



# Completion Report

Southern Sudan: Fund Management of the Basic Services Fund  
Phase 2, 2009-2010

September 2010  
Department for International Development (DFID)



Ministerie van  
Buitenlandse Zaken





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# BSF Phase 2 Completion Report

# Content

<b>Chapter</b>	<b>Title</b>	<b>Page</b>
<b>1.</b>	<b>Introduction</b>	<b>1</b>
1.1	Introduction	1
1.2	This report	2
<b>2.</b>	<b>Review of Progress and Performance at Completion</b>	<b>3</b>
2.1	Policy & Programme context	3
2.1.1	CPA	3
2.1.2	Millennium Development Goals & Gender	3
2.1.3	Compact	4
2.1.4	Primary Education	4
2.1.5	Primary Health	6
2.1.6	WATSAN	7
2.2	Objectives achieved	8
2.3	Activities	9
2.3.1	Management Agent (Service Provider) and BSF Secretariat	9
2.3.2	Steering Committee	10
2.3.3	BSF-2 Grant Recipients	10
2.3.4	Training & Capacity Building	13
2.4	Resources and Budget	15
2.4.1	BSF-2 Financial envelop	15
2.4.2	Disbursement	15
2.4.3	Unit costs of construction	18
2.4.4	Assumptions & Risks status and Sustainability	20
<b>3.</b>	<b>Lessons Learnt</b>	<b>22</b>
3.1	Primary Education	22
3.2	Primary Health	23
3.3	Water and Sanitation	23
	Annex 1: Logistical Framework	25
	Annex 2: Grant Recipient Overview	31
	Annex 3: BSF-2 Disbursement Overview [GBP]	33
	Annex 4: BSF-2 Individual Project Summaries	35
	Annex 5: Cumulative Targets & Achievements (BSF-1,-2 and IA)	42
	Annex 6: Targets & Achievements Primary Education	43
	Annex 7: Target & Achievements Primary Health	45
	Annex 8: Targets & Achievements Drinking Water	47
	Annex 9: Targets & Achievements Sanitation	48
	Annex 10: Targets and Achievements Short Term Training per NGO	49
	Annex 11: Target & Achievements Short Term Training per Sector	50
	Annex 12: Targets & Achievements per Category Trainees	51
	Annex 13: Target & Achievements Long term Training Primary Education	52
	Annex 14: Targets & Achievements Long Term Training Primary Health	53
	Annex 15: Steering Committee Meetings	54
	Annex 16: Technical Assistance Planned and Actual	55
	Annex 17: Field Trips	56
	Annex 18: BSF Key Dates	58

## Tables

Table 1.1:	BSF contract dates and amounts	2
Table 2.1:	Total beneficiaries broken down by sector (excluding training)	9
Table 2.2:	National and International NGOs (NNGO and INGO) in BSF-2 as lead agent and consortium members	10
Table 2.3:	Teacher training in BSF-1 and BSF-2 (see also Annex 13)	13
Table 2.4:	BSF-2 Short-term training per sector	13
Table 2.5:	Average costs per classroom	18
Table 2.6:	Average unit costs per PHCU [GBP]	19

## Figures

Figure 2.1:	Basic timeline CPA	3
Figure 2.2:	Disbursement process for NGOs' monthly financial reports	15
Figure 2.3:	BSF-2 Finance allocation per sector	16
Figure 2.4:	BSF-2 Budget re-allocations	17
Figure 2.5:	Average construction costs per classroom	19
Figure 2.6:	Average costs per newly drilled borehole [GBP]	20
Figure 2.7:	GoSS budgets of line ministries (MoE, MoH and MRWI)	21

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# Summary & Recommendations

Project Name	Basic Services Fund of the Government of Southern Sudan - Phase 2
Grants	1 January 2009 - 30 June 2010
Project Authority	GoSS Steering Committee chaired by Ministry of Finance
DFID contribution	UK £ 9,001,450
Dutch Government contribution	UK £ 6,500,000
Norway Government contribution	UK £ 3,720,000
CIDA contribution	UK £ 3,900,000
TOTAL donors contribution	UK £ 23,121,450
Grant component	UK £ 21,554,792
Location	Southern Sudan
Management Consultant	BMB Mott MacDonald

The purpose of BSF is to increase the coverage, access and use of basic services in primary education, primary health and water & sanitation for the people of Southern Sudan.

This is done in a sustainable way and includes strengthening of communities and GoSS' (central, state and county level) capacity to plan, monitor and co-ordinate the services delivered by non-state actors. BSF's main aims are to establish operational primary schools, primary health care facilities, drinking water points and latrines in parallel to capacity building which includes training, such as that of teachers and health professionals. The management training of local beneficiary groups, county authorities, ensures that the access gained by one million six hundred thousand people (Phase 1 and 2 combined) will be maintained at minimum levels for the medium term.

BSF operates under the assumption that the CPA holds; this has been the case in spite of local security crises particularly in 2009. Other important assumptions are that the budgets of the relevant line ministries should include sufficient funds to provide free primary health care and free primary education. These assumptions have not held which has complicated NGO exit strategies.

At times during 2009 inter-ethnic and other violence escalated, became more intense and of a different nature than before. Women and children were often deliberately targeted. Several Grant recipients were directly affected by insecurity.

BSF Phase 2 lasted from 1 January 2009 till 31 August 2010 and was financed by DFID as lead donor, with additional contributions from the governments of the Netherlands, Norway (NMFA) and Canada (CIDA). As such the BSF evolved into a multi-donor pooled fund with the administration and management of the fund contracted out to a service provider. BSF's Steering Committee authorized a third call for proposals in order to allocate the available resources. Preparations for the third call took place during the period of September-December 2008. The managed funds for BSF Phase 2 totalled GBP 21,554,792. In total 25 lead NGOs received grants for basic service provision, with grants having duration of 18 months, from 1 January 2009 till 30 June 2010.

## Implementation in Primary Education

By the end of BSF-2, BSF grantees built in total 31 (192 classrooms) of the targeted 24 primary schools. This brings the cumulative total number of primary schools funded by BSF-1 and BSF-2 to 51 (352 classrooms) compared with the target of 45. In BSF-2, BSF grantees provided a total of 40 primary

## BSF Phase 2 Completion Report

schools with services (including furniture, learning materials, training and teachers' salaries) against a target of 63. The failure to meet this target is due in part to a general lack of school textbooks in Southern Sudan.

### Implementation in Primary Health

By the end of BSF-2, BSF grantees completed the construction of the 5 targeted PHCCs and 15 PHCUs. They provided a further 25 PHCCs and 66 PHCUs with services (including drugs, training, management support and complementary salaries where necessary). The number of recorded consultations is on the rise from 170,000 (rounded) in BSF-1 to 1 million in BSF-2. This rise reflects the increased number of facilities and services.

### Implementation in Water

By the end of BSF-2, BSF grantees drilled a total of 143 boreholes against the target of 138. All, but 6, drilled boreholes were completed with hand-pump and platform. In addition BSF grantees rehabilitated 184 boreholes compared with a target of 110. This brings the cumulative (BSF-1 and 2) number of new boreholes at 316 compared with the original target of 333. The cumulative number of rehabilitated boreholes is 232 against a target of 194. Numbers of users vary widely depending on season and population. In the absence of a better indicator one can use 500 users per boreholes (SPHERE handbook).

### Implementation in Sanitation

By the end of BSF-2, BSF grantees constructed 389 institutional latrines against a target of 234 and assisted in the construction of 2,312 (target 1,123) household latrines. This brings the cumulative institutional and household latrines for BSF-1 and 2 to 2,701, against a target of 1,357.

### Implementation in Training

Most of the long-term (longer than a month) training was for primary education teachers (1,293 in BSF-2). 83 (25 female) health workers benefitted from long-term training in primary health.

In short-term training (less than a month) 13,513 (47% female) people received training in the education sector (teachers, PTAs, etc). In health sector 14,241 (41% female) people received training (health staff, VHCs, etc). 17,885 persons (for 33,533 training days, 56% female) participated in training in water & sanitation and hygiene awareness (pump mechanics, water point committees, school hygiene and sanitation clubs, etc).

### Disbursement results

By the end of BSF-2 the total disbursement reached GBP 21m or 98% of the financial envelop. There are 3 main contributing factors to this record. Firstly: DFID and BMB MM adhered to the invoicing-in-arrears schedule (settling invoices within 30 days) which provided up-to-date information on the financial progress made with projects. Secondly: the intensive monitoring of the BSF Secretariat team who, with a team of 3 monitors did 70 field monitoring trips in 18 months or almost 4 trips per month, resulted in up-to-date information about the technical progress or the lack thereof. Thirdly: the labour intensive budget reviews that were initiated in the first quarter of 2010 re-allocated resources from those falling behind with their

## BSF Phase 2 Completion Report

targets in favour of those who were on or ahead of target, and who had room to take on additional activities.

### MDGs

It is a cause for concern that in Southern Sudan the MDGs seem to have lost their operational appeal in the sense that these goals are not quoted anymore in NGO proposals and main institutional stakeholders accept the outdated information on their progress. For example, in Southern Sudan the most recent information is in the 2006 SHHS. Maternal Mortality (MMR per 100,000 live births) in this report ranges from 1,732 in Unity State to 2,329 in Western Equatoria State, with an aggregated Southern Sudan MMR of 2,054. The 2006 SHHS used the sister-method; as a result these data actually apply for the decade prior to the survey.

### Steering Committee

The BSF SC met 7 times, or once per quarter, over BSF-2's 18 month duration. It provided oversight to the implementation and decided on new application guidelines and the selection of the new grant recipients. Its terms of reference were revised, mainly to include new Sector Sub-Committees, one for MoH, MoE and MRWI respectively.

### Closing Down

BSF's management consultant (MC) reserved two months for closing down the BSF-2 grants but experience in BSF-1 taught that this was too short because the audit reports take longer to complete and often cannot start before the end of the project. In BSF-1A the MC will implement a two phased audit: the first phase will take place after nine months and will be reported on in an accountant's draft management letter with recommendations if relevant. These can be implemented before the second phase of the audit that will produce the standard audit report.

### Internal and External Evaluation

A second external Mid-Term Review (MTR) of the BSF took place from 16-25 August 2009 (the first one took place in January 2008). The review concluded that the fund had contributed to improved access to basic services in Southern Sudan, by between 5 and 10% overall. It has piloted an efficient and speedy mechanism for commissioning and managing non-state service providers. Its M&E work is providing important lessons about all aspects of basic service provision. In these areas, most commentators suggest it stands significantly ahead of the other pooled funds.

The review furthermore concluded that BSF makes a useful, but largely decentralized, contribution to the capacity of the GoSS at state and county level. This capacity building has been significant in the states, especially where BSF partners worked to build a coalition with state ministries. BSF did less to build capacity centrally and until the establishment of the Sector Sub-Committees was seen to have partially failed to create a sense of ownership in the key line ministries. Despite that, it can offer a good base, probably the best available, for a more strategic programme to build GoSS capacity to "plan, monitor and coordinate service delivery by non-state actors", and to improve "accountability between non-state service providers and GoSS".

## BSF Phase 2 Completion Report

According to the MTR a more strategic, long-term approach to supporting and developing basic services is needed, so that they can be handed over successfully and sustainably, to GoSS and the state governments. BSF would offer a good basis in this hand over.

DFID's own Annual Review (period 1 June 2009 - 30 May 2010) for BSF took place (through an email exercise without field trips) in August 2010. The next MTR is now planned for March 2011 and the next Annual Review in May 2011.

### Lessons learnt & Recommendations

The BSF monitoring system is primarily based on Quarterly Progress Report formats, filled in by grant recipients. The indicators to be reported on are key indicators, identified by the respective line ministries, and have a linkage with respective MDGs. GoSS MoH, MoE and MRWI recommend to carefully watch the number of indicators and to be selective, with bias towards GoSS standards. As the GoSS ministries gradually develop their own M&E systems, the BSF reporting formats have been further developed during BSF Phase 2. In BSF-IA the reporting formats should progressively be incorporated into the databases of the relevant line ministries. For example, BSF has the capacity to assist in introducing the computerised DHIS (District Health Information System) that MoH has officially adopted and is expected to introduce to State-MoHs and CHDs.

#### **Primary Education:**

Despite improvements in education management by GoSS MoE since the start of the BSF, most notably the development of an operational electronic payroll system, NGOs still have an important role to play in the education sector in Southern Sudan. They often have the time and resources to oversee implementation that CEDs do not have. However as Southern Sudan moves away from the recovery phase further into a development phase, NGOs have a duty to push more operational work onto the CEDs, whilst simultaneously continuing to support them in such work in a "learning by assisted doing" approach to capacity building.

#### **Primary Health:**

One of BSF's main assumptions is that that the policies and GoSS budgets for primary health are coherent and consistent. But this has consistently proven not to be the case. The States have not been allocating funds to basic operational budgets of the County Health Departments, while the payment of salaries has been irregular and often delayed. Until these CHDs are budgeted and fully operational, the fate of health facilities that are handed-over will remain precarious. Therefore, NGOs continue to play an important role in the delivery of the basic package of health services in Southern Sudan.

#### **Water and Sanitation:**

The BSF Secretariat has gradually optimized the approach for monitoring progress of rural water supply implementation since its first round in 2007 following documenting of lessons learnt culminating in various procedures for water quality testing, drilling supervision, drilling preparations and reporting. All these procedures were initiated jointly with the Ministry of Water Resources and Irrigation. Field reports, geophysical survey reports, borehole drilling logs, and water quality reports need to be handed in at county, state and national and incorporated into the SSWICH database operated by the government. The BSF Secretariat has an important role to play to monitor the submission and the quality of the reports.

# 1. Introduction

## 1.1 Introduction

BSF's purpose is to increase the coverage, access and use of the population of Southern Sudan of primary education, primary health, and water & sanitation basic services in a sustainable way. This specifically includes the strengthening of the capacity of communities and the GoSS (mainly at County and State level) to plan, monitor and co-ordinate this service delivery by non-state actors. BSF is implemented through grants to non-state actors who can apply for grants in calls for proposals of which the fund has issued 4 so far, the first in 2005, the second in 2006, the third in 2008 and the fourth in 2010. The rationale behind this implementation model is the dominance of these non state actors in Basic Service delivery, which was created already during the civil war (Operation Lifeline Sudan). Over 80% of health services in South Sudan's rural areas are still NGO / FBO supported. This purpose is consistent with BSF's overall goal namely GoSS' poverty reduction agenda within the six year interim period of the CPA between the signing of the CPA in January 2005 and the end of the post-referendum period in July 2011.

Main stakeholders are the beneficiaries, members of the rural communities, with particular inclusion of vulnerable groups; such as women and children, IDPs and returnees. Stakeholders are also County, State and GoSS authorities of the Ministry of Health (MoH), the Ministry of Education (MoE) and the Ministry of Water Resources and Irrigation (MWRI) / Ministry of Physical Infrastructure (MoPI), local government, BSF's international donors, INGOs and NNGOs.

The Department for International Development of the UK was the main initiator of the BSF, seeing the fund as a bridging operation to deliver basic social services by non-state service providers while GoSS capacity to manage, finance and deliver social services was being built up. In 2005, DFID engaged the Nairobi based NGO "Skills for Southern Sudan", assisted by IDL (UK), to organize the first selection round in which 6 NGOs received grants. After an international competitive tender, DFID appointed BMB MM as grant manager of the fund in August 2006. For the first round of NGO projects, BMB MM took over all the contracts from DFID. During the fourth quarter of 2006, BMB MM organized the 2nd call for proposals that led to the selection of 8 additional BSF grant recipients who signed grant contracts with BMB MM in January 2007.

After several extensions, BSF's phase-1 lasted almost 3 years from 1<sup>st</sup> April 2006 to 31<sup>st</sup> December 2008. It issued a total of GBP 16,221,447 in grants to NGOs . Each grant was for a duration of initially 24 months (extensions were allowed for primary health). Initially, DFID saw BSF as a transitional fund to support basic services prior to a Multi Donor Trust Fund becoming operational. But MDTF, following complicated World Bank procurement procedures, has been slow in getting its investments in basic services off the ground and consequently GoSS and DFID decided to extend BSF in a second phase. Another contributing factor to this decision was the fact that MDTF's second window, the Sudan Recovery Fund, managed by UNDP, was also delayed in becoming operational.

## BSF Phase 2 Completion Report

DFID and the BSF's Steering Committee authorized a third call for proposals, during phase-2. Preparation for the third call took place during the period of September-December 2008. The third round was financed by DFID, as lead donor, with contributions by the governments of the Netherlands, Norway (NMFA) and Canada (CIDA), effectively making the BSF a pooled donor fund. Round-3 contracts had duration of 18 months, from 1 January 2009 till 30 June 2010. The managed funds for BSF phase -2 totalled GBP 21,554,792. During phase 2 of BSF, 25 lead NGOs received grants for basic service provision (see table 1.1 below).

Table 1.1: BSF contract dates and amounts

BSF Contract dates							
	Total Contract	Managed Funds	NGO contracts	Grant Dates		BMB contract	
	£	£	#	from	to	from	to
phase 1	17,984,643	16,221,447	14	1-04-2006	31-12-2008	19-8-2006	31-12-2008
phase 2	23,568,485	21,554,792	24	1-01-2009	31-06-2010	1-1-2009	31-8-2010
phase IA	40,205,835	37,529,543	38	1-07-2010	31.12.2011	1-3-2010	28-2-2012
Total	81,758,963	75,305,782	76				

BSF's main expected results are the establishment of operational primary schools, primary health clinics, drinking water points and latrines in parallel with capacity building, including training of teacher and health professionals and management training of local beneficiary groups, county authorities and the Steering Committee (SC), to ensure that the access gained by one million six hundred thousand people (Phase 1 and 2 combined) will be maintained at minimum levels for the medium term (see Logical Framework in Annex 1).

## 1.2 This report

This Completion report of BSF-2 has been written by the technical assistance team of BMB MM, BSF's Management Consultant (MC). The data on the NGOs' progress are based on narrative and financial progress reports, field monitoring reports by the MC, and peer review lessons learnt. The structure of the report is based on BSF's log frame with its deliverables (or expected results or outputs) as defined in the BSF Secretariat's Terms of Reference in its Project Memorandum.

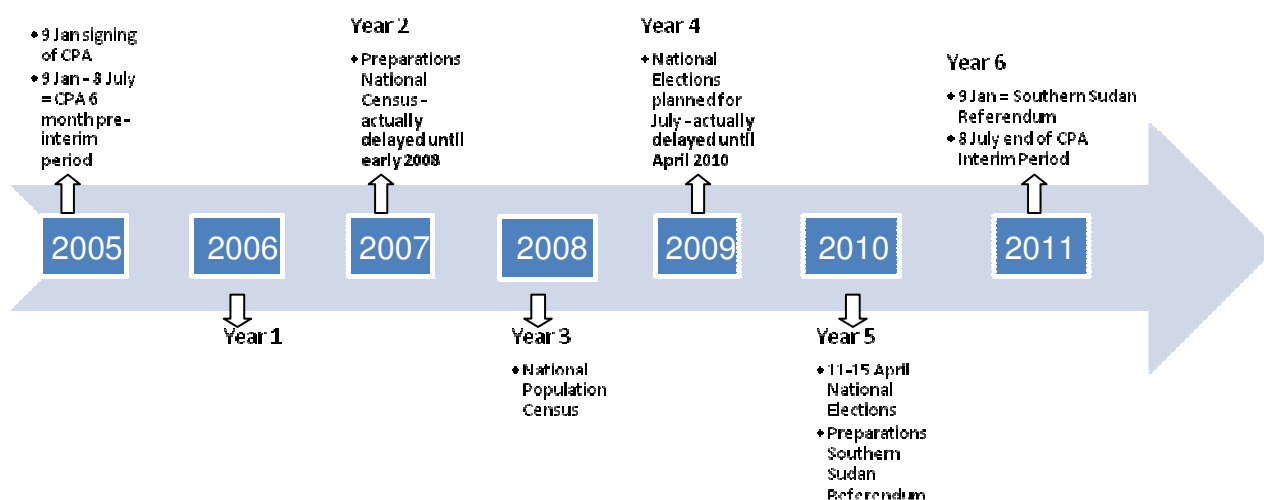
## 2. Review of Progress and Performance at Completion

### 2.1 Policy & Programme context

#### 2.1.1 CPA

BSF operates within the overall context of Sudan's Comprehensive Peace Agreement (CPA) and its 6 year Interim Period between 2005 and 2011, at the end of which a democratically elected government should be in place (Figure 2.1). One of the CPA's main milestones, the national elections, took place in April 2010. As part of the CPA and for the first time in 24 years the Sudanese people could cast their vote in a national election. Polling took place from Sunday 11 till Thursday 15 April 2010. Preparations for the next milestone, the Southern Sudan referendum on secession from or unity with northern Sudan on 9 January 2011, are ongoing but seriously delayed.

Figure 2.1: Basic timeline CPA



#### 2.1.2 Millennium Development Goals & Gender

The MDGs have 8 goals in total, as well as 18 targets that are tracked by 48 indicators. Seven of the 8 goals concern Basic Services (for example Goal 2: achieve universal primary education). Nine of the 18 targets concern Basic Services; for example Target 6: reduce by three quarters between 1990 and 2015 the maternal mortality rate. Of the total number of 48 Indicators, 23 concern Basic Services; for example, Indicator 30 "proportion of population with sustainable access to an improved water source, urban and rural". All BSF's grant recipients contribute to improve Southern Sudan's MDG status record, which remains among the lowest, if not the lowest, worldwide. Southern Sudan's maternal mortality is generally accepted as the highest in the world, with an MMR of 2054 per 100,000 (Southern Sudan Report on Sudan's Household Health Survey, 2006).

The most relevant MDG indicators for the BSF are:

- Nr.6 Net enrolment in primary education
- Nr 9 Ratio of girls to boys in primary education
- Nr.16 Maternal mortality rate
- Nr.17 Proportion of birth attended by skilled health personnel
- Nr.30 Proportion of population with sustainable access to improved water sources
- Nr.31 Proportion of population with sustainable access to improved sanitation
- Nr 34 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to Basic Social services (primary education, primary health, nutrition, water & sanitation).

BSF's gender approach is mainstreamed into basic services delivery and is therefore based on the MDGs. For example, primary school attendance and enrolment data are gender disaggregated, and increasing girls' access to education directly targeted (Indicator 9). BSF grantees and the MC work closely together to assure that no effort is too much to maximize participation of women and girls, notably in PTAs, Village Health Committees, Water Point Committees etc., in primary education and female participation in teacher training, health professional training etc.

It is a cause for concern that the MDGs seem to have lost their operational appeal in Southern Sudan, in the sense that these goals are not quoted anymore in NGO proposals, and that main institutional stakeholders accept the outdated information on their progress. For example, most recent information for Southern Sudan is derived from the 2006 SHHS. Data about Maternal Mortality Rates (MMR) relate to the decade prior to the survey, i.e. 1996-2006 (sister method).

### **2.1.3 Compact**

On June 30, 2009, in the wake of GoSS' 2009 budget crisis GoSS and its donor partners agreed on what is called the COMPACT protocol: a higher level of cooperation and commitment to accelerate progress in delivering peace dividends and improve the lives of the peoples of Southern Sudan in particular to enhance fiscal responsibility, strengthen public finance management systems, and accelerate private sector-led development with economic growth and poverty reduction. An automated and standard payroll system is part of GoSS's COMPACT commitment. Donors, among other commitments, will provide US\$ 600 per annum for the remaining years of the CPA Interim Period. The COMPACT text is published on BSF's website to assist GoSS and donors to disseminate agreed policies and assist in monitoring of the agreement.

### **2.1.4 Primary Education**

#### Terminology

Until the 2010 elections the entire education sector was headed by a single GoSS ministry, the Ministry of Education, Science and Technology (GoSS-MoEST). Following structural changes after the elections this has been split into two ministries at GoSS level: the Ministry of Education (GoSS-MoE) dealing with all pre-school, school and alternative level education, and the Ministry of Higher Education, Science, Research and Technology (GoSS-MoHERST) dealing with all tertiary level education and research. At State and County level the sector remains under the single structure of State Ministries of Education (SMoEs) and County Education Departments (CEDs). As BSF only funds basic education, BSF works with the GoSS-MoE at policy level.

## BSF Phase 2 Completion Report

### National budget

The education sector receives around 6% of the Southern Sudan national budget, proportionally far below its neighbouring countries with well-developed education sectors where the proportion is closer to 20%. As the security sector has been prioritised by GoSS during the Interim Period of the CPA receiving over 30% of the budget, it is unlikely that education will see a bigger slice of the national cake until the future of Southern Sudanese government is clear. Consequently the sector does not have the resources available to implement all required activities – payment of staff has been prioritized resulting in very little remainder for operations and capital investment – highlighting that NGOs and CBOs (and indirectly BSF through them) does still have a vital role to play in sustaining quality education in terms of training of teachers and establishment of physical infrastructure.

This is especially true as the GoSS-MoE currently operates in the absence of a legislative framework due to delays in process of the draft 2008 Southern Sudan Education Act, which has still not been passed.

### Payroll and sustainability

GoSS-MoEST was the first ministry to benefit from a new electronic payroll system introduced towards the end of 2008, which has resulted in education having arguably the best developed payroll system in GoSS – a fact reflected by the decision during the 2010 Budget Sector Working Group (BSWG) process to allocate sufficient resources to pay all registered teachers in all states at full salary grade from 2011.

Whilst in practice the different State Ministries of Education (SMoEs) are at different stages of development in terms of teacher management and payroll – i.e. not all teaching teachers are yet paid accurately and on time everywhere – the top prioritization of teachers' salaries demonstrates a level of sustainability in the education sector that is unmatched in the health and water sectors.

This has led BSF to progressively scale-down its payment of teachers through NGOs, and to increase BSF grant recipients working more closely with SMoEs and CEDs to ensure that BSF supported schools are staffed by registered, paid teachers. However, in some states – notably Central Equatoria – affordability problems have led to large-scale downsizing of teacher numbers (for example Lainya County now has only 45 registered teachers with Terekeka County on 24), meaning that immediate recruitment and training of new school staff is vital for continued sustainability of quality education.

### Teacher Training

Whilst the MDTF Education Rehabilitation Programme (ERP) has allocated funds for training of over 2000 teachers, both currently teaching and newly recruited in both pre-service and in-service programmes, this was still in the planning stages throughout BSF-2, meaning that BSF funded trainings using GoSS in-service curriculum (World Relief/ECS) and pre-service course (CMS Ireland/Yei Teacher Training College) were all the more necessary and will continue to be in the near future.

Arapi TTI in Magwi County, Eastern Equatoria State is the only GoSS run TTI that is widely recognised as fully operational and this with NPA support. National TTIs in Malakal, Aramweer and Maridi are planned to get large-scale investment and capacity support with MDTF ERP funding from September 2010, but are not yet properly operational.

The development of training materials has been ongoing, with significant support from JICA through the SMASESS project, though the later stages of the full in-service course and the accreditation of the qualifications of the pre-service course remain to be put in place by GoSS-MoE.

### School Construction

Whilst the MDTF ERP has allocated funds for the construction of 100 full schools across Southern Sudan, this has not materialised as multiple problems with planning, contracting and GoSS level oversight have stalled the process. BSF-2's contribution to school infrastructure at far more efficient unit cost than ERP has therefore been all the more significant, often investing through Sudanese construction firms (HARD in particular) with excellent local knowledge and reduced overhead when compared to large foreign firms used by ERP and others. USAID is looking to invest bilaterally in construction and is carrying out preparatory square metre unit cost surveys to ensure better value for money.

### Education Management Information System (EMIS)

GoSS-MoE has now developed a comprehensive school database, EMIS, with reliable data from the 2009 School Survey. However, several gaps still remain such as a lack of reliable GPS co-ordinates for pinpointing and mapping of schools, as well as no standard GoSS School Register template which leads to unreliable school enrolment and attendance figures. Several BSF NGOs (OXFAM Novib/MRDA in particular) continue to lead the way in both areas, and the BSF Secretariat is engaged in on-going data sharing with EMIS.

#### **2.1.5 Primary Health**

The MoH targets effective access to PHC facilities and services, offering an agreed 'Basic Package of Health Services', by at least 50% of the population. The key element in this BPHS is well-functioning Primary Health Care Units (PHCUs) serving a population of 15,000, and Primary Health Care Centres (PHCCs), serving a population of 50,000.

BSF grant recipients ideally aim to support at least 50% of PHC facilities in the Counties they work in. Coordinated planning and implementation with and between all main funding mechanisms is strongly emphasized by the MoH-GoSS, to ensure equitable and cost/efficient health service delivery. Other main funding sources, besides BSF, with a CPA-bounded timeline, have been the MDTF - Umbrella Health Programme, and the USAID funded Sudan Health Transformation Project. In practise, the initial claim of the MDTF-UHP support to PHC delivery has not been met, with services reaching only 3 out of 10 States by 2010, and with an effective capacity support that is inadequate to meet major needs for health facilities' construction – rehabilitation, drugs and medical material deliveries, supplementary support to MoH payroll of health staff and in-service and formal health training in supported Counties.

The USAID funded SHTP, managed since May 2009 by MSH, is largely complementary to BSF, with a good coordination ensuring avoidance of duplication and exchange of key health information. SHTP has a much more prescribed mandate than BSF, which excludes the payment of incentives to (MoH supported) health staff and delivery of additional drugs to MoH basic drugs kits.

While the key services standards of the MoH-GoSS are spelled out in the BPHS documents (final draft January 2009), key indicators linked to the most prioritized health activities have been only gradually developed. The Liverpool Associates of Tropical Health (LATH) firm has been supporting the MoH in

strategic development, including formulation of key indicators and the development of M&E tools, costing of health plans, health training assessments etc. BSF has been a source of information in this capacity support.

Informed by the Draft Constitution of Southern Sudan, all people have the right of access to free health services. The MoH-GoSS reinforces this, although in practise many health facilities have various hidden and sometimes open, users' fees or other inhibitions to free access. BSF has been informing grant recipients on MoH policies in this. There is considerable scope, on the other hand, for community-based contributions to health facilities e.g. community participation during the construction of buildings. Active Boma Health Committees are a critical factor in this, reflecting on the amount and quality of these committee members. There is scope for the introduction of forms of Performance-Based Financing in health care in south Sudan, but this is not much explored yet. Intensive community awareness about its merits, and engagement of e.g. Boma Health Committees in monitoring performance is required, again reflecting on quality of training of Village/Boma Health Committees.

### **2.1.6 WATSAN**

In July 2010, only 21% of the 2010 budget for the Ministry of Water Resources and Irrigation was used, 11% (150,000 SDG) of the 'Coordination, policy regulation, strategy formulation' budget line, 10% (275,000 SDG) of the 'Resource mapping assessment, feasibility studies and research' budget line, 3% of the 'Construction, rehabilitation and installation of water and sanitation services' budget line was spend (less than 1 million SDG) and 9% (230,000 SDG) on the 'Operation and maintenance of water and sanitation facilities' budget line. Many targets as set in the Budget Sector Working Plans were not achieved due to slow budget implementation procedures and the lack of a procurement plan. The challenges in the above mentioned sectors (and budget lines) are described in the following paragraphs.

#### [Coordination, policy regulation, strategy formulation](#)

The Ministry of Water Resources and Irrigation (MWRI) was established in 2005 and has since then developed the first Water Policy of the Government of Southern Sudan and developed manuals and guidelines have been developed for fourteen different water and sanitation facilities.

However, one of the main challenges for smooth implementation of water and sanitation service delivery are associated with the lack of a Water Act and Rural Water Supply and Sanitation Strategies. The ministry started in 2010 with the development of water and sanitation strategies in partnership with UNICEF through funds from the Netherlands Government. The first draft framework for both rural and urban water and sanitation strategies will be completed by December 2010. Part of the strategy will be state based development and investment plans. The official dissemination of Water and Sanitation Strategies is planned to take place in 2012-2013.

#### [Resource mapping and assessment](#)

The absence of a functioning water point database, hydrological and geological maps does not support the sector to plan effectively for comprehensive water provision. The Southern Sudan Water Information Clearing House, funded through UNICEF and UNECA which has already been under development for several years is, however, still not functioning and an assessment will take place under current MDTF Phase II. One water points inventory to enrich knowledge on status of water points' functionality was

## BSF Phase 2 Completion Report

carried out early this year in Eastern Equatoria State. More inventories are planned and budgeted for in 2011. New geological maps are under preparation under MDTF – Phase 2.

### Construction, rehabilitation and installation of water and sanitation services

Main actors in the rural areas are the following development partners: UNICEF, MDTF, EU (ECHO), Netherlands Government (through UNICEF) and the Egyptian Government.

### Operation and maintenance of water and sanitation facilities

For rural water and sanitation, state and county levels of government have responsibility for planning and managing service provision. During 2010, ten technicians were deployed in the ten state of Southern Sudan to monitor the delivery of rural water supply and sanitation interventions. These monitors joined during WATSAN field visits in 2010.

In the rural areas boreholes are owned by the community and therefore operation and maintenance costs should be financed by the community. However, the main concern is the borehole spare parts supply chain, which is in most states, although supported by UNICEF, non-functioning.

## 2.2 Objectives achieved

The purpose of the Basic Services Fund of the Government of Southern Sudan (BSF) 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 GoSS capacity to plan, monitor and co-ordinate this service delivery by non-state actors.

This purpose is consistent with BSF's goal namely GoSS' poverty reduction agenda within the six year interim period of the CPA (2005-2011). 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 the SC, to ensure that the access gained by one million six hundred thousand people (Phase 1 and 2 combined) will be maintained at minimum levels to assure medium-term sustainability.

In primary health there are two ways to measure numbers of beneficiaries: firstly to use consultations as recorded in the health facilities and secondly to use the planned capacity, as set by MoH in its BPHS norms, of the Primary Health Centre, which is a population of fifty thousand, and of the Primary Health Unit, a population of fifteen thousand. These capacity population figures are relevant for planning but do not give a good picture of the actual use of the facility. That is why BSF from now on will use the number of consultations, in line with MoH core indicators. This reduces the overall number of beneficiaries in primary health to 1.3m (rounded). Previous estimates, based on the capacity population were much higher.

In primary education, there is also more than one way to measure the number of pupils: firstly to use the capacity of 50 pupils per classroom and secondly to use enrolment and attendance. BSF's grantees are now requested to record and report enrolment and attendance which reached 50,000 (rounded) by the end of Round 3.

In Water and Sanitation 500 beneficiaries per borehole (according to SPHERE handbook) are used for the calculations, assuming that people use 15 litres per person a day and the hand pump has a maximum

discharge of 700 litres per hour. In reality however the number of users varies widely during the seasons. In the absence of a better indicator, the above mentioned SPHERE handbook indicator is used.

For the latrines, the beneficiaries for a household latrine are estimated at 5 persons as the average size of a household in Southern Sudan. For institutional latrines 40 beneficiaries per latrine stance is used, in line with the standards given in the SPHERE handbook.

For all three sectors combined this brings the total number of beneficiaries reached to 1.6m (Table 2.1).

Table 2.1: Total beneficiaries broken down by sector (excluding training)

Sector	BSF-1	BSF-2	Total
Primary Education	26,800	25,600	52,400
Primary Health	168,665	1,093,625	1,262,290
Drinking Water	109,500	163,500	273,000
Latrines	6,015	27,120	33,135
Total	310,980	1,309,845	1,620,825

Legend:

In primary education the indicator used is school enrolment

In primary health the indicator used is recorded consultations

In drinking water the indicator is based on the SPHERE standard of 500 beneficiaries per borehole

In sanitation, the indicator used is 5 persons per household latrine and 40 persons/stance for institutional latrines.

## 2.3 Activities

### 2.3.1 Management Agent (Service Provider) and BSF Secretariat

BSF's day to day operation is the responsibility of the BSF Secretariat in Juba that is staffed with technical assistance (TA) from BMB Mott MacDonald (Arnhem, Netherlands, who is DFID's appointed BSF's Management Agent or Service provider (Annex 16). The Secretariat has 6 main responsibilities:

- Support and supervision of BSF grant recipients in implementation (monitoring, coaching, advice);
- Assist in financial reporting (completeness and correctness, transparency, timeliness)
- Assure timely disbursement
- Serve as secretariat for the Steering Committee;
- M&E GoSS contributions in terms of policy, staffing and salaries (policy and actual);
- Assure effective coordination with other stakeholders, donors (UN, NGO Forum, NGO Health Forum, donor consultations for primary education, water & sanitation and primary health).

A number of senior consultants, notably BSF's Project Director, the Project Controller and the database expert are based at BMB MM's headquarters in Arnhem, Netherlands (Annex 16). Phase 2's TA budget is 3,002 work-days, of which a total of 2,928 days or 97.5% were used up in BSF-2. Of the eight long-term positions only the Financial Manager was replaced and the rest of the team served the whole phase.

### 2.3.2 Steering Committee

In this second phase BSF's Steering Committee met as scheduled four times in 2009 and four times in 2010 (Annex 15). The SC adopted a new version of its Terms of Reference that updated its membership and included Sector Sub-Committees for primary education, primary health and WATSAN. This new terms of reference is available on BSF's website.

### 2.3.3 BSF-2 Grant Recipients

Of the fourteen grant recipients of BSF's 1<sup>st</sup> (6) and 2<sup>nd</sup> Round (8), 6 (Caritas, OXFAM GB, SC-UK, HASS, IRC and World Relief) closed down and all 8 grant recipients in primary health received a cost-extension into BSF-2 (AMREF, CCM, OVCI, Merlin, GOAL, Medair, Tearfund and SC-US). In quarter 4 of 2008, BMB-MM organised a third call for proposals. In December 2008, the SC selected 11 NGOs for Round 3a funding and 5 for Round 3b ( "b" started 3 months later on 1 April 2009 due to the fact that DFID's delegated agreement with CIDA was signed at a later date (Annex 2). Short project summaries are included in Annex 4.

In BSF-1 and -2 together a cumulative total of 26 out of the 31 contracts were made with International NGOs as lead agent. In these 31 contracts 25 NNGOs (National NGO) participated as members of a consortium. The strategy is to maximize the participation, either as lead agent or consortium partners, of national NGOs to support civil society development, a key strategy to enhance sustainability of services (Table 2.2).

Table 2.2: National and International NGOs (NNGO and INGO) in BSF-2 as lead agent and consortium members

	Total contracts	Lead agent INGO	Lead agent NNGO	Consortium member INGO	Consortium member NNGO
BSF-1 Round 1	6	6			7
BSF-1 Round 2	8	7	1	4	6
BSF-2 Round 3a	11	9	2		8
BSF-2 Round 3b	5	4	1	1	4
Subtotal	30	26	4	5	25
BSF-IA Round 4a	32	30	2	1	23
BSF-IA Round 4b	6	6		1	4
Subtotal	38	36	2	2	27
Totals	68	62	6	7	52

### Capacity Building of Local NGOs

BSF-2 included in total 16 grants contracts with Lead Agents. Thirteen were with International NGO and 3 with National NGOs. There were in total 13 consortium members and of those 12 were National NGOs. The most ideal situation is that an International NGO builds the organisational and technical capacity of a National NGO, based on clear agreements and with a longer term commitment. The establishment of finance and administrative systems is a key area, in practise. Some good examples of successful international – national NGO partnerships; are Christian Aid – HARD, OXFAM Novib – MRDA, and ZOA Refugee Care - COMPASS. In all these cases, targeted capacity building has been provided to the local

## BSF Phase 2 Completion Report

NGOs for 6 to 10 years, resulting in mature and mutually accountable inter-NGO relationships and the basic capacity of Sudanese NGOs to implement complex projects.

### Primary Education (Annex 5 & 6)

Education sector achievements of BSF Round 3 as at 30 June 2010:

- 31 new schools had been completed against a target of 24
- 40 schools received services like books, comfort kits for girls, furniture, blackboards, teacher training and management support
- Enrolment increased from 14,800 (36% girls) in the 1st quarter of 2010 to 17,600 (also 36% girls) in the 2nd quarter
- Attendance fell from 9,200 (30% girls) to 6,600 (33% girls) across the same period. Figures probably reflect a usual drop in attendance during the wet season compounded by WFP FFE downscaling and a lack of good reporting on attendance.
- 6 against 2 targeted teachers are in pre-service teacher training
- 1463 (over the targeted 1060) teachers completed in-service training; of these 242 are female
- 79 (over the targeted 67) teachers received English Language Training
- 644 (36 female) head teachers completed short term training courses
- 2066 (1100 female) teachers completed various short term training courses – the figures show better inclusion of women in shorter, more informal trainings.
- 1001 (320 female) PTA members participated in training

Notable performances in the Education sector, BSF Round 3:

- Catholic Diocese of Rumbek: completed all planned construction work above target despite insecurity problems which hampered work until April 2010
- OXFAM Novib / MRDA: completed extra classrooms with a budget increase on time to exceed their target.
- CMS Ireland / ECS Diocese of Yei: completed extra classrooms with a budget increase on time to far exceed their target (196% implementation rate).
- HARD: completed pilot additions with a budget increase to schools to improve gender-friendliness and teacher retention on time.

### Primary Health (Annex 5 & 7)

- 22 County Health Departments were supported, at least 10 with significant organisational capacity building support.
- Notable examples of Counties with successful organisational capacity building of CHDs, with training etc. are Aweil West (CONCERN), Fashoda (Tearfund), Juba (OVCI).
- Four PHCCs (target 5) and 16 PHCUs (target 12) were built or extensively rehabilitated.
- Health services delivery has been carried on in 27 PHCCs and 84 PHCUs.

Implementation of health programmes by grant recipients has been particularly constrained in the case of:

- Akobo, Jonglei State (IMC): Security and accessibility constraints compounded by inadequate NGO management.
- Duk, Jonglei State (IRD): Security and accessibility constraints compounded by inadequate NGO management.
- Mayendit, Unity State (Swiss Red Cross): Delayed implementation due to prioritization of other funds and inadequate management; however improvement made in June-July 2010.

## BSF Phase 2 Completion Report

- Torit and Lapon, EES (Merlin): Much delayed implementation due to inadequate management (until Sept. 2009), thereafter great improvement.
- Terekeka, CES (AMREF): Delayed implementation and clinical quality concerns.

### WATSAN (Annex 5, 8 and 9)

#### Sector achievements:

- New water points: 143 (target 138): 104%. All, except for 6, boreholes are installed with hand pump and platform. At all new established water points in the communities, water point committees were established and trained. Pump mechanics were trained and given access to a tool kit (and in most cases provided with a fast moving spare parts kit).
- Rehab / repair water points: 184 (target 110): 167%. In reporting no distinction is made between repair and rehabilitation of boreholes. Rehabilitation should include a new platform, new pump, rods, and cylinder, etc and flushing of the borehole. In the new phase of BSF (BSF-IA) grant recipients will have to report on rehabilitation and repair differently. At the rehabilitated boreholes the water point committees received refresher training or were newly established.
- Institutional latrines: 389 (target 274): 142%. These are latrines at schools and health facilities. No public latrines were constructed as maintenance of these latrines is often a problem. In the case that latrines were constructed at schools, school hygiene clubs were also established and trained in hygiene promotion and maintenance.
- Household latrines: 2,312 (target 1,123): 206%. The target was only exceeded during the last reporting period, which shows that hygiene promotion only had effect after a year as it takes a long time for people to change their behaviour. Most latrines were constructed in Raga and Mabaan (Intermon OXFAM), Longuechok and Mathaing (OXFAM GB) counties were using a well structured and developed hygiene promotion methodology.
- 17,855 (57% female, 26% children) people reached with hygiene messages
- 1,498 (48% female) members of water committees trained in operation and maintenance of water points
- 430 (13% female) pump mechanics / care takers trained in minor and major repairs of boreholes
- 4 Public Health Technicians received long-term training

#### Notable performances in the WATSAN sector, BSF Round 3:

- UMCOR: managed to drill 10 instead of 4 boreholes (with some extra funding)
- Swiss Red Cross / Sudanese Red Crescent Society: were very behind in implementation due to management problems at both local (Bentiu) and national (Khartoum) level. However managed in the end to achieve the main targets and on top repaired another 23 water points above target.
- Intermon OXFAM and OXFAM GB caused the overall BSF-2 targets for household latrines to be exceeded by 200% due to strong hygiene awareness raising campaigns and hygiene promotion methodology.
- AMA: Suffered management issues and was therefore seriously behind on implementation. After close monitoring and several implementation planning meetings with the BSF secretariat, managed to drill 47 out of the targeted 48 boreholes. However, 6 boreholes still need a platform, 5 water committees need to be trained and approximately 23 of the boreholes still need water quality testing. At the time of writing the BSF Secretariat is still following up.

### Reasons for bottlenecks and budget re-allocations in all sectors

- Insecurity in the area of operations – e.g. DoR affected by violence in Warrap State in March 2010.
- Overstretched NGO management – esp. given 18 month grant period; esp. in multi-state programmes.
- Multi-funded projects, where more emphasis is given by the NGO to a donor other than BSF.
- Changes in circumstances on the ground from during the planning period required scaling down of activities.
- Six grant recipients also had implementation delays due to inadequate management. The BSF Secretariat intensified monitoring regimes with supportive technical advice for these grant recipients and this resulted in all but one case in improved management performance and implementation quality.

### 2.3.4 Training & Capacity Building

Most of the long-term (longer than a month) training was for primary education teachers (1,293 in BSF-2). 83 (25 female) health workers benefitted from long-term training in primary health (Table 2.3 and Annex 13). This reflects the low quality and coordination in health training facilities (*Mark Beesly 2010* for LATH) and also the fact that medical professional training often last longer than the grant period of 18 months.

Table 2.3: Teacher training in BSF-1 and BSF-2 (see also Annex 13)

Type of teacher training	BSF-1		BSF-2		Totals	
	Total	Female	Total	Female	Totals	Female
Pre-school			6	4	6	4
In-service	812	170	1248	192	2060	362
English language			39	19	79	19
Total	812	170	1293	215	2145	385

In WATSAN short-term training (less than a month) 17,885 persons (for 33,533 training days) participated in training in water & sanitation and hygiene awareness (Table 2.4). Fifty percent of the participants were female. Among those were 430 (11% female) pump mechanics, 1,498 (48% female) members of water point committees and 4,233 (57% female) members of school hygiene and sanitation clubs (Annex 12).

Table 2.4: BSF-2 Short-term training per sector

Sector	Participants			Training Days		
	Total	Female	% Female	Total	Female	% Female
Capacity Building - general	3079	1084	35	10678	3106	29
Primary Education	13513	6380	47	78790	31167	40
Primary Health	14241	5954	42	35760	15315	43
Water and Sanitation	17855	10133	57	33533	16566	49
Grand total	48688	23551	48	158761	66154	42

BSF-2 produced a special report on capacity building. This analysis concluded that the emphasis of BSF's efforts in this respect are with the state and county level government departments and that this is consistent with GoSS' policy for decentralization and devolution. Since "capacity building is more often than not used in a generic sense", BSF coined a definition for capacity building's relevance for BSF, as follows:

*"A package of interventions develops institutional, organizational and financial capacities of institution, to achieve its purpose in a sustainable way and as efficiently and effectively as possible."*

In BSF's context relevant organizations firstly governmental departments (county, state and central in that order of priority) but also secondly national civil society organizations, working to deliver basic services to the population, in particular relating to primary health, primary education and water & sanitation.

Institutional capacity building: Strengthen an organization within the context of its external relations.

Organizational capacity building: strengthen an organization within the context of its internal organizational development.

Key elements of capacity building are:

1. Training, both in the form of formal (longer term) and informal (often short term) training courses and programs;
2. Informal learning processes within an organization; such as coaching, mentoring, exchange learning and on-the-job training;
3. Provision of key information materials to an organization; such as (hard and soft copied) information, networking support, communication;
4. Management support; This can include but is not limited to strategic planning, financial management, Human Resources management, logistics management etc.;
5. Material and budgetary support to an organization, aimed specifically at organizational and institutional capacity development can be qualified as capacity building; computers, office equipment, basic transport facilities etc.

For example: The ongoing support (with financial assistance from CBTF, Southern Sudan's Capacity Building Trust Fund) for the development of payroll systems for GoSS-MoE and GoSS-MoH is a good example of capacity building: it has one clear objective namely a operational payroll system, it includes managerial and technical support and it also includes formal and on-the-job training.

## 2.4 Resources and Budget

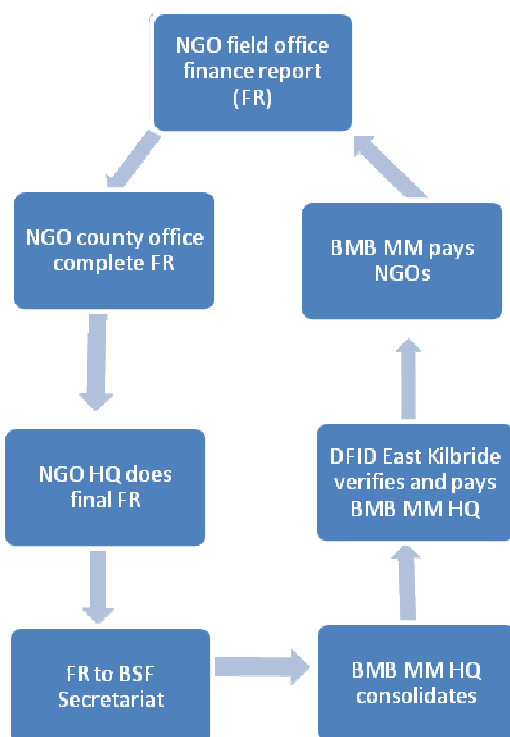
### 2.4.1 BSF-2 Financial envelop

BSF-2's total grant component is £ 21,554,792 with DFID as lead donor (£ 9,001,450). DFID signed "delegated cooperation agreements" for contributions to BSF-2 with the governments of Canada (£ 3,900,000), Norway (£ 3,720,000) and The Netherlands (£ 6,500,000). A total of £ 6M was reserved for extension of 8 BSF-1 contracts in Primary Health. For BSF-2 BMB MM signed in total 24 (8 + 16) new grant contracts all with a value of minimum £300,000 and maximum £1,500,000 (Annex 2).

### 2.4.2 Disbursement

The same disbursement method as in BSF-1 applied for BSF-2. In other words the grants are disbursed "in-arrears". In BSF-2 BMB MM streamlined the system with monthly deadlines for submission of the monthly financial reports to assure the shortest delay in payment to the NGO. BMB MM aims at doing the payment 4 weeks after approving the monthly report (Figure 2.2). The grant recipient emails their monthly financial report supported by the individual transaction list to the BSF Secretariat who, after checking, forwards it to BSF's controller in BMB MM head quarters where the reports are consolidated and forwarded to DFID's East Kilbride office in the UK. Based on the electronic copies of the financial reports DFID pays out to BMB who in turn reimburses the grant recipient (for the record hard copies follow at a later date).

Figure 2.2: Disbursement process for NGOs' monthly financial reports

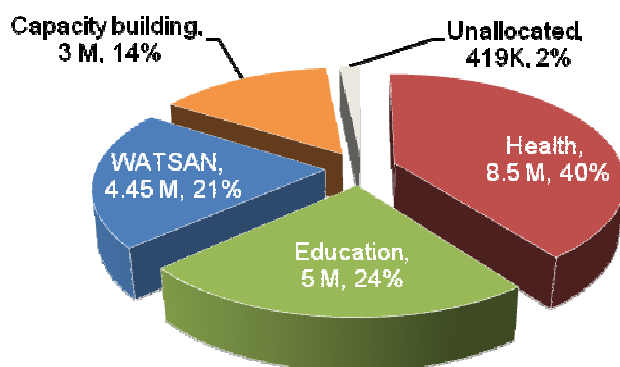


## BSF Phase 2 Completion Report

Overall disbursement reached 98% in line with the implementation record (Annex 3). By 30 September 2010 two grant recipients still have their last payment blocked (World Vision and AMA). These amounts will be cleared for payment once BMB MM receives the audit reports and has approved the audit reports.

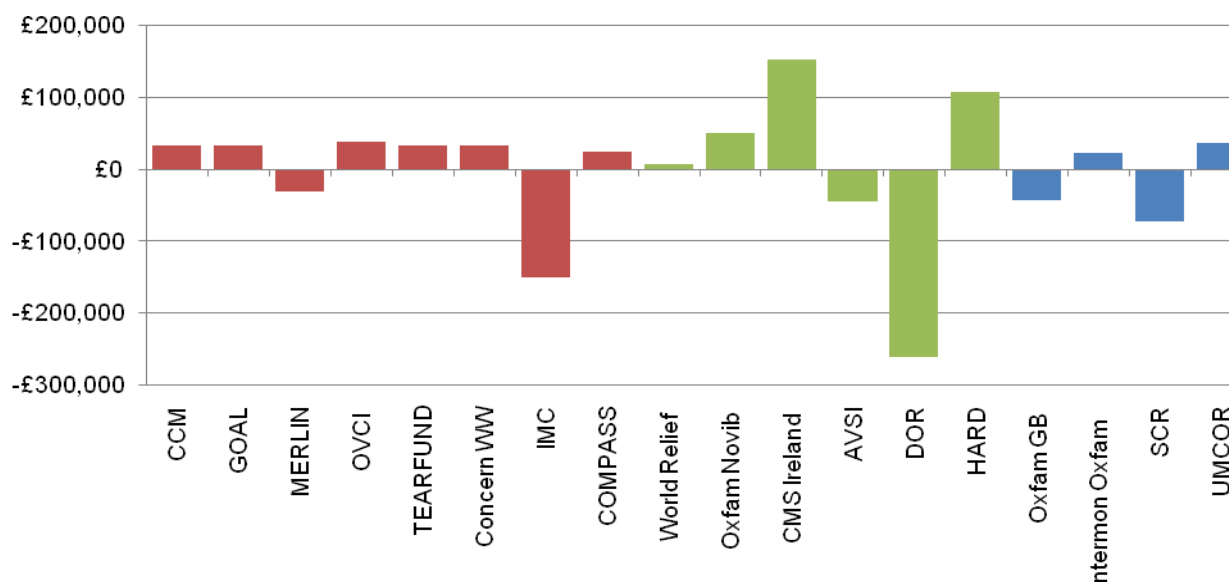
In the allocation per sector primary health took 40%, primary education 24%, WATSAN 21% and capacity building 14%. The dominance of primary health can be attributed to the cost-extensions of BSF-1 grantees into BSF-2 (see Figure 2.3 below).

Figure 2.3: BSF-2 Finance allocation per sector



The good disbursement record is in a large part attributable to the intensive budget re-allocations that the grantees and the BSF Secretariat negotiated and effectuated over the first quarter of 2010 when it became obvious that some would fall short of their targets and other had more capacity. Six saw their budget reduced and twelve received an increase. The biggest increase was for CMS Ireland of GBP150,000 and the biggest reduction for the Diocese of Rumbek of GBP 260,000 (see Figure 2.4). This process reduced the budget of a grantee that was behind schedule in favour of a grantee that was ahead or on target at least. This labour intensive exercise (with some 30 fieldtrips and numerous meetings) was completed in close cooperation with the relevant grant recipients and with the Sector Sub-Committees of the SC. Without the re-allocations the disbursement rate would have been much lower.

Figure 2.4: BSF-2 Budget re-allocations



### Closing down

The main components in this ongoing closing down are:

- Last financial report with the detailed list of all transactions as a downloadable file (preferably in Excel) out of the grant recipient's financial accounting system (actually this procedure is repeated for each and every invoice received from grant recipients).
- External audit of the lead agent's BSF grant, leading to the submission of an Expenditure Verification report produced by an independent audit firm.
- Handing-over of assets documentation, including an inventory of assets purchased under this BSF Accountable Grant Contract having an initial purchase value exceeding GBP 1,000 and documentation about the hand-over of these assets to counterpart organisations (national NGOs, local government, community groups).
- Narrative Completion Report, summarising the activities carried out by the grant recipient and the results achieved.

Two months were reserved for the closing down of the grants but in practice this period is too short. The main reason is the delays in the external audits. In BSF-IA BMB MM will therefore split the external audit up in two: one financial system audit after nine months that will be recorded in a draft management letter from the auditor to the grant recipients and shared with the management consultant, and one final audit in the month after the grant closes on 31 December 2010.

For BSF-2, closing down is completed except for two last payments to World Vision and AMA that are still pending due to delayed audit reports (Annex 3).

### 2.4.3 Unit costs of construction

The monitoring set up did not always allow the unambiguous determination of unit prices for all constructed items such as classrooms, clinics and boreholes. For example in a number of cases rehabilitation works and new construction could not be separated. In case there was serious doubt on which items were included in the total expenses these items were excluded from the analysis of unit prices presented below.

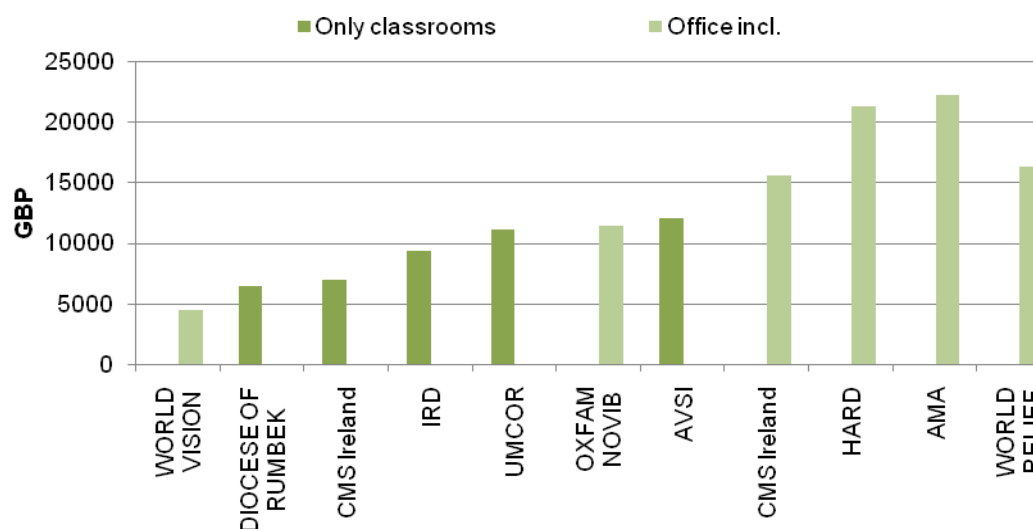
#### Primary Education

The average cost per classroom per grant recipient varies widely from £4,500 to slightly more than £22,000. This is explained by factors like materials used, transport costs and whether construction is done by contractors or done directly, with or without beneficiary contribution. The main factor is that in many cases other costs are included like furniture and other construction like toilets, store rooms, offices and staff rooms. For example AVSI constructed its schools with the communities participating in the construction, while some classrooms constructed by the Diocese of Rumbek also received contributions from sources other than the BSF. The average costs for classrooms are presented in the Table 2.5 and Figure 2.5.

Table 2.5: Average costs per classroom

Grant recipient	Only classrooms		Classrooms & offices	
	#	GBP	#	GBP
WORLD VISION			8	4,424
DIOCESE OF RUMBEK	12	6,429		
CMS Ireland	6	6,975		
IRD	12	9,357		
UMCOR	4	11,061		
OXFAM NOVIB			48	11,398
AVSI	4	11,994		
CMS Ireland			21	15,549
HARD			18	21,250
AMA			24	22,147
WORLD RELIEF			12	16,276
<b>Average/ total</b>	<b>38</b>	<b>9,163</b>	<b>131</b>	<b>15,174</b>
<b>Weighted average</b>		<b>8,513</b>		<b>15,407</b>

Figure 2.5: Average construction costs per classroom



## Primary Health

Six grant recipients implemented construction activities on health clinics. However, for Medair it was not possible to determine unit costs since the invoices did not distinguish between new construction and rehabilitation. The size of the PHCUs presented in Table 2.6 range from 3 rooms (World Vision) to 5 (Swiss Red Cross). The average weighted cost per PHCU is £37,000. An important factor in the costs is the foundations. Due to weak subsoil both IRD and Swiss Red Cross had to construct expensive foundations. In the second phase some PHCCs were rehabilitated, but no complete centres were built. It is foreseen that in the BSF-IA phase unit cost analysis will include total costs per square metre.

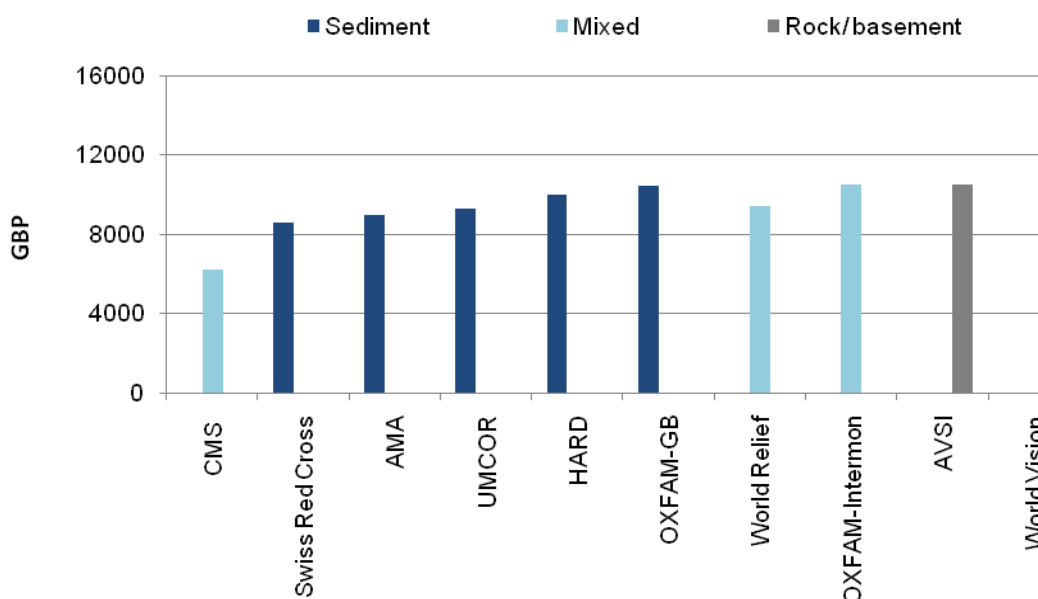
Table 2.6: Average unit costs per PHCU [GBP]

Grant recipient	Unit Cost / PHCU	# PHCU
Swiss Red Cross (Unity)	43,608	2
IRD	58,911	3
CCM	29,373	1
CONCERN (NBG)	26,005	3
World Vision (WEQ)	17,694	2
<b>Weighted Average</b>	<b>36,975</b>	<b>11</b>

### Water and Sanitation

Ten grant recipients drilled boreholes with hand pumps in areas with differing transportation costs and under various geological conditions. Figure 2.6 compares boreholes drilled in easier (sediment) and other geological formations. In two cases boreholes were drilled in mixed formations. OXFAM-GB drilled in a difficult area; having to drill deeper and encountering a number of dry boreholes. CMS drilled in the area around Yei, which is quite accessible and where transport and communication costs are low. The average unit cost per grant recipient ranges from £6,239 in easier formations to £12,346 in more difficult formations.

Figure 2.6: Average costs per newly drilled borehole [GBP]



#### 2.4.4 Assumptions & Risks status and Sustainability

(Assumptions here are defined as external factors which could affect the progress or success of the project, but over which project management has no direct control (EC-PCM manual). Assumptions are formulated positively e.g. the CPA holds. When formulated negatively assumptions become risks e.g. the CPA does not hold.)

BSF has two main assumptions: one is that the CPA holds and the second is that line ministries budget sufficiently to finance free primary health care and free primary education. DFID with BMB MM should agree to correct the current log-frame in Annex 1 to include only these two assumptions and remove all other statements that are not assumptions but in fact issues over which management has direct control:

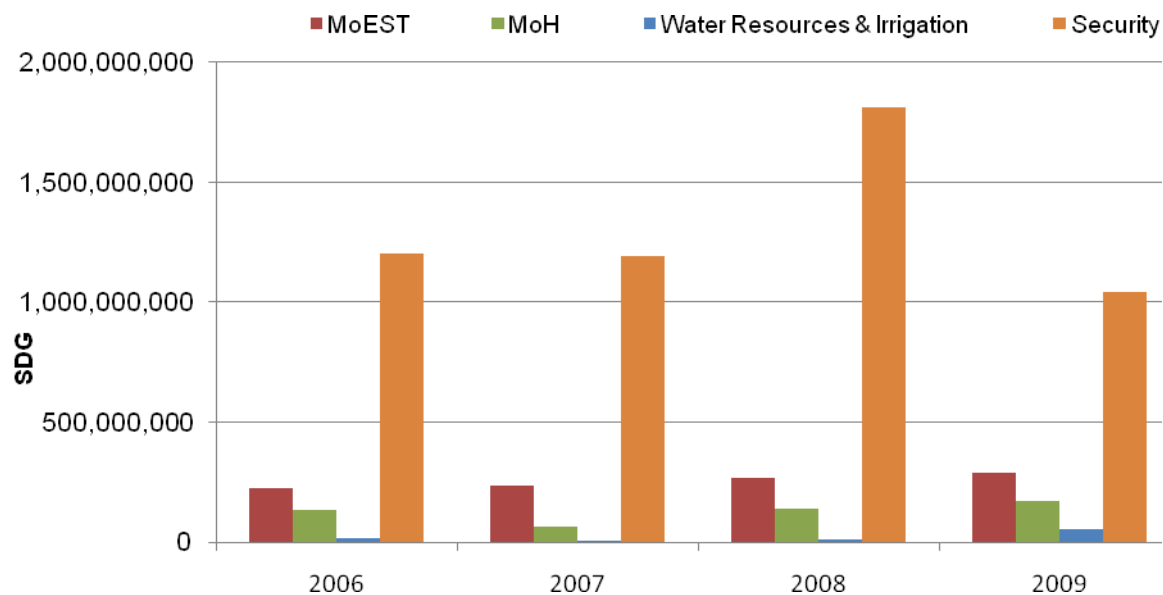
e.g. “communities are willing to provide reasonable support” which is the mandate of the grantee to develop.

MoH 2009 budget is for 70% salaries and leaves the equivalent of US\$ 30M for operational expenses and capital costs which is only a fraction of what will be needed eventually to cover the costs of free primary health care. The evidence from other developing countries demonstrates that basic primary health care services can be delivered for US\$ 3-6 per capita. MoH MDTF’s Umbrella Health Project has budgeted US \$ 2.3 per capita for performance-based contracting for health services. The risk is real that in the medium term this funding gap will remain which compromises the NGOs’ exit strategies to hand the operation and management of the facilities over to the County Health Departments.

As GoSS has allocated so much of the national budget (around 33%) to the security sector during the CPA Interim Period in order to guarantee its future, it is unlikely that this national funding gap in the basic service sectors will be filled before the future of Southern Sudanese government is clear following the referendum and end of the Interim Period. Until such as time as GoSS can effectively budget for and manage basic services spending there is still a major role to be played by donor funding such as BSF.

Figure 2.7 below shows the disparity between basic service sector funding and the security sector during the Interim Period.

Figure 2.7: GoSS budgets of line ministries (MoE, MoH and MRWI)



## 3. Lessons Learnt

### 3.1 Primary Education

Quality improvements to schools for better teaching and girls' retention – e.g. dormitories, staff accommodation and gender segregated washing areas – should be considered as basic education services by donors. These innovations under BSF Round 3 have led to better teacher and girls' retention in schools. Other methods for girls' retention used by NGOs included distribution of comfort kits, provision of uniforms, girls' feeding programmes, girls' counselling and PTA training to change parental attitudes towards sending girls to school.

Inclusion of SMOE and CED staff in NGO training programmes and monitoring visits is an effective method of targeting better education management through “organic” capacity building – the idea of building up capacity strength for a government “entry strategy” in service management as part of the NGO “exit strategy”.

“Software” components – e.g. teacher and PTA training – are the most important project aspects for targeting quality, longer-term effectiveness of education. However, these are always the most difficult to monitor, and require appropriate indicators that better measure “quality” rather than “quantity”, “success” rather than “implementation”. For example, rather than only counting the numbers that attend trainings and the length of time they are trained for, test scores before and after training might be recorded, and follow-up visits to the classes of newly trained teachers included in projects. Regarding the latter, if such visits are jointly carried out by NGO staff and by newly-trained CED and/or SMOE inspectors they serve in monitoring both the newly trained teachers and inspectors as part of an organic capacity building strategy towards government staff.

Short-term trainings appear to be better for including women. This is most likely due to their shorter, more informal nature which is closer to the home and requires fewer formal qualifications or language skills to participate in. However, due to their informal nature they are more difficult to regulate, monitor and for obtaining accurate data regarding qualifications and effectiveness. The leading education training project (World Relief/ECS) also piloted the use of babysitters in order to increase female retention in formal training courses – making women feel that they had the time to attend by providing childcare for infants.

The keeping of registers in schools is vital for obtaining accurate attendance figures. Not all NGOs have been doing this well in BSF Round 3. In future NGOs should be encouraged to assist the CEDs in keeping good school registers in order that attendance figures be fed back into EMIS, perhaps through assistance in delivering register books and through inspection visits. To target better attendance, NGOs should look to developing sustainable school feeding programmes with the PTAs and CEDs in order to move away from reliance on WFP FFE.

Despite improvements in education management by GoSS MoE since the start of the BSF, most notably the development of an operational electronic payroll system, NGOs still have an important role to play in the education sector in Southern Sudan. They often have the time and resources to oversee implementation that CEDs do not have. However as Southern Sudan moves away from the recovery phase further into a development phase, NGOs have a duty to push more operational work onto the CEDs, whilst simultaneously continuing to support them in such work in a “learning by assisted doing” approach to capacity building.

### 3.2 Primary Health

One of BSF's main assumptions is that the policies and GoSS budgets for primary health are coherent and consistent. But this has proven not to be the case. The States have not been allocating funds to basic operational budgets of the County Health Departments, while the payment of salaries has been irregular and often delayed. Until these CHDs are budgeted and fully operational, the fate of facilities that are handed-over will remain precarious.

As part of the assignment for the Primary Health Lessons learnt exercise, the consultant drafted the proceedings and disseminated reports of the 2nd GoSS Health Assembly that took place in Juba from 24-26 October 2008. For Primary Health the assembly recommended:

A Community owned and governed model of County Health Systems, founded on PHC principles, will be developed and rolled out with at least one per state by the end of 2009.

Southern Sudan, having the highest maternal and child mortality rates in the world, commits to:

- Establishing a directorate for RH at the central and RH departments at the state level
- Increasing the budget allocation for RH in the 2010 budget cycle
- Providing skilled birth attendants, well equipped facilities, and increasing community awareness of the availability of RH services
- Improving infrastructure and logistics for easier accessibility to health facilities

Implementing an integrated package of child survival interventions, including IMCI, immunisation, vitamin A, de-worming, LLITN, exclusive breast feeding promotion.

### 3.3 Water and Sanitation

The BSF Secretariat has gradually optimized the approach for monitoring progress of rural water supply implementation since its first round in 2007 following documenting of lessons learnt culminating in various BSF workshops, the proceedings of which are on BSF's website. During BSF-2 the following lessons were learned, of which some have already been implemented. Others will be implemented under BSF-IA.

#### Repair and rehabilitation

During Phase 1 only new boreholes were drilled although the rehabilitation of boreholes is cheaper than drilling new boreholes. This lesson learned was implemented and under Phase 2 where, as previously mentioned in other paragraphs, 184 boreholes were repaired and rehabilitated and 143 newly constructed. However, grant recipients do not always distinguish between rehabilitation and repair. Rehabilitation of boreholes should include new platform, pump, cylinder, rods, etc. A rehabilitated borehole should, in order to give it a longer lifespan, also be flushed. This is not the current practice among the BSF-2 grant recipients and minor repairs (e.g. crack in platform) are also reported on as rehabilitation.

Rehabilitation works should only start after a field report has been made on the reasons of break down and the works that need to be done. These field reports should also include field research on water quality issues in the area and the borehole in particular as boreholes which previously had water quality issues do not need rehabilitation.

## BSF Phase 2 Completion Report

### Water quality testing

Water quality testing for new and rehabilitated water points is not common practice in Southern Sudan as it is generally believed that the groundwater resources are of good quality. However, there is no real data available to substantiate this and the BSF Secretariat therefore conducted, together with the Ministry of Water Resources and Irrigation, a water quality workshop. MoWRI has developed a set of minimum standards for drinking water. BSF applies this minimum for water quality testing, but strongly recommends that implementing partners analyse the water points for all parameters in MWRI's more elaborate list for rural drinking water quality. In case water points exceed maximum allowable concentrations, an alternative water point has to be constructed. Chemical water quality is not related to the drilling process, so boreholes with unacceptable water quality will be paid for, though not installed with a hand pump. Water quality testing is now regarded by all grant recipients as a measure to be taken and reports are submitted to government authorities and the BSF Secretariat.

### Drilling supervision

Independent full-time drilling supervision is needed in order to come to the most cost-efficient way of drilling and rehabilitating good quality boreholes. During BSF-2 one grant recipient reported wrongly on the number of boreholes drilled and this became only clear after a drilling supervision visit. Drilling supervision will also improve the quality of the borehole as the supervisor will make sure the borehole has a minimum sustainable yield and that good practices for the whole drilling process are employed. Although some grant recipients included drilling supervision, as advised by the BSF Secretariat, more drilling supervision is needed during future works.

### Drilling preparations

A geophysical survey needs to be done and budgeted for. The geophysical locating is recommended to include geo-electric profiling of at least 750 metres, 10 metre interval, and 3 electrical soundings. The measurement results will need to be documented. The driller, who drills at the recommended drill site of the geophysical survey, can then be paid for the costs incurred on dry boreholes, which will reduce the unit cost of boreholes drilled. The BSF Secretariat advises Grant recipients to include Bills of Quantity in contracts.

Before drilling starts an analysis needs to be done on water quality issues in the region (based on geo-hydrological map, water quality data of existing boreholes in the area, and/or local knowledge on water quality issues in the area). This analysis also has to be part of the field report for non-functioning boreholes that can be rehabilitated.

### Reporting

Field reports, geophysical survey reports, borehole drilling logs, and water quality reports need to be handed in at county, state and national (for the SSWICH database) government levels, the BSF Secretariat also receiving a copy. However in practice it takes months before the reports are received and the data in the reports are not always correct. The BSF Secretariat needs to intensify, in future BSF rounds, monitoring on the submission and the quality of the reports.

## Annex 1: Logistical Framework

Basic Services Fund for South Sudan version 20 Sept 2010							
PROJECT NAME							
GOAL	Indicator	Baseline (1999/2000)	Milestone 1 (2006)	Milestone 2 (2009)	Target ( Dec 2011)		
Expand education, health and water and sanitation to communities recovering from conflict	MDG 2: Net enrolment in primary education	20%		30%	52%		
		<b>Source</b> JAM Vol 1, P20, Sudan Household Health Survey 2006, 2009, GoSS statistics					
	MDG 3: Ratio of girls to boys in primary education	0.56 (36% of pupils are female)			0.67 (40% of pupils are female)		
		<b>Source</b> JAM Vol 1, P20, Sudan Household Health Survey 2006, 2009, GoSS statistics					
	MDG 4: Under-5 mortality per 1,000 live births	250	132	tbd	MDG target in 2015: 66% reduction		
		<b>Source</b> JAM Vol 1, P20, Sudan Household Health Survey 2006, 2009, GoSS statistics					
	MDG 5: Maternal mortality per 100,000 live births	1,700	2,045	tbd	Is there a GoSS target?		
		<b>Source</b> JAM Vol 1, P20, Sudan Household Health Survey 2006, 2009, GoSS statistics					
	MDG 7: Proportion of population with sustainable access to improved water sources and sanitation	27%, 15%	48%, 6%	tbd	> 40%, GoSS target for sanitation?		
		<b>Source</b> JAM Vol 1, P20, Sudan Household Health Survey 2006, 2009, GoSS statistics					
	PURPOSE	Indicator	Baseline (2006)	Milestone 1 (Dec 2008, BSF-1 achievements)	Milestone 2 (June 2010, BSF-1 & -2 achievements)	Target (Dec 2011, achievements BSF-1 & -2 and target BSF-IA)	Assumptions
	Expand coverage and use of basic services in Southern Sudan	Number of people with new/ improved drinking water sources	0	109,500	279,000	482,500	1. CPA holds and transitions to a stable situation post-2011.  2. GOSS is able to steadily increase budget allocations to basic service provision.
<b>Source</b> BSF reports.							
	Number of people with access to improved sanitation facilities	0	6,015	28,205	97,725	3. GOSS is able to recruit and retain qualified basic services	

## BSF Phase 2 Completion Report

						staff.
	<b>Source</b>					
	BSF reports.					
<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	26,800	52,400	63,000		
	<b>Source</b>					
	BSF reports.					
<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%	10%	20%	30%		
	<b>Source</b>					
	GoSS Ministry of Health Strategy 2009 - 2012; UN since it is a MDG indicator					
<b>Indicator</b>	<b>Baseline (2006)</b>	<b>Milestone 1 (Dec 2008)</b>	<b>Milestone 2 (June 2010)</b>	<b>Target ( Dec 2011)</b>		
BSF-IA supports delivery of central and state targets	GoSS Basic Services targets are national	Not available	BSF-IA priorities are set in consultation with line ministries and are in line with GoSS Basic Services targets and priorities	All BSF-IA projects integrated into GoSS state-level planning		
	<b>Source</b>					
	Minutes BSF-IA line ministry consultation meetings. Budget Sector Working Plans (BSWP)					
<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	160	352	564	1. Dec 2011 target figures based on minimum GoSS targets in priority paper
	<b>Source</b>					
	BSF reports.					
						2. BSF Implementing partners deliver to plan. 3. Teacher's salaries paid.

## BSF Phase 2 Completion Report

IMPACT WEIGHTING	Indicator	Baseline (2006)	Milestone 1 (Dec 2008)	Milestone 2 (June 2010)	Target ( Dec 2011)	
20%	No. of teachers trained/AES trained	0	1,095	2,564	4,560	4. State governments able to manage education service effectively. 5. Communities are willing to provide reasonable support.
		<b>Source</b>				<b>RISK RATING</b>
		BSF reports. Includes pre-services, in-service and english courses. Doesn't include short term training of teachers (= less than a month) on subject matters.				<b>Medium</b>
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
	£9.65 million	(£3 million)	£8.175 million	£16.95 million	51.8% (excluding indicative GoSS share @ 20%)	
INPUTS (HR)	DFID (FTEs)					
OUTPUT 2	Indicator	Baseline (2006)	Milestone 1 (Dec 2008)	Milestone 2 (June 2010)	Target ( Dec 2011)	Assumptions
Strengthen primary health services.	No. of PHCC/PHCUs built/reconstructed	0	13 PHCC/23 PHCU	17 PHCC/39 PHCU	28 PHCC/86 PHCU	1. BSF implementing partners deliver to plan. 2. GOSS and/or donor partners agree plans to sustain services post BSF. 3. State governments develop capacity to maintain services for the long term. 4. Communities are willing to provide reasonable support.
		<b>Source</b>				
		BSF reports.				
	Indicator	Baseline (2006)	Milestone 1 (Dec 2008)	Milestone 2 (June 2010)	Target ( Dec 2011)	
	No. of PHCC/PHCUs supported with medical services only	0	7 PHCC/20 PHCU	32 PHCC/89 PHCU	71 PHCC/191 PHCU	
		<b>Source</b>				
		BSF reports.				
	Indicator	Baseline (2006)	Milestone 1 (Dec 2008)	Milestone 2 (June 2010)	Target ( Dec 2011)	
	No. of health professionals trained (Nurses & midwives/TBA's, etc)	0	4862 (2506 female) short term training	11,674 (5025 female) short term, 51 (13 female) long term	tbd	
		<b>Source</b>				
	BSF reports. Includes all informal and formal short and long term training (more than 1 month) in the health sector					
IMPACT WEIGHTING	Indicator	Baseline (2006)	Milestone 1 (Dec 2008)	Milestone 2 (June 2010)	Target ( Dec 2011)	
50%	Number of patient consultations	0	168,665	1,262,290	2,404,789	

## BSF Phase 2 Completion Report

		Source				RISK RATING	
		BSF reports.				High	
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)		
	£18.4 million	(£4 million)	£15.95 million	£32.6 million	51.07% (Excluding indicative GoSS share at 20%)		
INPUTS (HR)	DFID (FTEs)						
OUTPUT 3	Indicator	Baseline (2006)	Milestone 1 (Dec 2008)	Milestone 2 (June 2010)	Target ( Dec 2011)	Assumptions	
Strengthened water and sanitation services.	No. of new/improved water points provided	0	219 boreholes (173 new, 48 rehab), 1 gravity scheme	558 boreholes (327 new, 233 rehab), 8 other sources	955 boreholes (502 new, 455 rehab and repair), 120 other water points	1. BSF implementing partners deliver to plan. 2. Dec 2011 target figures based on minimum GoSS targets in priority paper 3. Workable models for community management. 4. Secure spare supplies. 5. Hygiene training includes - hygiene & sanitation, public basic hygiene and sanitation, school hygiene and sanitation clubs, village health motivators & water quality.	
		Source					
		BSF reports.					
	Indicator	Baseline (2006)	Milestone 1 (Dec 2008)	Milestone 2 (June 2010)	Target ( Dec 2011)		
	No. of new/improved sanitation facilities provided	0	1203 (household and institutional latrines)	3,846 (2,312 household and 231 institutional latrines)	13,788 (11,688 household and 897 institutional latrines)		
		Source					
		BSF reports.					
	Indicator	Baseline (2006)	Milestone 1 (Dec 2008)	Milestone 2 (June 2010)	Target ( Dec 2011)		
	No. of people trained in hygiene/sanitation or environmental awareness	0	2697 (1261 female)	20,422 (11,319 female)	tbd		
		Source					
		BSF reports. Includes all training in the WATSAN sector.					
	IMPACT WEIGHTING	Indicator	Baseline (2006)	Milestone 1 (Dec 2008)	Milestone 2 (June 2010)		Target ( Dec 2011)
20%	No. of staff and community members trained to maintain and monitor water and sanitation systems	0	1,017 (462 female)	2,978 (1,239 female)	tbd		
		Source					
		BSF reports. Includes only the training of pump mechanics, water management committees and training on water quality.				RISK RATING	
						Medium	
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)		
	£8.75 million		£7.775 million	£15.65 million	50.3% (Excluding indicative GoSS share at 20%)		
INPUTS (HR)	DFID (FTEs)						
OUTPUT 4	Indicator	Baseline (2006)	Milestone 1 (Dec 2008)	Milestone 2 (June 2010)	Target ( Dec 2011)	Assumptions	
Strengthen GoSS capacity to plan and monitor basic service	Number of State-level line ministry staff trained as part of NGO projects	0	64 (6 female)	589 (78 female)	tbd		
		Source					

## BSF Phase 2 Completion Report

delivery		<b>Source</b>				
		BSF reports. Staff government civil servants only.				
	<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 BSF-IA projects planned and monitored jointly with state- and county- level line ministries	0	100%	100%	100%	
		<b>Source</b>				
		BSF field visit reports				
<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>RISK RATING</b>
10%						
		<b>Source</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>					



## Annex 2: Grant Recipient Overview

Id	Lead Agency	Consortium Members	From	To	Budget GBP	Re-allocated
					Original	GBP
1.1a	AMREF	ACCOMPLISH, COMPASS	01/01/2009	30/06/2010	698,617	658,617
1.1b	COMPASS	-	05/12/2009	30/06/2010	195,900	220,600
1.3	CCM	-	01/01/2009	30/06/2010	931,018	965,018
1.6	SC-US	NIP, MRDO	01/01/2009	30/06/2009	162,154	
2.1	GOAL	-	01/01/2009	30/06/2010	987,885	1,021,885
2.4	MERLIN	-	01/01/2009	30/06/2010	866,364	836,364
2.5	OVCJ	Catholic Archdiocese of Juba	01/01/2009	30/06/2010	198,210	236,210
2.7a	TEARFUND	-	01/01/2009	30/06/2010	904,427	938,427
2.7b	MEDAIR	-	01/01/2009	30/06/2010	988,406	
<b>Totals health extensions</b>		<b>(9 grant recipients)</b>			<b>5,932,981</b>	<b>4,877,121</b>
3a.01	AMA	-	01/01/2009	30/06/2010	1,237,525	
3a.02	AVSI	DoT	01/01/2009	30/06/2010	967,720	923,647
3a.03	CMS Ireland	ECS Yei, ECS Lainnya Dioceses	01/01/2009	30/06/2010	833,045	983,945
3a.04	CONCERN worldwide	-	01/01/2009	30/06/2010	828,834	862,834
3a.05	DIOCESE OF RUMBEK	-	01/01/2009	30/06/2010	574,699	313,130
3a.06	INTERMON OXFAM	-	01/01/2009	30/06/2010	1,273,349	1,296,759
3a.07	IRD	JDSF	01/01/2009	30/06/2010	1,498,868	
3a.08	OXFAM GB	-	01/01/2009	30/06/2010	1,454,853	1,412,642
3a.09	OXFAM NOVIB	MRDA, NSWF	01/01/2009	30/06/2010	1,018,892	1,070,252
3a.10	SWISS RED CROSS	Sudanese Red Crescent Society	01/01/2009	30/06/2010	539,441	466,441
3a.11	WORLD RELIEF	ECS	01/01/2009	30/06/2010	1,492,808	1,500,808
<b>Totals 3a</b>		<b>(11 grant recipients)</b>			<b>11,720,034</b>	<b>8,832,895</b>
3b.01	HARD	-	01/04/2009	30/06/2010	547,503	655,502
3b.02	IMC UK	PRDA, NHDF	01/04/2009	30/06/2010	1,155,000	1,005,000
3b.03	MEDAIR	Fashoda Youth Forum, Malaria Consortium	01/04/2009	30/06/2010	1,059,174	1,059,174

## BSF Phase 2 Completion Report

<b>Id</b>	<b>Lead Agency</b>	<b>Consortium Members</b>	<b>From</b>	<b>To</b>	<b>Budget GBP</b>	<b>Re-allocated</b>
3b.04	UMCOR		01/04/2009	30/06/2010	315,719	352,719
3b.05	WORLD VISION UK	Catholic Diocese of Tambura-Yambio	01/04/2009	30/06/2010	825,174	
	<b>Totals 3b</b>	<b>(5 grant recipients)</b>			<b>3,902,570</b>	<b>3,072,395</b>

## Annex 3: BSF-2 Disbursement Overview [GBP]

Grant No.	Grant recipient	Contract amount [GBP]	Period	Project duration [month]	Amount invoiced [GBP]	%	Budget remaining [GBP]
BSF 2 - 01	African Medical & Research Foundation (AMREF)	698,617	01.01.09 - 30.06.10	18	637,947	91	60,670
BSF 2 - 02	Comitato Collaborazione Medica	965,018	01.01.09 - 30.06.10	18	964,756	100	262
BSF 2 - 03	Save the Children Federation, Inc -USA	162,154	01.01.09 - 30.06.09	6	146,607	90	15,547
BSF 2 - 04	GOAL	1,021,885	01.01.09 - 30.06.10	18	1,021,885	100	0
BSF 2 - 05	MERLIN	836,364	01.01.09 - 30.06.10	18	781,106	93	55,258
BSF 2 - 06	OVCi la Nostra Famiglia	236,210	01.01.09 - 30.06.10	18	234,218	99	1,992
BSF 2 - 07	TEARFUND	938,427	01.01.09 - 30.06.10	18	914,449	97	23,978
BSF 2 - 08	MEDAIR	988,406	01.01.09 - 30.06.10	18	976,307	99	12,099
BSF 2 - 09	International Relief Development	1,498,868	01.01.09 - 30.06.10	18	1,498,868	100	0
BSF 2 - 10	World Relief	1,500,808	01.01.09 - 30.06.10	18	1,500,808	100	0
BSF 2 - 11	Concern Worldwide	862,834	01.01.09 - 30.06.10	18	818,224	95	44,610
BSF 2 - 12	Oxfam Novib	1,070,252	01.01.09 - 30.06.10	18	1,046,430	98	23,822
BSF 2 - 13	CMS Ireland	986,382	01.01.09 - 30.06.10	18	986,382	100	0
BSF 2 - 14	Oxfam GB South Sudan	1,412,642	01.01.09 - 30.06.10	18	1,400,074	99	12,568
BSF 2 - 15	AVSI	923,647	01.01.09 - 30.06.10	18	869,244	94	54,403
BSF 2 - 16	Intermon Oxfam	1,296,759	01.01.09 - 30.06.10	18	1,296,759	100	0
BSF 2 - 17	Swiss Red Cross (SCR)	466,441	01.01.09 - 30.06.10	18	456,232	98	10,209
BSF 2 - 18	Diocese of Rumbek	313,130	01.01.09 - 30.06.10	18	300,943	96	12,187
BSF 2 - 19	Assistance Mission for Africa (AMA)	1,237,525	01.01.09 - 30.06.10	18	1,234,885	95	2,640
BSF 2 - 20	Hope Agency for Relief and Development (HARD)	655,502	01.04.09 - 30.06.10	15	655,502	100	0
BSF 2 - 21	International Medical Corps UK (IMC)	1,005,000	01.04.09 - 30.06.10	15	1,005,000	100	0
BSF 2 - 22	World Vision - UK	825,174	01.04.09 - 30.06.10	15	825,174	100	0

## BSF Phase 2 Completion Report

Grant No.	Grant recipient	Contract amount [GBP]	Period	Project duration [month]	Amount invoiced [GBP]	%	Budget remaining [GBP]
BSF 2 - 23	United Methodist Committee on Relief (UMCOR)	352,719	01.05.09 - 30.06.10	14	352,059	100	660
BSF 2 - 24	MEDAIR	1,059,174	01.06.09 - 30.06.10	13	1,051,991	99	7,183
BSF 2 - 25	COMPASS	220,600	01.12.09 - 30.06.10	7	218,240	99	2,360
	<b>Total allocated BSF Phase II</b>	<b>21,534,538</b>			<b>21,194,090</b>	<b>98</b>	<b>340,448</b>
	<b>Budget BSF Phase II</b>	<b>21,554,792</b>					
	<b>Unallocated Phase II</b>	<b>20,254</b>					

## Annex 4: BSF-2 Individual Project Summaries

### 1.1a AMREF

- AMREF implements an integrated health and watsan rehabilitation project in 3 (out of 8) Payams of Terekeka County, CES. The project worked over time with local consortium partners (Aquafund, ACCOMPLISH, COMPASS) but not resulting in a hand over of functions to these partners. 2 out of 3 targeted were served.
- One PHCC and 2 PHCUs were constructed; in addition minor rehabilitation on 6 PHCUs. In total 18 boreholes were drilled + installed; another 10 rehabilitated. 5 VIP latrines and 16 Household latrines constructed (far below target).
- Supported health facilities received drugs, salaries to all health- and support staff, referral of patients to referral hospital; etc.
- Support to training of 16 CHWs and short in-service courses.
- In general, services below targets and quality standards. The budget was consequently reduced in Dec. 2009, with COMPASS contracted for elements not provided.

### 1.1b COMPASS

- COMPASS (Sudanese NGO, based in Terekeka) carried out some essential PHC program elements, not implemented by AMREF, with a contract w.e.f. 6-12-2009.
- Setting up an effective EPI outreach in 3 Payams, with building and setting up of an EPI centre, with 4 cold chain hubs, implementation of mass EPI outreach.
- Construction of 1 PHCC, (left at 35% completion by AMREF for 1 year), 2 VIP latrines, 1 rainwater collection system at a PHCU, repairs of 8 boreholes, with setting up a tools and spare parts' system for sustained maintenance.
- Short training courses of 50 Hygiene promoters, 30 AIDS peer educators, 30 pump mechanics, and 24 EPI vaccinators.
- Contract carried out at, or even above, targets; however finance-administrative reporting capacity of COMPASS has been inadequate, requiring backstopping by BSF.

### 1.3 CCM

- Integrated PHC support in 2 large, relatively inaccessible Counties in Warrap State.
- Rehabilitation and extension of 2 PHCCs; construction of 3 (large) PHCUs that can easily be upgraded to PHCCs, construction of one smaller PHCU (with additional funding) and services supported in an additional 4 PHCUs. Services include drugs (nearly 100%) and all staff positions.
- Intensive supervision outreach to health facilities and EPI outreach schedule. Due to the inaccessible terrain and security constraints, EPI coverage still low.
- Regular in-service training of staff, e.g. CHWs and TBAs. In/house training of 6 laboratory assistants.
- Support to the gradually emerging Tonj East CHD. The Tonj North CHD has not been established yet.
- Security necessitates temporary withdrawals of staff in 2009 and 2010; the Ananatak PHCU has been closed since Dec. 2009, due to intra-tribal conflict.

### 1.6 Save-USA

- Project carried out in 3 Counties of Upper Nile State, implemented by 2 local NGOs. Save US implemented from 1/1/2009 to 30/6/2009 in Phase II, followed by other funding.
- Health services (salaries of staff, drugs and materials) were supported in 1 large PHCC and 9 PHCUs. The PHCC and 4 PHCUs were constructed in the previous phase.
- Service delivery included limited EPI outreach and integrated HIV-AIDS control. Save focused on training of staff of the partner NGOs with in-service courses.

## BSF Phase 2 Completion Report

- CHDs were formed in Maiwut and Mabaan Counties in 2009 by the State MoH. Coordination of supervision and management roles between Save, partner NGOs and CHDs has been discussed, in view of very gradual handover of facilities to CHDs.
- BSF facilitated an organizational capacity assessment with planning between Save, local partner NGO (NID) and County Health Department in Maiwut County in Sept. 2009.

### 2.1 GOAL

- GOAL supports all health services in Baliet County and partially in Ulang County, Upper Nile, in close coordination with the State Ministry of Health. Baliet County has been sub-divided in Baliet and Akoka Counties in 2010. Nagdier PHCU (Panyikang County) was destroyed (tribal conflict) in Feb. 2009, later handed over to World Vision for support.
- 2 PHCCs and 4 to 5 PHCUs were supported with staff (in addition to MoH paid staff), drugs, medical equipment, in-service training. 16 CHWs were trained in GOAL's own training centre at Baliet in 2009. The coordination with SMOH is exemplary.
- Outreach activities (nutrition monitoring, health (HHPs) and sanitation promotion is concentrated on intervention zones around facilities. An effort is made to County wide EPI outreach, but with difficult access. Annual surveys inform program planning.
- CHDs have been formed in Baliet and Ulang in 2009, but with inadequate resources. GOAL has been building their respective organisational and clinical-supervision capacity.
- Water collection systems were constructed in 2010, with minor budget increase

### 2.4 MERLIN

- Clinical support was targeted initially on 2 PHCCs and 2 PHCUs in Torit and Lapon County, EES. In the course of 2010, a further 3 PHCCs were supported (with drugs, clinical and support staff, in-service training).
- Construction of 1 PHCC (Lafon) was completed in May 2010 (scheduled before 2009), Kudo PHCC has been operational since August 2009.
- The programme was constrained by a management crisis in the first half of 2009. This was effectively addressed by, in coordination with BSF, by appointment of crisis manager and organizational change.
- Torit CHD has been established in 2009 and effective, Lafon CHD is not yet effective.
- A district wide Health Management Information System has been piloted by Merlin in 2010 and used in own facilities. This HMIS can be rolled out to Counties / States.

### 2.5 OVCI

- Four large PHCCs were supported in Juba town (CES)- one (Usratuna PHCC) owned by the Catholic Archdiocese, three others by the State MoH.
- Close cooperation with the State MoH. OVCI has been working a facilitating role, with much emphasis on in-service training of staff. The SMOH has been paying all staff in the 3 SMOH PHCCs, and supplied about 80 % of all drugs. The additional drugs and equipment provided by OVCI.
- Intensive training programme of clinical staff by visiting consultants, benefiting also other clinical staff in Juba.
- Formal handover of the 3 MoH facilities to the SMOH in May 2010.
- Piloting of maternity health support in all PHCCs, to be further strengthened in the next phase of BSF implementation.

### 2.7a TEARFUND

- Programme includes the integrated health service delivery to Fashoda County, and one Payam in Manyo County, Upper Nile State. Programme supervision is carried out in close coordination with the (under-sourced but motivated) CHD in Kodok.

## BSF Phase 2 Completion Report

- 3 PHCCs and 9 PHCUs were supported with services, 3 PHCUs were rehabilitated with community participation. Kodok PHCC was handed over to State MoH before July 2010.
- Training of 9 female CHWs at Tearfund's own CHW training centre. HIV-AIDS awareness with VCT is mainstreamed into the programme.
- Installation of 5 EPI hubs (solar-powered refrigerators) with a budget increase in 2010.
- The programme has been adversely affected by insecurity. One PHCU was closed throughout 2010, due to inter-tribal tension. W.e.f. 27-6-2010, staff are withdrawn from area after arrest and torture of staff by the local SPLA. This seriously jeopardises the presence and capacity of the programme.

### 2.7b MEDAIR

- Provision of integrated health care in Melut County (Upper Nile State), with one PHCC at Melut, and 6 PHCUs. The delivery of full range of BPHS is implemented.
- Programme includes a County TB control programme, with TB unit at Melut, and a VCT with HIV-awareness outreach. Integrated facility/based nutrition rehabilitation in all health facilities.
- In-service training of clinical staff through short courses.
- MoU with the County Health Department and operations' agreements. However, contribution by SMOH to salaries (payroll inclusion) etc. Has been very limited.
- Support to the County HMIS system, with training, implemented in collaboration with Malaria Consortium facilitators.

### 3a.01 AMA

- Sudanese multi-sector NGO working in several states of Southern Sudan. Headquarters still in Nairobi with liaison offices in Juba and several other states.
- Relationship with State and County government not as close as it could be. Many expat staff in many different areas makes involved community level work difficult.
- Construction of two 8-classroom primary schools in Gogrial East County and one in Twic County of Warrap State. Completed on schedule, though unfurnished. Drilled 47 out of the targeted 48 boreholes in Gogrial East and West, though 5 are still missing platforms, app 20 still need water quality testing due to inaccessibility of the sites during rainy season.
- All targeted pump mechanics trained, 4 WUC's not trained.
- AMA did not follow correct tender procedure in school construction and reported inaccurately on number of drilled boreholes. AMA needed close monitoring in order to reach targets and quality assurance in WATSAN sector

### 3a.02 AVSI

- Italian Catholic INGO in partnership with the RC Diocese of Torit providing health care, education and WATSAN services. Offices in Kitgum, Uganda and Isoke, EEQ. Global HQ in Milan, Italy.
- Health work implemented through the Church, education in partnership with the SMOE.
- Construction of 4 classrooms at 2 schools, support to St Theresa PHCC and 4 outlying PHCUs, drilling of 5 new boreholes and rehab of 13, and erection of 24 institutional latrines stances and 250 household latrines in Ikotos County.
- Own methodology for hygiene promotion, but slow acceptance by community. Planned ISTT for P1-3 teachers failed due to lack of available trainers from EESMoE.
- Have suffered problems with their relationship with DoT over payment of staff at St. Theresa PHCC, though services have continued well.

### 3a.03 CMS Ireland

- Irish Anglican Church mission agency working directly with the Sudanese Episcopal dioceses of Yei and Lainya. Sudan HQ in Yei, global HQ in Belfast, UK.

## BSF Phase 2 Completion Report

- All work done at community level. Closer working relationship with the partner dioceses than with State and County government, though work co-ordinated with the Counties.
- Construction of 31 classrooms at 5 school sites, drilling of 8 boreholes and construction of 76 institutional latrine stances in Yei and Morobo counties. Finalised the construction of a PHCC in Lainya. Mobile clinic services provided to villages in Yei and Lainya.
- PTA trainings provided at all supported schools, Stage 1 ISTT given to 40 teachers in a 3 month course at YTTC, 6 teachers enrolled for full PSTT at YTTC. 10 health workers trained in Kampala, Uganda. VHCs trained in 5 villages surrounding Yei and Morobo.
- Several budget increases given for 14 extra classrooms to be constructed above original target, at 3 further school sites.

### 3a.04 CONCERN

- CONCERN supports 1 PHCC and 6 PHCUs in Aweil West County (Northern Bahr el Ghazal); with limited support to a few facilities in Aweil North County.
- Health services supported topping up of salaries (in addition to MoH support), include additional drugs, equipment etc.
- Two PHCUs were built, and one rehabilitated in 2010 (with a minor budget increase).
- Strong integration of health facilities in community-based nutrition rehabilitation and community development (with “Community Conversations” approach etc.)
- Targeted support to the County Health Department, with clear mutually agreed work-plans, MoUs etc.

### 3a.05 Diocese of Rumbek

- The Roman Catholic Church in Rumbek, the diocese supports schools in Lakes, Warrap and Northern Bahr El Ghazal states from Rumbek and a liaison office in Nairobi.
- The diocese does not work with State and County government as close as it could – this mainly due to external support from Europe and its own highly developed standards.
- Construction of 27 classrooms at 4 different schools in Lakes and Warrap states completed satisfactorily. ALP classes established.
- PTAs at some schools trained, but not all. ALP teachers trained in short-term training.
- Budget severely reduced after planned feeding programme in Northern Bahr El Ghazal was no longer needed. Some funds re-allocated to construction. Suffered from serious delays due to insecurity in early 2010, though still exceeded classroom construction targets by the close of the grant period.

### 3a.06 INTERMON OXFAM

- Spanish INGO working in Raga County, Western Bahr el Ghazal. Offices in Wau and Juba (Southern Sudan HQ), global HQ in Barcelona.
- Strong capacity building component of the County Rural Water and Sanitation Department. Good coordination with State level authorities.
- Drilled 16 boreholes (15 targeted) and rehabilitated 30 boreholes in Raga County. Strong sanitation and hygiene promotion component and due to intensified promotion 1,066 household latrines constructed (target 350). Construction of 40 institutional latrines stances at schools, complete with washing facilities and provision hygiene kits.
- Training of WUC and pump mechanics according satisfactory completed and tool kits provided. CWD received computer and water quality monitoring training
- Budget increase given to procure extra borehole spare parts and emergency stock.

### 3a.07 IRD

- American INGO working with a Sudanese NGO (the John Dau Foundation) in Jonglei State. Southern Sudan HQ in Juba, global HQ of both NGOs in Washington DC.

## BSF Phase 2 Completion Report

- Working relationship with the State and County governments, as well as at community level, worked on progressively, as IRD didn't work before in Jonglei state.
- Construction of 12 classrooms at 3 schools, construction of 3 PHCUs, support to 1 PHCC, rehabilitation of 15 boreholes, and erection of 28 institutional latrines stances in Duk County of Jonglei State.
- Short term training of CHWs and other clinical staff was conducted, as well as HIV/AIDS awareness and VTC training given.
- Problems with implementation planning, coordination and division of responsibilities/ and accountability of their Sudanese partners, and insecurity/logistical issues caused delays.

### 3a.08 OXFAM GB

- British INGO working in Southern Sudan mainly in the WATSAN and livelihood sector. HQ in Juba, and field office in Malakal.
- Challenging working relationship with the county authorities as there are no county water and sanitation authorities existing in Maban and Longuechok counties in Upper Nile, however strong community mobilisation component.
- Drilled and installed 28 boreholes out of the targeted 35 boreholes, rehabilitated 33 (target 20). Additionally established 5 (4 targeted) other water points (hafirs and water harvesting). Constructed 39 latrine stances at 9 schools and 854 household latrines. Performs water quality monitoring at household level.
- Commendable hygiene promotion implementation strategy. Trained and established school hygiene clubs, WUCs, pump mechanics, village health motivators.
- Budget decreased due to the fact that not all boreholes could be drilled in the challenging geophysical environment and failure of contractor.

### 3a.09 OXFAM Novib

- Dutch INGO acting as funding agency partner to community-based Sudanese NGOs MRDA and NSWF. Activities all managed from Mundri, Western Equatoria State.
- Close working relationship with both the State and County government, majority of development work grounded at community level.
- Construction of 52 classrooms at 6 schools in villages in both Mundri East and Mundri West counties completed on schedule to good quality. Quality improvements to schools highly commendable: hand washing facilities and excellent record keeping.
- ISTT, ALS teacher training, PTA training and CED staff training all carried out in Kotobi TTI and at schools. HIV/AIDS awareness conducted in school communities.
- Budget increase given for 4 extra classrooms to be constructed at Mundri Parish School to exceed construction targets.

### 3a.10 SWISS RED CROSS

- Swiss INGO, working from Khartoum, with HQ in Bern. Implementation mainly done by their partner the Sudanese Red Crescent Society, with a HQ in Khartoum and branch office in Bentiu. SRC provided the overall project management.
- Good working relationship with county and state authorities through among others embedding state ministry staff in the implementation team. Set up a community based health system through volunteers.
- Constructed two primary health care units, which started up satisfactory at the end of the grant period, drilled through a sub-contractor 20 boreholes, and provided 120 household latrine slabs and drums in Mayendit County, Unity state.
- 3 nurses and 1 midwife received formal health training. All WUC trained.
- Budget reduced due to implementation delay. Delay was mainly caused by managerial issues at both the field and Khartoum level. However, they managed to reverse their implementation progress and

## BSF Phase 2 Completion Report

delivered all construction targets. SRC committed itself to support the health facilities for another 18 months.

### 3a.11 World Relief

- American Christian INGO working in partnership with the Episcopal Church of Sudan's Education Office. Multi-state training programme based out of ECS' Juba HQ.
- Closer working relationship with the partner ECS dioceses than with the State and County governments, though all training well co-ordinated and as per GoSS curriculum.
- Construction of three 4-classroom schools in Ezo, Yirol West and Yirol East counties. Progress suffered from poor contractors and bad management, though completed satisfactorily.
- Stages 1 and 2 of the GoSS-MoE ISTT given to 827 teachers across 7 states of Southern Sudan. Participants receive certificates from the SMOEs.
- Head teacher, PTA, CED and HIV/AIDS training also given in various locations.
- Budget increases given for the drilling of boreholes at the Ezo and Yirol East schools.

### 3b.01 HARD

- Sudanese community-based NGO founded in Nairobi during the war. Now relocated to Jur River County, WBeGS.
- Close working relationship with both the State and County government, majority of development work grounded at community level.
- Construction of three 6-classroom primary schools in 3 villages surrounding Wau Town, contracted to Sudanese firms and completed on schedule to satisfactory quality.
- Stage 1 of the GoSS-MoE in-service teacher training programme given to 100 teachers in a 3 month course in Wau Town, completed satisfactorily and participants received certificates from the WBeGSMoE.
- Budget increases given for quality improvements to target girls' and teacher retention: hand washing facilities, dormitories and accommodation blocks.

### 3b.02 IMC

- Integrated health services delivery to Akobo County (Jonglei), out of two compounds in Akobo and Walgak respectively. Accessibility (by road and air) is main constraint. Implementation in consortium form with 2 local NGOs; NHDF and PRDA.
- Health component supported service delivery; staff posting and salaries, drugs and medical equipment, limited in-service training of clinical staff in 2 PHCCs and 11 PHCUs. This target was not achieved (5 PHCUs were not effectively supported) due to access and internal management constraint.
- A watsan component repaired 9 boreholes and installed 68 household latrines.
- Delayed implementation was flagged by BSF, leading to a "crisis management" mode, and a budget reduction.
- The CHD in Akobo is weak, with conflicting Officers appointed; not having capacity to effectively supervise services. Local conflicts caused serious famine conditions with a higher profile for humanitarian action in the County.

### 3b.03 MEDAIR

- Medair established a project base in Wadekona; County HQ of Manyo County and supports integrated health / watsan projects in the area. The programme builds on existing MoH capacity in this County, with a MoU guiding this.
- 2 PHCCs (Wadekona, Kaka) have been rehabilitated; repair of buildings, re-training of (SMoH employed) staff, new furnishing. 2 PHCUs were built with services provided.
- An EPI outreach programme was supported, not covering the whole County yet.

- Community hygiene promotion, with training of voluntary hygiene promoters,. This is implemented by local consortium partner; Fashoda Youth Forum.
- Targeted capacity building of the CHD staff by management training, carried out by consortium partner; Malaria Consortium. Thus partner also supported introduction and training of a computerised HMIS at the State MoH of Upper Nile State in Malakal.

### 3b.04 UMCOR

- American Christian INGO working independently in several states of Southern Sudan with mostly Sudanese staff. HQ in Yei, liaison offices in several states.
- Close working relationship with both the State and County government, though lack of local staff at ground level slows community involvement and management.
- Construction of one 4-classroom school in Malek Alel, Aweil South County HQ, with accompanying latrines and borehole. A further 9 community boreholes drilled and 6 latrine stances erected.
- WUCs, PTAs, hygiene promoters, teachers, CWD staff and Payam Development Committees all received short-term training. 18 teachers received ELT.
- Budget increase given for 6 extra boreholes in excess of the original target. All drilled satisfactorily and within the grant period.

### 3b.05 World Vision UK

- Global multi-sector Christian INGO working in partnership with the RC Diocese of Tambura-Yambio. HQ in Juba, though with a large field office in Yambio, WEQ.
- Supervision of clinics is jointly carried out by DoTY and the WES MoH. World Vision facilitates the access of MoH staff in 2 Counties to clinics, transports drugs etc.
- Construction of 8 classrooms at 1 school, support to 2 PHCC and 5 PHCUs, construction of 2 PHCUs, drilling of 5 new boreholes and rehab of 15, and erection of 14 institutional latrines stances in Yambio, Ezo and Tambura counties.
- ISTT for 78 teachers conducted, along with PTA training, at 10 schools.
- The school construction was set back by fire damage during the April 2010 elections, though completed on time. Have suffered from a quick turnover of staff and a lack of direct supervision; to a large extent this is attributed to the difficult security situation in the volatile area where World Vision works (LRA insurgency).

## Annex 5: Cumulative Targets &amp; Achievements (BSF-1,-2 and IA)

	BSF-1			BSF-2			BSF-IA		Cumulative BSF-1, -2 and IA	
	Target	Achieved	%	Target	Achieved	%	Target	Achieved	CUM target	CUM achieved
New schools constructed	21	20	95%	24	31	129%	24	-	75	51
New Classrooms constructed	152	160	105%	161	192	119%	212	-	564	352
School office blocks constructed	19	14	74%	-	-		24	-	38	14
Schools rehabilitated	-	-		-	-		6	-	6	-
School services	51	47	92%	63	40	63%	-	-	87	87
<b>Education beneficiaries (students)</b>	<b>28,000</b>	<b>26,800</b>	<b>96%</b>	<b>33,250</b>	<b>25,600</b>	<b>77%</b>	<b>10,600</b>	<b>0</b>	<b>63,000</b>	<b>52,400</b>
Consultations	-	168,665		-	1,093,625		1,142,499	-	2,404,789	1,262,290
PHCC construction	18	13	72%	5	5	100%	11	-	29	18
PHCC services	6	7	117%	21	25	119%	39	-	71	32
PHCU construction	36	23	64%	12	16	133%	47	-	86	39
PHCU services	5	20	400%	75	69	92%	102	-	191	89
<b>Health beneficiaries (capacity)</b>	<b>1,815,000</b>	<b>1,645,000</b>	<b>91%</b>	<b>2,605,000</b>	<b>2,775,000</b>	<b>107%</b>	<b>4,735,000</b>	<b>-</b>	<b>9,155,000</b>	<b>4,420,000</b>
New boreholes	195	173	89%	138	143	104%	185	-	501	316
Rehab boreholes	84	48		110	184	167%	222	-	454	232
Total boreholes	279	219	78%	248	327	132%	407	-	953	546
Other sources	1	1	100%	10	8	80%	120	-	129	9
<b>Water beneficiaries (users)</b>	<b>139,500</b>	<b>109,500</b>	<b>78%</b>	<b>124,000</b>	<b>163,500</b>	<b>132%</b>	<b>203,500</b>	<b>-</b>	<b>476,500</b>	<b>273,000</b>
Institutional latrines (stances)	-	-		234	389	166%	566	-	955	389
Household latrines	-	-		1,123	2,312	206%	9,376	-	11,688	2,312
Total latrines	783	1,203	154%	1,357	2,701	199%	9,942	-	13,846	3,904
<b>Sanitation beneficiaries</b>	<b>3,915</b>	<b>6,015</b>	<b>154%</b>	<b>14,975</b>	<b>27,120</b>	<b>181%</b>	<b>69,520</b>	<b>-</b>	<b>102,655</b>	<b>33,135</b>

## Annex 6: Targets &amp; Achievements Primary Education

ID	Lead Agency	Schools - Construction and Services				School - Services				Beneficiaries			
		Target schools	Target classrooms	Actual schools	Actual classrooms	Target	Actual	Target	Actual	Enrolment Total	Girls	Attendance Total	Girls
3a.01	AMA	3	24	3	24		0	1200		902	81	902	81
3a.02	AVSI			2	4	9	9			2616	991	1641	538
3a.03	CMS Ireland	2	16	5	31		0	800		1661	712	515	200
3a.05	DIOCESE OF RUMBEK	2	20	4	27	1	1	900		5377	1679	0	0
3a.07	IRD	3	12	3	12	23	0	600		1291	578	556	238
3a.09	OXFAM NOVIB	6	48	6	52	20	20	2400		2724	1240	1031	483
3a.11	WORLD RELIEF	3	12	3	12		0	600		781	275	0	0
<b>Subtotal</b>		<b>19</b>	<b>132</b>	<b>26</b>	<b>162</b>	<b>53</b>	<b>30</b>	<b>6500</b>	<b>0</b>	<b>15352</b>	<b>5556</b>	<b>4645</b>	<b>1540</b>
3b.01	HARD	3	18	3	18		0	900		1410	443	1280	396
3b.04	UMCOR	1	3	1	4	10	10	150		522	220	424	190
3b.05	WORLD VISION UK	1	8	1	8		0	400		307	94	240	62
<b>Subtotal</b>		<b>5</b>	<b>29</b>	<b>5</b>	<b>30</b>	<b>10</b>	<b>10</b>	<b>1450</b>	<b>0</b>	<b>2239</b>	<b>757</b>	<b>1944</b>	<b>648</b>
<b>Total</b>		<b>24</b>	<b>161</b>	<b>31</b>	<b>192</b>	<b>63</b>	<b>40</b>	<b>7950</b>	<b>0</b>	<b>17591</b>	<b>6313</b>	<b>6589</b>	<b>2188</b>

Assumption 1: 50 beneficiaries per classroom

Assumption 2: 8\*50 beneficiaries per school that receives services

Assumption 3: Beneficiary target equals enrolment figures plus those receiving services

<sup>1</sup> Kind of services to be provided differ and can range from delivery of school books, new furniture to school management and training of teachers

## BSF Phase 2 Completion Report

<sup>2</sup> AVSI constructed 2 classrooms at two schools (outside target, within same budget)

<sup>3</sup> CMS Ireland received more funding (re-allocation) and therefore increased target to 5 schools, 31 classrooms.

<sup>4</sup> The targets of Diocese of Rumbek originally was to re-construct 16 classrooms and construction of 4 totally new classrooms. However in consultation with BSF secretariat a budget revision was handed in for: rehabilitation 9 classrooms and 2 offices, and construction of 18 new classrooms.

<sup>5</sup> Target adjusted to 3 instead of 5. Three is according to the original submitted proposal. Books for the 23 schools have arrived in the county and handed over to the CED, however, distribution will have to take place in the dry season as not all schools are accessible. IRD will assist with transport under BSF-IA.

<sup>6</sup> Oxfam Novib received more funding for an extra classroom block of 4 classrooms.

<sup>7</sup> Providing scholastic materials and comfort kits to 15,000 pupils. Comfort kits has been distributed to 15,000 girls

<sup>8</sup> One school in Ezo County still needs some finalising as contractor had to move due to LRA activities.

<sup>0</sup> School books for 23 schools were procured and arrived in the county however they could yet be distributed because of the rainy season.

## Annex 7: Target &amp; Achievements Primary Health

ID	Lead Agency	PHCC Construction		PHCC Services		PHCU Construction		PHCU Services		Beneficiaries		
		Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Consultations
1.1a	AMREF	1	0	1	1			8	8	133,000	140,396	76,244
1.1b	COMPASS	0	1									
1.3	CCM	1	1	1	1		1	7	6	310,000	281,334	196,163
1.6	SC-US			1	1			9	9	220,000	187,866	56,172
	<b>Subtotal</b>	<b>2</b>	<b>2</b>	<b>3</b>	<b>3</b>	<b>0</b>	<b>1</b>	<b>24</b>	<b>23</b>	<b>663,000</b>	<b>609,596</b>	<b>328,579</b>
2.1	GOAL			2	2			4	4	137,046	133,054	82,846
2.4	MERLIN	1	1	1	4			2	2	143,752	299,266	46,384
2.5	OVC			4	4					200,000	372,413	137,825
2.7a	TEAR FUND			3	3			9	9	250,000	201,011	90,709
2.7b	MEDAIR			1	1			6	6	140,000	49,242	66,745
	<b>Subtotal</b>	<b>1</b>	<b>1</b>	<b>11</b>	<b>14</b>	<b>0</b>	<b>0</b>	<b>21</b>	<b>21</b>	<b>870,798</b>	<b>1,054,986</b>	<b>424,509</b>
3a.02	AVSI			1	1			4	4	125,000	84,649	43,523
3a.03	CMS Ireland	1	1			2	2			68,000	620,058	11,996
3a.04	CONCERN worldwide			1	1	2	3	5	4	212,065	104,047	69,333
3a.07	IRD			1	1	4	3			110,000	65,588	16,400
3a.10	SWISS RED CROSS	1	0			1	2			15,000	53,783	1,974
	<b>Subtotal</b>	<b>2</b>	<b>1</b>	<b>3</b>	<b>3</b>	<b>9</b>	<b>10</b>	<b>9</b>	<b>8</b>	<b>530,065</b>	<b>928,125</b>	<b>143,226</b>
3b.02	IMC UK			2	2			11	10	385,587	140,296	66,134
3b.03	MEDAIR		1	2	1	2	2			130,000	167,481	34,453
3b.05	WORLD VISION UK				2	2	2	6	4	30,000	168,562	96,724
	<b>Subtotal</b>	<b>0</b>	<b>1</b>	<b>4</b>	<b>5</b>	<b>4</b>	<b>4</b>	<b>17</b>	<b>14</b>	<b>545,587</b>	<b>476,339</b>	<b>197,311</b>
	<b>Grand Total</b>	<b>5</b>	<b>5</b>	<b>21</b>	<b>25</b>	<b>13</b>	<b>15</b>	<b>71</b>	<b>66</b>	<b>2,609,450</b>	<b>3,069,046</b>	<b>1,093,625</b>

## BSF Phase 2 Completion Report

1. COMPASS took over the construction target of AMREF
2. SC-US: project finished in June 2009, therefore no reporting of beneficiaries
3. MERLIN included 3 PHCCs (March 2010) in the project, within the same budget
4. One PHCU is not functioning as all services are available in very nearby PHCU, also supported by AVSI. However, this one PHCU was also not part of their target, therefore 4 out of the 4 PHCUs are functioning.
5. CMS Ireland is supporting 8 PHCUs, using two mobile clinics
6. CONCERN has upgraded/ constructed additional PHCU, using budget from the budget re-allocations
7. Swiss Red Cross had no sufficient budget to build one PHCU and one PHCC, and has therefore constructed two PHCUs
8. Tearfund handed over in June 2010 one of the three PHCCs to SMoH
9. Previously reported on as provision of services to two PHCCs however the service of one became a major construction.
10. Target has been adjusted from four to three because of insecurity in the area and the beneficiaries left

## Annex 8: Targets & Achievements Drinking Water

ID	Lead Agency	BH with hand-pump		Rehabilitated BH with hand-pump		Gravity scheme/other water source		Beneficiaries	
		Target	Actual	Target	Actual	Target	Actual	Target	Actual
1.1b	COMPASS			10	8		1		0
2.1	GOAL						1		
	<b>Subtotal</b>	<b>0</b>	<b>0</b>	<b>10</b>	<b>8</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>0</b>
3a.01	AMA	48	47				0	24000	24500
3a.02	AVSI		5		13	5	0	2500	9000
3a.03	CMS Ireland	9	8		1		0	4500	4500
3a.06	INTERMON OXFAM	15	16	30	36	1	0	23000	22500
3a.07	IRD			15	15		0	7500	7500
3a.08	OXFAM GB	35	28	20	32	4	5	29500	32000
3a.10	SWISS RED CROSS	19	20		26			9500	500
3a.11	WORLD RELIEF	0	1						
	<b>Subtotal</b>	<b>126</b>	<b>125</b>	<b>65</b>	<b>123</b>	<b>10</b>	<b>5</b>	<b>100500</b>	<b>100500</b>
3b.01	HARD	3	3					1500	1500
3b.02	IMC UK			20	38			10000	0
3b.04	UMCOR	4	10					7000	5000
3b.05	WORLD VISION UK	5	5	15	15		1	10000	12000
	<b>Subtotal</b>	<b>12</b>	<b>18</b>	<b>35</b>	<b>53</b>	<b>0</b>	<b>1</b>	<b>28500</b>	<b>18500</b>
	<b>Grand Total</b>	<b>138</b>	<b>143</b>	<b>110</b>	<b>184</b>	<b>10</b>	<b>8</b>	<b>129000</b>	<b>119000</b>

0. GOAL constructed with extra funding a roof water harvesting system and one of their health facilities
1. AMA drilled one borehole less, 5 boreholes still need a platform, but are functioning. BSF secretariat is following up.
2. AVSI drilled 5 boreholes instead of 5 alternative water sources.
3. OXFAM GB drilling target reduced with 4; therefore rehabilitation target increased with 7, one additional water harvesting scheme, and rehabilitation of one water scheme.
4. WORLD RELIEF received extra funding to drill one borehole at one of the schools under construction.
5. UMCOR received funding to drill 4 additional boreholes, and drilled another 2 extra boreholes within the same budget (budget revision)

## Annex 9: Targets &amp; Achievements Sanitation

ID	Lead Agency	Institutional latrines (stances)		Household latrines		Beneficiaries	
		Target	Actual	Target	Actual	Target	Actual
1.1a	AMREF						
1.1b	COMPASS		4				
	<b>Subtotal</b>	<b>0</b>	<b>4</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
1.3	CCM						
1.6	SC-US						
2.1	GOAL						
2.4	MERLIN						
2.5	OVC						
2.7a	TEARFUND						
2.7b	MEDAIR						
	<b>Subtotal</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
3a.01	AMA	24	24			120	
3a.02	AVSI	6	24	500	250	2530	150
3a.03	CMS Ireland	10	78			50	3262
3a.04	CONCERN worldwide		6				
3a.05	DIOCESE OF RUMBEK						
3a.06	INTERMON OXFAM	40	52	350	1064	1950	
3a.07	IRD	40	35			400	160
3a.08	OXFAM GB	40	39		854	200	1650
3a.09	OXFAM NOVIB	24	48			120	
3a.10	SWISS RED CROSS		4	189	120	945	600
3a.11	WORLD RELIEF	12	11			60	
	<b>Subtotal</b>	<b>196</b>	<b>321</b>	<b>1039</b>	<b>2288</b>	<b>6375</b>	<b>5822</b>
3b.01	HARD		10				
3b.02	IMC UK	10	20	60		350	
3b.03	MEDAIR		8				
3b.04	UMCOR	12	12	24	24	560	600
3b.05	WORLD VISION UK	16	14			80	
	<b>Subtotal</b>	<b>38</b>	<b>64</b>	<b>84</b>	<b>24</b>	<b>990</b>	<b>600</b>
	<b>Grand Total</b>	<b>234</b>	<b>389</b>	<b>1123</b>	<b>2312</b>	<b>7365</b>	<b>6422</b>

Assumption 1: In case beneficiary number is not reported on for a school or health facility, 40 beneficiaries per stance.

Assumption 2: Beneficiaries for household latrines is the average size of a household in Southern Sudan, therefore 5 beneficiaries per household latrine.

1. Activity was lacking behind, however Intermon Oxfam did an assessment in the villages they are working in and found many more latrines than reported on in previous reports. These latrines are not supported by IO, however dug in the villages they are doing hygiene and sanitation awareness campaigns.
2. Oxfam GB reporting on household latrines not clear and number might be higher than reported.
3. Not all the slabs were distributed; pits dug and also received the oil drums (as an alternative for expensive lined latrines).
4. All slabs are distributed; however activity still needs follow up under BSF-IA.

## Annex 10: Targets and Achievements Short Term Training per NGO

ID	Lead Agency	Participants				Training Days			
		Target	Total	Female	% Female	Target	Total	Female	% Female
1.3	CCM	180	141	4	3	900	1147	52	5
1.6	SC-US	330	42	0	0	1650	224	0	0
	<b>Subtotal</b>	<b>510</b>	<b>183</b>	<b>4</b>	<b>2</b>	<b>2550</b>	<b>1371</b>	<b>52</b>	
2.1	GOAL	500	781	343	44	2500	2411	1085	45
2.5	OVCII	1100	530	382	72	5500	2909	2101	72
2.7a	TEARFUND	1750	1016	476	47	8750	5636	2849	51
2.7b	MEDAIR	990	6813	2732	40	4950	15985	5724	36
	<b>Subtotal</b>	<b>4340</b>	<b>9140</b>	<b>3933</b>		<b>21700</b>	<b>26941</b>	<b>11759</b>	
3a.01	AMA	2968	359	91	25	5349	1432	364	25
3a.02	AVSI	3836	3646	1750	48	11924	5914	2306	39
3a.03	CMS Ireland	114	180	61	34	1970	1062	456	43
3a.04	CONCERN worldwide	295	286	119	42	735	1992	564	28
3a.05	DIOCESE OF RUMBEK	37	208	764	367	158	3564	3484	98
3a.06	INTERMON OXFAM	3111	1945	1021	52	39864	8778	4423	50
3a.07	IRD	152	2064	805	39	1806	3081	1112	36
3a.08	OXFAM GB	648	12055	7293	60	7992	17453	9227	53
3a.09	OXFAM NOVIB	340	463	144	31	8880	13168	3593	27
3a.10	SWISS RED CROSS	359	735	242	33	1610	2480	570	23
3a.11	WORLD RELIEF	2304	11083	5229	47	41400	56623	23119	41
	<b>Subtotal</b>	<b>14164</b>	<b>33024</b>	<b>17519</b>		<b>121688</b>	<b>115547</b>	<b>49218</b>	
3b.01	HARD	37	122	29	24	310	1450	355	24
3b.02	IMC UK	293	322	158	49	1450	820	505	62
3b.03	MEDAIR	2	972	483	50		2047	1247	61
3b.04	UMCOR	56	515	136	26	185	1270	240	19
3b.05	WORLD VISION UK	8460	838	277	33	10075	4088	1317	32
	<b>Subtotal</b>	<b>8848</b>	<b>2769</b>	<b>1083</b>		<b>12020</b>	<b>9675</b>	<b>3664</b>	
	<b>Grand total</b>	<b>27862</b>	<b>45116</b>	<b>22539</b>		<b>157958</b>	<b>153534</b>	<b>64693</b>	

## Annex 11: Target & Achievements Short Term Training per Sector

Sector	Total participants			Training Days		
	Total	Female	% Female	Total	Female	% Female
Capacity Building – general	3079	1084	35	10678	3106	29
Primary Education	13513	6380	47	78790	31167	40
Primary Health	14241	5954	42	35760	15315	43
Water and Sanitation	17855	10133	57	33533	16566	49
<b>Grand total</b>	<b>48688</b>	<b>23551</b>	<b>48</b>	<b>158761</b>	<b>66154</b>	<b>42</b>

## Annex 12: Targets & Achievements per Category Trainees

Topic/ Category	Participants			Training Days		
	Total	Female	% Female	Total	Female	% Female
Clinical Officers	61	29	48	449	215	48
Community health workers	1113	343	31	2892	681	24
Community leaders	3381	1210	36	10733	3203	30
Community mobilization	19625	11103	57	21371	11512	54
EPI teams	308	111	36	1930	717	37
Head teachers	736	63	9	8453	706	8
Health & Hygiene Promoters	21	16	76	43	30	70
HIV/ AIDS	867	313	36	4553	949	21
Hygiene and sanitation	6535	2748	42	7248	2938	41
Lab technicians	94	49	52	1350	300	22
Laboratory Assistant	12	0	0	210	0	0
Midwives/ TBA	1584	1179	74	5858	4875	83
Midwives/Traditional Birth Attendants	15	15	100	8	8	100
NGO Staff	124	43	35	320	102	32
Nurses	237	190	80	925	747	81
Nutrition Assistants/ extension workers	70	29	41	385	197	51
Pharmacy technicians	27	0	0	102	0	0
PHC staff	890	314	35	4237	1228	29
Promoters/ Community mobilisers	399	169	42	1611	688	43
PTA	1082	355	33	4188	1237	30
PTC staff	38	18	47	114	54	47
Public Basic Hygiene and Sanitation	226	146	65	928	578	62
Pump mechanics	430	56	48	3788	414	48
School Hygiene and Sanitation Clubs	4665	2637	31	40110	21535	24
State Gov Civil Servants	727	87	36	4467	426	30
Teachers	992	550	57	16056	5042	54
Village health committees	989	298	36	3269	928	37
Village Health Motivators	1596	759	9	8639	4589	8
Water committee members	1498	714	76	4491	2248	70
Water Quality	33	7	36	33	7	21
<b>Grand Total</b>	<b>48375</b>	<b>23551</b>	<b>42</b>	<b>158761</b>	<b>66154</b>	<b>41</b>

## Annex 13: Target & Achievements Long term Training Primary Education

Contract	Lead Agency	Pre-service			In-Service			English Course	
		Target	Total	Female	Target	Total	Female	Total	Female
3a.01	AMA								
3a.02	AVSI				40				
3a.03	CMS Ireland	2	6	4		38	4		
3a.05	DIOCESE OF RUMBEK								
3a.07	IRD					123	17		
3a.09	OXFAM NOVIB				40	72	13	39	19
3a.11	WORLD RELIEF				640	835	135		
	<b>Subtotal</b>	<b>2</b>	<b>6</b>	<b>4</b>	<b>720</b>	<b>1068</b>	<b>169</b>	<b>39</b>	<b>19</b>
3b.01	HARD				60	102	16		
3b.04	UMCOR				40				
3b.05	WORLD VISION UK				20	78	7		
	<b>Subtotal</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>120</b>	<b>180</b>	<b>23</b>	<b>0</b>	<b>0</b>
	<b>Grand Total</b>	<b>2</b>	<b>6</b>	<b>4</b>	<b>840</b>	<b>1248</b>	<b>192</b>	<b>39</b>	<b>19</b>

## Annex 14: Targets & Achievements Long Term Training Primary Health

ID	Lead Agency	Clinical Officer		Nurse		Midwife		Lab Technician		Pharmacy Technician		Dispenser		CHW		TBA		VCT		Public Health Technician		
		T	F	T	F	T	F	T	F	T	F	T	F	T	F	T	F	T	F	T	F	
1.1a	AMREF					1	1														2	
1.3	CCM							6	0													
	Subtotal	0	0	0	0	1	1	6	0	0	0	0	0	0	0	0	0	0	0	0	2	0
2.1	GOAL							1	0					18	0							
2.4	MERLIN																		1	0	1	0
2.7a	TEARFUND	3	0	2	0	5	5	2	0	3	0			8	8					1	0	
2.7b	MEDAIR	3	1			3	0	1	0													
	Subtotal	6	1	2	0	8	5	4	0	3	0	0	0	26	8	0	0	1	0	2	0	
3a.03	CMS Ireland	1	1	1	1	1	1	1	1					10	2							
3a.04	CONCERN worldwide			5	0	3	3	1	0													
3a.07	IRD																		1	0		
3a.10	SWISS RED CROSS			3	0	1	1															
	Subtotal	1	1	9	1	5	5	2	1	0	0	0	0	10	2	0	0	1	0	0	0	
	Grand Total	7	2	11	1	14	11	12	1	3	0	0	0	36	10	0	0	2	0	4	0	

## Annex 15: Steering Committee Meetings

No.	Date	Place	Agenda	Participants
1	28 October 2005	Rumbek	BSF and TOR SC	n.a.
2	10, 11 January 2006	Juba	Capacity building of SC and selection proposals	20
3	6, 7 April 2006	Juba	Update on progress and 2nd call for proposals	20
4	6, 7 September 2006	Juba	Evaluation of BSF NGOs, procedure for 2nd call	18
5	17 October 2006	Juba	Pre-selection 2nd call	9
6	13 December 2006	Juba	Selection of short listed proposals	
7	7 May 2007	Juba	Progress on implementation	15
8	22 August 2007	Juba	Progress on implementation	14
9	6 December 2007	Juba	Progress on implementation	14
10	10 January 2008	Juba	Briefing MTR	15
11	19 January 2008	Juba	De-briefing MTR	20
12	14 May 2008	Juba	Progress on implementation and future of BSF	
13	27 May 2008	Juba	BSF and TOR SC	15
14	15 July 2008	Juba	BSF extension	12
15	19 August 2008	Juba	Planned	
16	15 September 2008	Juba	3rd round priorities (special session on planning)	12
17	4 November 2008	Juba	3rd round concept papers pre-evaluation	14
18	10 December 2008	Juba	3rd round proposal ranking	11
19	10 March 2009	Juba	Update on closing down Phase-1, starting up Phase-2	16
20	13 July 2009	Juba	Update on implementation and exit strategies	20
21	26 August 2009	Juba	Annual review debriefing	
22	20 October 2009	Juba	Progress on implementation and future of BSF	25
23	27 January 2010	Juba	Implementation update	25
24	24 March 2010	Juba	Disbursement update, revised SC ToR, application procedures new round of proposals	18
25	14 May 2010	Juba	BSF-2 & BSF-IA	17
26	1 June 2010 15:00PM	Juba	BSF-2 & BSF-IA	25
27	8 September 2010	Juba	BSF-IA	26
28	1 December 2010	Juba	BSF-IA	planned

## Annex 16: Technical Assistance Planned and Actual

Name	Designation	No Days Budgeted	No. of Days Realised	Balance
Klaziena Louwes	Team Leader	469	464	+5
Geerte van der Meijden	Monitor – WatSan	435	435	0
Serena Bossi	Financial Manager	199.5	199.5	0
Gerard Fischer/A. Jansen	Financial Manager	238.5	240	-1.5
Sarah Baba Lasuba	Office Manager	454	450	+4
Nic Ramsden	Monitor - Education	175	176	-1
Wim Groenendijk	Monitor - Health	428	425.5	+2.5
<b>Short Term</b>				
Dirk Doorn	Commercial Manager	20	14	6
Ivo Gijsberts	Project Director	110	110	0
Piet de Wildt	Contracts Manager	5	5	0
Paolo Operti	Primary Health Specialist	15	15	0
Una Macaskill	Primary Health Specialist	61	61	0
Anna Vassall	Primary Health Specialist	0.25	0.25	0
Charlie Goldsmith	Education Specialist	25	25	0
Rob Denny	Capacity Building Specialist	46	46	0
Clarissa Mulders	WatSan Specialist	28	28	0
Erik Holtus	Project Controller	110	110	0
Rainier Battenberg	Webmaster	30	23	7
Wim Romp	MIS Specialist	25	25	0
Florent Lasry	GIS Specialist	25	25	0
Betty Gimu	Financial Administrator	103	51	52
<b>TOTAL INPUT BSF PHASE II (A)</b>		<b>3,002</b>	<b>2,928.25</b>	<b>97.5%</b>

## Annex 17: Field Trips

	Date	Grant Recipient; State
1	23 – 24 Feb. 2009	Diocese of Rumbek; Lakes
2	26 – 28 February 2009	AVSI; Eastern Equatoria
3	5 – 8 March 2009	AMREF; Central Equatoria
4	13 – 16 March 2009	CCM; Warrap
5	20 – 21 March 2009	MERLIN; Eastern Equatoria
6	31 March 2009	HASS; Central Equatoria
7	20 – 22 April 2009	OXFAM NOVIB, Western Equatoria
8	22 – 25 April 2009	CMS Ireland, Central Equatoria
9	10 -15 May 2009	IRD, Jonglei
10	12 – 14 May 2009	SRC, Unity
11	18 – 22 May 2009	Medair; Upper Nile
12	18 - 20 May 2009	AMA, Warrap
13	22 – 25 May 2009	Tearfund; Upper Nile
14	26 – 30 May 2009	GOAL; Upper Nile
15	6 – 7 June 2009	Save USA; Upper Nile
16	7 – 12 June 2009	OXFAM GB; Upper Nile
17	8 – 9 June 2009	Diocese of Rumbek, Northern Bahr el Ghazal
18	10 – 12 June 2009	CONCERN; Northern Bahr EL Ghazal
19	28 June – 1 July 2009	AMREF; Central Equatoria (together with Dr Felix Loro and Dr Elizabeth Benga-De of MSH)
20	15 – 17, 20, 22 July	HASS; Central Equatoria State
21	20 – 23 July 2009	AMREF; Central Equatoria
22	13 – 15 August 2009	Swiss Red Cross; Unity
23	17 August 2009	Diocese of Rumbek; Lakes
24	21 August 2009	World Relief; Western Equatoria
25	21 – 24 August 2009	Medair, Tearfund, GOAL; Upper Nile. MTR!!
26	21 – 23 August 2009	Merlin, Caritas; Eastern Equatoria - do-
27	24 August 2009	OVCI; Central Equatoria -do-
28	28 – 31 August 2009	Intermon OXFAM; Western Bahr El Ghazal
29	27 August, 4 September 2009	HARD; Upper Nile
30	1 – 7 September 2009	Save USA; Upper Nile
31	7 - 8 October, 2009	MERLIN; Eastern Equatoria
32	8 – 10 October, 2009	AVSI; Eastern Equatoria
33	13 - 17 October, 2009	WORLD VISION; Western Equatoria
34	1-4 November, 2009	AMREF; Central Equatoria (MoH verification mission; MoH-GoSS, BSF, MSH)
35	4 November, 2009	OXFAM NOVIB; Western Equatoria
36	5-7 November, 2009	Exchange visit to CHDs of Katigiri and Lainya, Central Equatoria
37	16 – 18 November, 2009	CONCERN; Northern Bahr El Ghazal
38	16 November, 2009	UMCOR; Northern Bahr El Ghazal
39	21 and 28 November,2009	DIOCESE OF RUMBEK; Lakes
40	24 – 26 November,2009	AMA; Warrap
41	2 – 4 December,2009	IRD; Jonglei

## BSF Phase 2 Completion Report

	Date	Grant Recipient; State
42	4 – 9 December,2009	CCM; Warrap
43	9 – 16 December,2009	IMC; Jonglei
44	26 – 29 January 2010	AMREF and COMPASS, Central Equatoria
45	2-4 February 2010	MERLIN, Eastern Equatoria
46	4-9 February 2010	TEARFUND, MEDAIR & Malaria Consortium, Upper Nile
47	4 – 8 February 2010	IRD, Jonglei
48	8-10 February 2010	HARD, Western Bahr El-Ghazal
49	10-13 February 2010	WORLD VISION, Western Equatoria
50	11-12 February 2010	OXFAM NOVIB, Western Equatoria
51	15-17 February 2010	SC-UK, Jonglei
52	16-17 February 2010	UMCOR, Northern Bahr El Ghazal
53	17-20 February 2010	CONCERN, Northern Bahr El Ghazal
54	17 – 24 February 2010	IMC. Jonglei
55	18 – 21 February 2010	WORLD RELIEF and DIOCESE OF RUMBEEK, Lakes
56	18 – 20 February 2010	SWISS RED CROSS, Unity
57	23 – 27 February 2010	OXFAM GB, Upper Nile
58	25 -27 February 2010	OVCI. Central Equatoria
59	1-3 March 2010	CMS Ireland, Central Equatoria
60	15-17 March 2010	HARD, Western Bahr El-Ghazal, and AMA, Warrap
61	18 – 19 March 2010	AVSI, Western Equatoria
62	22 – 26 March 2010	INTERMON OXFAM, Western Bahr el Ghazal
63	6 – 8 May 2010	AMREF and COMPASS; Central Equatoria State
64	24 – 26 May 2010	World Relief and Diocese of Rumbek, Lakes State
65	14 – 21 June 2010	AMA, Warrap
66	20 - 22 July 2010	SRC, Unity

## Annex 18: BSF Key Dates

Year	Date	Event and details	
2005	September	DFID Khartoum contracts the IDL group and Skills for Southern Sudan to help prepare the establishment of the Basic Services Fund	
	October	First Steering Committee Meeting in Rumbek announcing the launch of the Basic Services Fund	
	November	Skills for Southern Sudan launches first call for proposals	
	December	DFID invites 6 consultancy companies to tender for the provision of management consultancy services to the BSF	
2006	January	Second SC meeting to decide on selection of projects DFID informs selected NGOs about award of contract	
	February	Deadline for the submission of tenders for the proposals for the management consultant	
	March	DFID Khartoum signs accountable grant agreements with NGO grant recipients	
	Q2	Grant recipients receive first payments directly from DFID	
	August	DFID signs contract with selected management consultant BMB Mott MacDonald (formerly Arcadis BMB)	
	Q 4	BMB MM starts transfer of contracts with grant recipients from DFID to BMB MM; DFID closes all grant agreements by Dec. 2006	
	September	BMB MM launches 2nd call for proposals	
	October	Information workshop in Juba with pre-selected NGO	
	November	BSF Team Leader Kate Louwes starts assignment	
	December	Steering Committee meeting to decide on selection of NGOs BMB MM informs selected NGOs about award of contract	
	2007	January	Second round project contracts signed between Grant recipients and BMB MM and effective 1 January 2007
		February	DFID and BMB MM sign contract amendment no.2 which includes £14.94m in NGO programme funds (omission in initial contract)
March		BMB MM starts to reimburse first claims from NGOs	
November		Planned Mid Term review gets delayed until December and later until January 2008	
2008	January	Post election crisis in Kenya delays return of many Kenyan NGO staff	
	January	Mid Term Review (originally planned for Nov 2007) takes place	
	April	DFID extends contract with BMB MM with 8 months until 31 December 2008 and tops up programme funds with £1.68m	
	Q1-2	Contracts with NGOs are extended till 30 September 2008; all receive a cost extension, except AMREF, SC-US and SC-UK due to delays with implementation	
	July	Fieldtrip fro Lessons Learnt analysis Primary Education	
	12 August	Start dissemination Lessons Learnt workshop Primary Education	
	Q3	Contracts with NGOs are extended till 31 December 2008; this is a no-cost extension, without additional funding	
	Q 4	Decision to extend all first and second round BSF Grant recipients in primary health	
	September	BMB MM launches 3rd call for proposals Launch SRF (verify date) 1st call proposals	
	26-29 October	GOSS-second National Health Assembly (BSF consultant assisted in preparing the proceedings (on website)	
	November	Information workshop in Juba with pre-selected NGOs	
December	Steering Committee meeting to decide on selection of NGOs BMB MM informs selected NGOs about award of contract		

## BSF Phase 2 Completion Report

Year	Date	Event and details
2009	January	DFID as lead donor signs agreements with NORAD and DGIS for additional contributions to BSF.
	January	DFID and BMB MM sign contract amendment no.9 which includes extension till 31 August 2010 (phase 2) and new programme funds of £17.4m
	February	Phase 2 project contracts signed between Grant recipients and BMB MM and effective 1 January 2009 for a duration of 18 months
	12 February	Start dissemination and sharing Lessons Learnt in Water & Sanitation
	April	CIDA contribution is confirmed and DFID and BMB MM sign contract amendment no. 10, which includes additional programme funds of £3.9m
	4th April	Kick-off meeting with third round BSF grantees
	April	Field work on follow-up lessons learnt Primary Education
	April	BMB MM signs contracts with 4 additional grant recipients selected as runners-up during the third call evaluation process; project have a start date of 1 April 2009 and a duration of 15 months
	20 May	Financial reporting workshop
	June	Closure of all contracts signed with grant recipients selected in calls 1 and 2 (phase 1)
	5 June	Financial reporting workshop
	16 June	Closing workshop on first Peer Review that took place in Q 4 of 2008 (presentation of main findings and conclusions)
	22 September	DFID and BMB sign contract amendment no. 11 including a reduction of the CIDA contribution (due to sterling – dollar exchange rate fluctuations) plus a transfer of unspent programme funds from phase 1 to phase 2
	October	Third GoSS Health Assembly (BSF will assists again with consultant for the drafting of proceedings) did this take place?
	26 October	Submission of Phase 1 Final Report
2010	20 March	Closing down workshop for BSF Implementing Partners
	13-15 April	National Elections
	March-April	Round of negotiations with NGO Implementing Partners to re-allocate budgets
	April-May	Contract amendments (budget revisions) with NGO Implementing Partners
	30 June	End of contracts Primary Health extension (round 1 and 2)
	30 June	End of contracts Round 3A and 3B
	July - August	BSF grantees submit final completion report, updated asset list, expenditure verification report (audit) and final invoice
	31 August	End of contract DFID-BMB MM
	30 September	Submission of Phase 2 Final Report