delivery of central and state targets	n/a <i>GoSS Basic Services targets are national</i>		All BSF-IA projects integrated into GoSS state-level planning		0	Not assessed.
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Indicator	Baseline 2006	Achievement JUN 2010	Target DEC 2011	Achievement DEC 2010	Rating	Comment
<b>Output 1: Strengthened education services (Impact weighting 20%)</b>						
No. of classrooms constructed or rehabilitated	0	352 cum	729/210 564 [BSF-IA: 212 new classrooms 6 schools rehab]	2 new schools (16 classrooms)	2	Construction of the 236 classrooms targeted for construction or repair in BSF-IA has started on all but two sites. 25 of the 32 schools should be completed before the end of the dry season.
No. of teachers trained/AES trained	0	1,095 ph.1 <sup>58</sup> 1,248 ph. 2 2,343  (AES trained ?)	5,856 [teachers], 100 [AES] 4,560 cum. [BSF-IA: 1996]	Just over half (1,170) of the targeted (1,996) teachers have begun or completed training	2	At halfway through the BSF-IA grant period, just over half (1,170) of the targeted (1,996) teachers have begun or completed training <sup>59</sup> . A cumulative total of 4,229 teachers trained is anticipated by the end of BSF-IA
<b>Output 2: Strengthen primary health services (Impact weighting 50%)</b>						
No. of PHCC/PHCUs built/reconstructed	0	18/39 cum.	tbd after call for proposals 28 PHCC/86 PHCU [cum] [13/42 BSF-IA]	0/0	2	Delays due to rain and other factors. Only 2PHCCs and 1PHCU are reported to be at high risk of non-completion. BSF has good record of completion.
No. of PHCC/PHCUs supported with medical services only	0	32/89	tbd after call for proposals 71 PHCC/191 PHCU [cum]  [implies 39 PHCCs and 102 PHCUs to be supported by IA]	45/112 [current]	1	

<sup>57</sup> 14.7% of births nationally are assisted by skilled attendants according to the Abridged Household Survey 2010, p2

<sup>58</sup> BSF Phase 1 Completion Report January 2010, Annex 8, p69

<sup>59</sup> drawing upon figures in Annex 8, summary table of primary education training, BSF QPR 1:2011, p37

Indicator	Baseline 2006	Achievement JUN 2010	Target DEC 2011	Achievement DEC 2010	Rating	Comment
No. of health professionals trained (Nurses & midwives/TBA's, etc)	0	Short term 4,862 Ph 1 <sup>60</sup> 5,954 Ph 2 10,816  Long term 85 Ph 2	tbd	1,200 (573 female)  59 LT trainings planned, of which 16 CHWs cancelled, as no longer required by MOH	0	No target.
Number of patient consultations	0	168,665 Ph1 1,093,625 Ph2 1,262,290 cum	Tbd 2,404,789[cum.] [implies 1,142,499 consultations in BSF-IA]	274,229	2	Reduced level attributed to non-completed of facilities, and higher morbidity to come in rainy season.
Output 3: Strengthened water and sanitation services (Impact weighting 20%)						
No. of new/improved water points provided	0 new	316	Cum. target 501 185 under BSF-IA	6	2	Major acceleration since start of dry season not yet reported
	0 rehab	232	Cum. target 454 222 under BSF-IA	42	2	Rehab includes boreholes new since the Baseline 2006 (not necessarily built with BSF funding)
	0 other sources	9	150 Cum. target 141 under BSF-IA	59	2	Major acceleration since start of dry season not yet reported
No. of new/improved sanitation facilities provided	0 HH	2,312	Cum. target 11,688 9,376 under BSF-IA	498	3	None in BSF Phase 1 Achievement of target substantially dependent on CLTS pilot of PSI, which is now producing results following CLTS triggering earlier in period
	0 Institutional	389	Cum. target 955 566 under BSF-IA	43	2	Stances 4 in BSF Phase 1 Construction of latrines matching progress in construction of school, now in dry season
No. of people trained in hygiene/sanitation or environmental awareness <sup>61</sup>	0	Phase 1: 1,348 (F 738) Phase 2:	Cum. target 50,000 37,623 under BSF-	1,463 (F 850)	2	Reported as people receiving training Trainings: • hygiene & sanitation

<sup>60</sup> BSF Phase 1 Completion Report January 2010, Annex 8, p70. Long term training not identified separately.

<sup>61</sup> It is not clear that the target setting and reporting of training is consistent – number of participants per training, irrespective on length of training; or number of participant training days

Indicator	Baseline 2006	Achievement JUN 2010	Target DEC 2011	Achievement DEC 2010	Rating	Comment
		13,055 (F 6,297) Total: 12,377 (F 7,305)	IA			<ul style="list-style-type: none"> <li>• Public basic hygiene and sanitation</li> <li>• School hygiene and sanitation clubs</li> <li>• Village health motivators</li> <li>• Water quality</li> </ul> Under-reporting by NGOs
No. of staff and community members trained to maintain and monitor water and sanitation systems	0 community	Phase 1: 1,285 Phase 2: 5,309 Total: 6594	Cum. target: ? 5,000 under BSF-IA	401 (F 202)	2	Reported as people receiving training Trainings: <ul style="list-style-type: none"> <li>• Community leaders</li> <li>• Water committee members;</li> <li>• Pump mechanics</li> </ul> Dec 2011 cumulative target not stated
	0 staff	Phase 1: 174 Phase 2: ? Total: ?	Cum. target: ? 300 – 800 under BSF-IA	25 (other 153)	3	Dec 2011 cumulative target not stated Rating marked 3 due to lack of clarity
Output 4: Strengthen GOSS capacity to plan and monitor basic service delivery (Impact weighting 10%)						
Number of State-level line ministry staff trained as part of NGO projects	0				0	No target
% of BSF-IA projects planned and monitored jointly with state- and county-level line ministries	0				0	No target

## **Appendix 3: Terms of Reference**

### **Basic Services Fund – Interim Arrangement (BSF-IA)**

#### **Mid-Term Review**

#### **Terms of Reference**

The purpose of the Basic Service's Fund Interim Arrangement (BSF-IA) is to increase the coverage, access and use of the population of Southern Sudan to Basic Services in primary education, primary health and water & sanitation in a sustainable way and therefore includes the strengthening of the Government of southern Sudan's (GOSS) capacity to plan, monitor and co-ordinate this service delivery by non-state actors.

This purpose is consistent with BSF-IA's goal namely GoSS' poverty reduction agenda within the six year interim period of the CPA from 2005 to 2011. The main expected results are the establishment of operational primary schools, primary health clinics, drinking water points and latrines. These results are all accompanied by capacity building, such as management training of local beneficiary groups and county authorities, but also of the Steering Committee, to ensure that the access to basic services gained by one million six hundred thousand people (Phase 1 and 2 combined) will be maintained at minimum levels to assure medium-term sustainability.

#### **1. Objectives**

1. Review BSF-IA's progress towards its objective of supporting the GoSS in expanding the access to Primary Health, Primary Education and Water, Sanitation and Hygiene Promotion
2. Produce an inventory of issues and solutions for a new aid architecture applicable after the CPA's interim period that ends 8 July 2011. Considering the fact that most MDGs concern one of the Basic services, and considering the fact that MDGs are coming close to their end –date of 2015, the new aid architecture should address how best to reach these goals.

## 2. Scope

This Mid-Term Review will assess outcomes against the log-frame, report on achievement to date in BSF-IA on the following issues and make suggestions on how to improve performance and performance monitoring in these areas for the remainder of BSF-IA and for design of any future follow on mechanism(s):

### 2.1 General

- The extent to which BSF-IA has expanded coverage, and improved the quality and use of basic services in health, education and water, sanitation and hygiene promotion.
- The extent to which BSF-IA has increased delivery of services to geographical areas under-served by basic services and, if applicable, areas with relatively high displacement and returnee rates in this project phase.
- How BSF-IA or any potential sectoral follow-on mechanisms can improved the capacity of the GoSS at, especially State and County levels, to plan, monitor and co-ordinate service delivery through non-state service providers. This covers access to information systems and coherence with GoSS policy, planning and coordination.
- How BSF-IA/successor mechanism(s) can improved mutual accountability between non-state service providers and GoSS at all levels, and between service providers and their clients (men and women, other relevant social groupings etc.)
- The extent to which BSF-IA has developed common standards and shared approaches for service delivery, including lessons learned from other pooled funding mechanisms, disseminated best practice, evidence of its use in the service sectors and how this can be improved.
- The extent to which GoSS budgets for MoH and MoE can deliver free Primary Health care and free Primary Education as specified in GOSS's constitution.
- Assess the key features of BSF-IA tendering process. Identify the learning points for other projects operating in similar conflict and emergency contexts.

### 2.2 Primary Health

- Assess progress to date on reaching BSF-IA health targets/delivery of key Basic Package of Health Service (BPHS) services and suggest ways in which performance could be improved in the rest of BSF-IA and any new mechanisms.
- Review technical assistance/capacity building given to the MoH at GoSS, State and CHD levels) and implementing partners to implement the BPHS in joint collaboration with BSF-IA health service providers.
- Review extent to which the MoH at different levels has ownership/oversight over NGO performance and how it could be improved.

- Review the situation with regard to qualified health professional staff on the delivery of essential drugs, vaccines and medical equipment to health facilities, with logistics' chain planning and management.
- Assess coordination capacity at CHD and SMOH levels, between NGO-contracted and MoH-managed services and contribution by NGOs to co-ordination capacity
- Assess future of Result-based contracting.

### **2.3 Primary Education**

- Establish the conflict and emergency context in which BSF-IA education interventions are implemented. This would include GoSS, SMOE and community efforts in running quality primary education.
- Assess quality of management, including community participation and teaching at BSF-IA supported schools.
- Assess the quality of BSF-IA supported teacher training courses and institutions – review should include effectiveness of different training models, quality and management of training staff, length and content of trainings and duration of teaching service following training.
- Assess the gender-inclusivity of BSF-IA supported primary schools and teacher training courses.
- Highlight the salient features of the BSF-IA results monitoring strategy and systems. Mention how data was integrated in project planning and implementation.

### **2.4 Water, Sanitation and Hygiene Promotion**

- Assess the quality and effectiveness of BSF-IA supported sanitation and hygiene promotion activities in both the education and health projects with an integrated water, sanitation and hygiene promotion component as well as stand alone water, sanitation and hygiene promotion projects.
- Assess the capacity of the State directorates of rural water supply and sanitation, and the county water and sanitation departments, to plan, supervise and sustain water, sanitation and hygiene promotion activities, including borehole drilling supervision, supply chain management and (ground) water resources management. The review should include the operational status of the Southern Sudan Water Information Clearing House (SSWICH).
- Assess whether the BSF-IA funded water points have quality assurance procedures (e.g. contracting, drilling supervision, water quality testing).
- Assess whether community ownership of water points is effectively promoted in the BSF-IA projects and whether pre-conditions are in place for community based operation and maintenance of boreholes (e.g. training of pump mechanics, existence of a spare parts supply, County Water Departments, etc.). The review should include an assessment of current cost sharing practices for operation and management of water points at village level.

- The degree to which water, sanitation and hygiene promotion have been integrated into health and education services – e.g. schools, clinics and households having access to WatSan facilities.
- Assess how BSF-IA supported water, sanitation and hygiene promotion activities are co-ordinated with the Ministry of Water Resources and Irrigation (MWRI) monitoring and reporting structures at all levels, especially in regard to the flow of information to SSWICH.

## **2.5 Sustainability**

- The current organisational and institutional capacity of the GoSS, particularly at State and County level, to effectively plan, budget and coordinate the delivery of basic services.
- The degree and mechanisms by which GoSS has met recurrent and capital expenditure obligations to ensure project continuity post funding phase.
- The extent to which the BSF-IA Steering Committee, chaired by GoSS, has directed the BSF-IA; and the suitability and effectiveness of its mandate in promoting sustainability of basic services.
- The extent to which the BSF-IA projects have shared information with other programmes working in the same field, and its cooperation with the relevant government departments.
- Effectiveness of community consultation (with men and women, across different social groups etc.) and coordination with local management systems. This includes the effectiveness of community management structures, maintenance mechanisms, back up mechanisms by local government (e.g. availability of spare parts for borehole maintenance).
- The extent to which the BSF-IA has built the technical and organisational capacity of NGO implementing partners, in particular Sudanese NGOs.
- The degree to which the access to services can be maintained and expanded with a longer term perspective (3 to 5 years), in the context of forecast scenarios of the capacity of the GoSS to effectively support basic services.

## **2.6 Monitoring and Evaluation**

- The extent to which Monitoring and Evaluation procedures involve GoSS at all levels and can demonstrate disaggregated and relevant outcomes and impact (appropriateness of indicators etc.).
- The extent to which BSF-IA lesson learning and best practise is shared. This should cover the mechanisms used.

## 2.7 Program Management

1. The effectiveness of BMB Mott MacDonald's programme management including, but not restricted to:
  - Organisation of 4<sup>th</sup> call for proposals
  - Secretariat to the Steering Committee
  - financing arrangements (payments, NGO forecasting arrangements, BMB Mott MacDonald forecasting arrangements etc)
  - monitoring & evaluation.
2. The relative strengths and weaknesses of the BSF-IA as a funding mechanism in terms of its management structure, relationship with government, duration of funding etc. in comparison with other aid instruments in Southern Sudan with a view to providing recommendations as to future funding mechanisms for basic services;
3. Assess BSF-IA reporting mechanisms and standards
4. The effectiveness of the BSF-IA website as a guide to implementing partners and results.

## 3. Methodology

### 3.1 Consultancy team

The team will consist of:

- A Team Leader with an expertise in monitoring and/or evaluation plus at least 10 years experience in working in basic services programmes in his/her field of expertise. He/She must have experience as a Team Leader in review, monitoring and/or evaluation missions.
- A specialist in primary education, with background in basic education development with teacher training systems, education economics.
- A specialist in primary health, with a background in health systems analysis/planning and public health economics.
- A specialist in water, sanitation and hygiene promotion with a background in both technical and community participation aspects of drinking water provision, sanitation and hygiene promotion.
- One of these four specialists will be Team Leader and will have
- The 2 other specialists will have at least 5 years experience in the implementation of basic services programmes, in their fields of expertise.
- Each specialist will have at least 5 years experience in developing countries of which at least 3 years should be in the East Africa/Horn of Africa region.
- The team must have a thorough contextual understanding of governance (by State and non-state actors) in Southern Sudan.

The consultancy will co-ordinate with other donors to the 3 basic services sectors, and especially with those with reciprocal commitments to reviews. Staff from other donors could be seconded to the BSF-IA Review where appropriate.

GoSS, State and County officers and NGO staff will accompany consultants on their field trips and in their meetings.

### **3.2 Activities**

- A desk based file/literature review of key BSF-IA documentation and results database as well as recent reviews of the MDTF, CHF, SRF, and USAID (SHTP-2).
- A briefing from DFID Sudan's BSF-IA programme manager and lead adviser.
- Interviews with BSF-IA Steering Committee members, government, international and national NGO grant recipients, DFID and JDT staff, and other funders (Norway, Netherlands, Sweden, European Commission) as well as other relevant stakeholders.
- Project site visits to selected BSF-IA project areas. The choice of project sites will be agreed in conjunction with DFID and the BSF-IA Secretariat (see ANNEX 1 for suggested field visits).
- Report writing.
- A presentation of the draft report in a debriefing session with DFID and other stakeholders before finalisation of the report.

### **3.3 Reporting**

The consultants will provide:

1. Debriefing presentation to the Steering Committee with all main findings and conclusions,
2. A draft report of maximum 25 pages (excluding Annexes) in standard prism format, which includes an executive summary with all main conclusions and recommendation to be submitted within 10 days of the end of the country visit. All recommendations should have been raised at the BSF-IA Steering Committee meeting on 30 April 2011.
3. Main stakeholders, notable, DFID Sudan, BSF-IA's Steering Committee and management consultant have 5 working days to provide feedback on this report.

### **3.4 3.4 Governance arrangements**

BSF-IA's SC is chaired by the GoSS Ministry of Finance. Voting members include the GoSS Ministries of Health, Education, and Water; international and national NGOs; and DFID. To ensure donor coherence, the Joint Donor Team, USAID, European Commission and representatives of the MDTF and SRF participate as non-voting observers.

The SC has the responsibility for: i) approving BSF-IA operational procedures; ii) determining the geographical and sectoral priorities; iii) project approval; reviewing monitoring reports; and iv) prioritising and disseminating lessons learned.

The SC has 3 Sub-Committees, comprising relevant line-directorate staff of the 3 GoSS basic services ministries: Health, Education and Water. Responsibility for the determination of geographical and activity priorities, approval of grant recipient budget alterations and monitoring of progress lies with these 3 Sub-Committees by sector.

For information on the BSF-IA the consultants should go to the website <http://www.bsf-south-sudan.org/>

## 4. DFID co-ordination

### 4.1 DFID Co-ordination

The BSF-IA programme manager in the DFID office in Juba, will be the focal point in DFID for co-ordination. Technical and policy advice will be supplemented by relevant DFID advisors. The BSF-IA Secretariat will assist with arranging field visits and meetings in Southern Sudan (see ANNEX 1 for suggested options for field visits).

### ANNEX 1 – Suggested field visit options

Option	State(s)	Counties	Lead Agents with sector	Nights	Transport
1	Western Equatoria	Mundri East, Mundri West, Maridi, Ibba, Yambio, Nzara, Ezo, Tambura	OXFAM Novib (PE) Malteser (PH) Cordaid/ DoTY (PH) World Vision (PH) Intersos (WS)	5	Drive from Juba (via Mundri) stopping in Maridi (Monday), Ibba, Nzara, Yambio (Tuesday), Ezo and Tambura (Wednesday and Thursday), turning to Yambio (Friday). Fly YBO-JUB on UNHAS (Saturday).
2	Western Bahr El-Ghazal; Warrap	Wau, Jur River, Gogrial West, Gogrial East	HARD (PE) ACTED (WS) Intermon OXFAM (WS) HealthNet (PH) ACF (WS)	4	Fly JUB-WAU on UNHAS (Monday), Jur River, Wau (Tuesday - Wednesday) Gogrial W+E (Wednesday-Thursday), Fly WAU-JUB on UNHAS (Friday).
3	Northern Bahr El-Ghazal;	Aweil South, Aweil East, Aweil North, Aweil West,	UMCOR (PE) ACF (WS) Concern (PH) Malaria Cons. (PH) Windle Trust (PE) <i>World Relief (PE)?</i>	4	Fly JUB-AWL on 748 (Monday), Aweil W+N (Tuesday) Aweil E (Wednesday) Aweil S (Thursday) Fly AWL-JUB on 748 (Friday)
4	Upper Nile	Malakal, Baliyet, Ulang, Nasir, Fashoda, Melut	GOAL (PH) Food for the Hungry (PE) ADRA (PH) Tearfund (PH) Medair (PH)	7	Fly JUB-MAL on UNHAS and drive to Baliyet (Tues.), road or river to Ulang (Wedn.), river to Nasir (Thurs.), fly NAS (from Nasir or Kiech Kon)-MAL on UNHAS (Friday), river to Kodok (Saturday), river to Melut (Sunday),

					fly PAL-JUB on MAF (Tuesday).
5	Eastern Equatoria	Torit, Ikotos, Budi, Kapoeta South	Caritas CH (PE) Merlin (PH) AVSI (PH) ADRA (PH) ARC (PH)	5	Fly JUB-TOR on UNHAS (Thursday), drive Torit-Ikotos (Friday), Ikotos-Chukudum (Saturday), Chukudum-Kapoeta (Sunday), Kapoeta counties (Monday), Fly KAP-JUB on UNHAS (Tuesday)
6	Central Equatoria	Terekeka, Juba	ZOA (WS) CRS (PE) OVCI (PH) PSI (WS)	3	Drive Juba-Tali via Kowori (Monday), Tali-Terekeka (Wednesday), Terekeka-Juba (Thursday)
7	Unity	Mayom, Abiemnhom, Rubkona, Guit, Pariang, Leer	Marie Stopes (PH) Windle Trust (PE) CARE (PH) <i>World Relief (PE)?</i>	4	Fly JUB-THR on 748 or JUB-RUB on UNHAS (Tuesday), drive Bentiu-Guit-Leer-Bentiu (Wedn.), Drive Bentiu-Mayom (Thursday) Drive Mayom-Bentiu (Friday) Fly THR-JUB on 748 (Saturday)
8	Jonglei	Akobo, Uror, Duk, Twic East	IMC (PH) Tearfund (WS) IRD (PH/WS)	5	Fly JUB-AKB on UNHAS (Wednesday), Akobo (Thursday), drive Akobo-Motot via Walgak (Friday), Motot (Saturday), Drive Motot - Duk (Sunday), Duk (Monday) MAF flight DUK – JUB on Tuesday

## ANNEX 2

Generic Itinerary based on 17 workdays for 3 persons Most fieldtrip require travel by air which has to be booked well in advance, say at least a week before the team arrives.

Day nr	Day	Date	Time	Activity	Details
				Literature review (BSF website etc)	
	Saturday			Literature review (BSF website etc)	
	Sunday			Travel to Juba, Southern Sudan	
1	Monday	14	AM PM	Am: Arrival In Juba and check in Link Hotel PM: briefing at BSF secretariat (passport registration and logistics) and DFID	
2	Tuesday	15		Briefings meetings with DFID, BSF secretariat, Line ministries, NGO Forum, usaid etc;JDO Details field trip options completed	
3	Wednesday	16		Briefings meetings with DFID, Line ministries, NGO Forum, management consultant; usaid etc Details field trip options completed.	
4	Thursday	17		Fieldtrip ; if mission is split-up in 2 teams each team can aim at two fieldtrips;	Two options

				team 1 PH+CC ;team 2 PE+ watsan	
5	Friday	18		Fieldtrip	
6	Saturday	19		Fieldtrip	
7	Sunday	20		Fieldtrip	
8	Monday	21		Fieldtrip team1 PH +watsan ;team 2 PE +CC	Two more options
9	Tuesday	22		Fieldtrip	
10	Wednesday	23		Field trip	
11	Thursday	24		Return to Juba	
12	Friday	25		Draft report	
13	Saturday	26		Draft report	
14	Sunday	27		Draft report	
15	Monday	28		Send draft debriefing presentation doc to Steering Committee	
16	Tuesday	29		If there is time do presentation to SC subcommittees	
17	Wednesday	30		AM: Debriefing Steering Committee PM debriefing NGO forum	
18	Thursday	31		Draft report ( agree with DFID in report deadlines)	
19	Friday	1		Departure Juba	

## Appendix 4: Principal people consulted

Moses Mabiore Dew	Director General, Aid Coordination,	MOFEP
Dr Samson Baba	Director General, Coordination...	MOH
Dr Richard Laku	Director of Monitoring and Evaluation,	MOH
Simon Gould	Programme Manager,	Liverpool Associates for Tropical Health
Dr Charles Lerman, Cliff Lubitz	S Health Transformation Programme,	USAID
Esther Akumu Achire	Director of Development Partners	MoE
John Lujang	Deputy Director Teacher Education	MoE
James Odick	Deputy Director Physical Planning	MoE
Sammy Mussoke	Education Consultant	MoE
Utem Watba	Director of Development Partners (previous)	MoE
Martin Luther	Head of Payroll	MoE
Fahim	EMIS advisor	Southern Sudan EMIS & Policy Support Unit
Kate Louwes	Project Manager	BSF Secretariat
Wim Groenendijk	Monitoring and Evaluation Officer (Health)	BSF Secretariat
Geerta van der Meijden	Monitoring and Evaluation Officer (WASH)	BSF Secretariat
Nic Ramsden	Monitoring and Evaluation Officer (Education)	BSF Secretariat
Allard Jansen	Financial Manager	BSF Secretariat
Addie van Ommering	Project Director	BSF Secretariat
Various representatives	BSF NGO Partners Health, Education and WASH Fora	
	BSF Steering Committee	
	BSF Sub-Committees	
Mark Mallalieu	DFID Southern Sudan Head of mission	DFID, Juba
Rachel Grant	Deputy Programme Manager	DFID, Juba
Fazle Rabbani	Education Adviser	DFID, Juba
Sarah Goldsmith	Health consultant	DFID, Juba
Manhiem Bol Malek	Director	Directorate of Rural Water Supply & Sanitation, MWRI
Peter Mahal Dhieu Akat Chooli	Director General, Rural Water Supply and Sanitation	MWRI
Emmanuel Parmenas Lupai	Ag. D.G. Planning & Projects	MWRI
Peter Jalyath Saverio	Technical Advisor	Directorate of Rural Water Supply & Sanitation, MWRI
Augustino Yohannes	Monitoring and Evaluation	MWRI
Lillian	Deputy Director, Water Quality	MWRI
Peter Poul	AI Director, Information Management & Research	SSWICH, MWRI
Bert van Ommen	Team Leader, TA Support Team	MWRI
Wondwossen Teffera	Water & Sanitation Advisor	MSI, USAID
Ken Maskall	Chief of WASH Programme	UNICEF
Julie Steiger	Country Representative	PSI
Simon Yango Taban	Program Manager Sanitation	PSI
David Atem	Sanitation Officer	PSI

Santa Abwoyo Paul		
Lado Kenyi	Admin Officer, Boma	Kator Payam
Onno Van Manen	Country Director Chair of WASH NGO Group, and members	ACF
Ivor Morgan	Policy Focal Point, NGO Secretariat	Southern Sudan NGO Forum
<b>Eastern Equatoria</b>		
Ersilia Lakulu	CMO	Magwi CHD
Olga Eunice Odera	Pharmacy Supervisor	Magwi CHD
Ochaya Emmanuel	Disease Surveillance Supervisor	Magwi CHD
Otim Samuel Akim	AIDS Commission Supervisor	Magwi CHD
Tewodros Alemayehu	Health Coordinator	ARC and partners
Peter Oyat	Programme Manager, Community Life Changing Programme	ARC and partners
Opaka Johnson	Community Mobilisation officer	ARC and partners
Roselate	Community Health Volunteer	ARC and partners
James Dongola	Acting In-Charge,	Magwi Town PHCC
Dr Lenore Crisostomo	Senior health coordinator	Merlin Torit
Janette Macleod	Operations Manager	Merlin South Sudan
Melissa Mullan (outgoing) Natalie Pedersen (incoming)	Project coordinator	Merlin Torit
Wilson Haworu	PHCC In-charge	Hjala PHCC
Kwol Kenyatta John	EPI in-charge	Hjala PHCC
Archangelo Oburak	Pharmacy assistant	Hjala PHCC
David Oratu	Lab technician	Hjala PHCC
Data clerk	Jacob Asaba	Hjala PHCC
Dr Nathan Riak Atem	Team Leader	Norwegian People's Aid
Alessandro Cordato	Programme Manager	AVSI
Dr David Mpaka	Health Coordinator	AVSI
Matthew Lobwo	Hygiene Promotor	AVSI
Palma Lanyero Felicity	PHCU supervisor	AVSI
Fr Martin Vuni	Health Programme Coordinator	Catholic Diocese of Torit
Emmanuel Douglas	Health Coordinator	Catholic Diocese of Torit
John Omoro Franco	Untrained nurse	Chahari PHCU
Rosa, Rosina	TBAs	Chahari PHCU
Dr Elijo Omoro	Acting DG for Health	
Dr Augustine Okwahi	Hospital Director	Torit Hospital
Lily Diana Bartel Ohya	Assistant Commissioner	Torit CHD
Alessandro Bagnariol	Project Manager	OVCi Nostra Famiglia
Dr Samuel Setagachew	Coordinator MCH Services and Outreach	OVCi Nostra Famiglia
Sr Paulina Paul	Senior Midwifery Supervisor	OVCi Nostra Famiglia
John Manase	Community Development Officer Supervisor	OVCi Nostra Famiglia
Carla Patricia Dani	Midwifery Supervisor	OVCi Nostra Famiglia
Emmanuel Yosia	Project Assistant	OVCi Nostra Famiglia
Anna Mary Otin	Medical Assistant in Charge, Usratuna PHCC	OVCi Nostra Famiglia
Celestino Oryem	Medical Assistant in Charge, Nyakuron PHCC	OVCi Nostra Famiglia
Sister Lucia Kedi Michael	Senior Nurse Midwife, Nyakuron PHCC	OVCi Nostra Famiglia

<b>Central Equatoria</b>		
Poppy Spens	Outgoing CMS Project manager, health	CMS Ireland
Jenny Bell	Incoming CMS Project manager, health	CMS Ireland
John Spens	CMS Project manager	CMS Ireland
Bero David	In-charge, Martha Clinic	CMS Ireland
Alex Taban Matthew and others	Vaccination team	CMS Ireland
Abuyi Simon Costa	CO, Ophthalmology	CMS Ireland
Roba Jerisa	Community Midwife	CMS Ireland
Chandiga Nelson	Administrator	CMS Ireland
Khemis Martin, James Malish Salome	CHW, CO and Midwife	members of outreach team Goja Village
Ezra Kenyi Misaka	Chairperson	Goja Community
Tabatha Buheitel	Visiting health educator	Goja Community
Various	Members of the Village Health Committee and community education class	Goja Community
Cons Guya	Administrator	Yei River CHD
	Education Director & Schools Inspector	County Education Department, Mundri
	Principal	KITE
	Director of Initial Teacher Education	KITE
Light Wilson Aganwa	Executive Director	MRDA
Remijo Amule	BSF Project Manager	MRDA
Ben Bataringaya	Programme Manager	ZOA
Michael Kamya	Project Manager, Community Development	ZOA
Emmanuel Maluk	Payam Director	Tali
	Principal	YTTC
Susan Voga	Senior lecturer in education	YTTC
Simone	Lecturer in education	YTTC
Samuel Taban Khamis	SSRRC Secretary, Water in Charge	Tali
Alala Santo Peter	Program Coordinator	Tali Youth Association
Benea Bero Lado	Acting Commissioner of Rural Water County Water Technician	Terekeka County
Adon Likinu		Tereka Payam
Willie Kiarie	Education Program Manager	CRS
Linos Wafula	Team Leader (Drilling Team)	CRS
Justus Mutuku	Hydrogeology Officer	CRS
Suwatang Benea	Water quality technician	CRS
Masaura Tikpo	Education Officer	CRS
Malish Joseph	Community Development Officer	CRS
Nijara Fred Julius	Construction technician	CRS
<b>WBEG</b>		
Sebit Veterino Rabat	Director of Water Supply	Directorate of Water & Sanitation, WBEG
Ben Cutner	Programme Manager WatSan Infrastructure	ACTED
Hygiene Promotion Team		SAWASAWA
	County Education Director	County Education

		Department, WBEG
	State Minister of Education	MoE, WBEG
Wenceslas Emongor	Education Project Manager	HARD
Peter Gar	Education Project Manager	HARD
<b>Warrap</b>		
Pierluigi Sinibaldi	Field Manager	Intermon Oxfam
Evarest Ochola	Watsan Officer	Intermon Oxfam
Camilla Marks	Public Health Promotion Officer	Intermon Oxfam
Oliver Mou Thikk	Acting Director	County Water Department, Gogrial East
<b>NBEG</b>		
Abraham Aleu	Director for Water and Sanitation	State Water Department
Paul Anei	Assistant Commissioner for RWSS	Aweil East
Akile Michael	Program Manager	ACF-USA
Michael Duku	WASH Project Officer	ACF-USA
Lucy Ellis	Head of Base, Maluakon	ACF-USA
Tom Otieno	BSF Project Manager / Programme Manager	UMCOR

## Appendix 5: Itinerary

### Itinerary - Monday 14 March-Friday 1 April 2011

Mission members: Mr Jeremy Ockelford (WES); Mr Thomas Power (PE);

Mr Richard Johnson (PH); Mr Charles Chol (MOFEP)

Day nr	Day	Date	Place	Activity
	Fri	11		Literature review (BSF website etc)
	Sat	12		Literature review (BSF website etc)
	Sun	13		Travel to Juba, Southern Sudan
1	Mon	14	Juba	UNICEF, SSWICH, MOFEP Briefing BSF secretariat
2	Tues	15	Juba	WASH Cluster, MoH, MRWI NGO Forum Primary Education, NGO Forum Primary Health
3	Wed	16	Juba	NGO Forum WES, DFID, LATH, MOH, JDO
			Juba	Team A Health Richard Johnson & Charles Chol Eastern and Central Equatoria
				Team B Tom Power, Education Jeremy Ockelford, WASH Central Equatoria, Western Bahr el Ghazal, Warrap and Northern Bahr el Ghazal
4	Thurs	17	Magwi	Magwi CHD, Magwi Town PHCC.
				Kator, Juba Mundri West
				PSI and Kator Payam Office MRDA schools, KITE and CED Mundri
5	Fri	18	Torit	Merlin, CDoT, NPA, Hyala PHCC and Life Skill Centre
				Yei
				Tali
				ZOA/Compass/TAYA, Payam Water Department
6	Sat	19	Isohe	AVSI/St Theresa PHCC
				Terekeka
				CRS, CWD
7	Sun	20	Isohe	AVSI
				Juba
8	Mon	21	Isohe (Ikotos)	Chahare PHCU, Lobira PHCU, St Theresa PHCC
				Wau Jur River
				State MoE, CED WTI, HARD
				Wau Jur River
				State MPI, CWD ACTED
9	Tues	22	Torit	SMoH, Torit CHD
				Jur River
				HARD
				Gogrial West
				Intermon Oxfam, CWD
10	Wed	23	Juba	OVCI, Ustratuna PHCC, Nyakuron PHCC.
				Acumcum, Wau, Awiel
				HARD, Atido School ISTT and Udici School

11	Thurs	24	Yei	CMS Ireland, Martha PHCC, Goja Mobile Clinic	Awiel Awiel North	State MoE, UMCOR/Windle	Awiel Awiel East	State MPI ACF
12	Fri	25	Yei	CHD Yei	Travel Awiel to Juba			
			Juba	BSF				
13	Sat	26	Juba	Share findings				
14	Sun	27	Juba	Draft presentation and report				
15	Mon	28	Juba	Draft presentation and report				
16	Tues	29	Juba	Education Steering Subcommittee Debriefing DfID Debriefing Health Steering Subcommittee Debriefing WASH Steering Subcommittee Debriefing				
17	Wed	30	Juba	Steering Committee Debriefing NGO forum Debriefing				
18	Thurs	31	Juba	Draft report				
19	Fri	1	Juba	Complete and submit draft report Depart Juba				
				Submit final report				