



South Sudan/Somaliland Country Office

**Foundations for Local NGOs to Adequately Support Health Services
(FLASH)**

Fourth Quarter and Annual Report 2005



The two blocks of Maiwut Primary health care unit, rehabilitated under the project.

May, 2006

Name and Address of the organization	Save the Children Federation Inc. USA 54 Wilton Road, Westport, CT 06880, USA PO Box 949-00606 Nairobi, Kenya Telephone: 254-2-3744228 Fax: 254-2-3740943
Name and title of contact person(s)	Kathleen Campbell South Sudan/Somaliland Country Director Email Address: kcampbell@savechildren.or.ke Tel: +254 722236033/ 0203740943
Title of Proposed Project	Foundations for Local NGOs to Adequately Support Health Services (FLASH)
Project Location (Region, state, county, payam)	Rashad, Lagawa and Kadguli Counties in the Nuba Mountains; Akobo, Maiwut, Manyo / Tonga, Maaban, Nasir, Ayod, Luakpiny, Ulang, Nyirol and Wurol counties of Eastern Upper Nile, Central Upper and Jonglei region
Type of Hazard	Post Conflict Recovery and Development
Period of Implementation	January 1 2005 – December 31, 2005
Dollar amount requested from OFDA	\$3,498 970
Estimated amount of in-kind contribution (UNICEF)	\$95,000.00
Others	\$77,800
Total Project Cost	\$3,671,770

Acronyms

ANC	Antenatal Care
ARI	Acute Respiratory Infection
CAC	Community Action Cycle
BCC	Behavior change and Communication
CCRI	Cush Community Relief International
CHD	County Health Department
CHW	Community Health Worker
EUN	Eastern Upper Nile
FLASH	Foundations for Local NGOs to Adequately Support Health services
EPI	Expanded Program on Immunization
GARDOS	Global Alliance Relief and Development organization for Sudan
GoSS	Government of South Sudan
IDPs	Internally displaced persons
IR	Intermediate result
LLITN	Long Lasting Insecticide Treated Nets
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
MoH	Ministry of Health
MRDO	Maban relief and Development organization
MSF	Medicines Sans Frontiers
NCDA	Nasir Community Development Association
NGO	Non-Governmental Organization
NHDF	Nile Hope Development Foundation
NRRDO	Nuba Relief, Rehabilitation and Development organization
OFDA	Office of foreign disaster assistance
PDQ	Partnership Defined Quality
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PSF	Pharmaciens sans frontiers
SC	Save the Children
SDA	Sobat Development Agency
SO	Strategic Objective
SoH	Secretariat of Health
SUHA	Sudan health association
SRDA	Sudan Rural Development agency
SWIDAP	Sudan Women in Development and Peace
STIs	Sexually Transmitted infections
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UNICEF	United Nations Children Fund
UNKEA	Upper Nile kalazar eradication Association
USAID	United States Aid for International Development
VHDC	Village Health and Development Committees
WFP	World Food Program
YARRDSS	Youth Relief and rehabilitation development for South Sudan

I. EXECUTIVE SUMMARY

The last 12 months have seen tremendous achievements for the women, children and families of South Sudan particularly in the Nuba Mountains, Upper Nile and Jonglei, through successful implementation of the Foundations for Local NGOs to Adequately Support Health Services (FLASH) project with funding support from USAID/OFDA. The goal of FLASH was to improve the health and nutritional status of Sudanese children, women and their families by increasing the use of primary health care services and key preventive and promotive services and practices. This was achieved through increasing the availability, access, and demand for primary health care services and in conjunction with strengthening the local capacity of southern Sudanese people. The project built on Save the Children US (SC) principle of mobilizing and working with communities in order to usher them from relief to development through building their capacity and strengthening the existing rudimentary and nascent health systems in the impact areas.

Several initiatives have been launched in the impact areas. Impact areas are traditionally underserved areas as shown by the low rates of utilization of preventive and promotive services and practices. These initiatives have reversed the negative morbidity trends and other adverse health outcomes experienced during the decades of civil war and limited service provision, particularly in Eastern Upper Nile (EUN) region reflected in NSCE 2004 South Sudan estimates. In Nuba Mountains, services were scaled up with coverage expanding beyond the counties that were earmarked for the project.

Over this period, SC in partnership with the indigenous Sudanese NGOs (SUHA, GARDOS, NHDF, SWIDAP, Servants Heart, NCDA, CCRI, SDA, UNKEA, YARRDSS, MRDO, and NRRDO the only LNGO in the Nuba mountains) operated and managed **41** health facilities. In Nuba Mountains, **22** Primary Health Care Units (PHCUs) formed a network of facility-based decentralized service provision with four Primary Health Care Centers (PHCCs) serving as referral centres for each unit in each catchment area. In the Eastern Upper Nile, the project established service provision in **19** PHCUs in five counties and supported a PHCC within the same region. Over the reporting period the facility total attendance has been 187,000 people, while outreach services continued to be provided within the returnee corridors of selected counties. The resulting health care establishments extended EPI services to women of child bearing age through routine and outreach schedules. A total of 6,424 women of child bearing age and 1548 children were fully immunized. During the reporting period, regional disparities in service provision were experienced as a consequence of various operational issues and technicalities. This caused deviations in regional results, putting the Nuba region in a definite advantage over the Eastern Upper Nile that had rudimentary health systems. The same project saw the complete rehabilitation of three facilities, while basic repairs and construction work in other PHCUs is currently ongoing.

Throughout the project, SC undertook the critical role of the capacity building within the transitional post conflict era in South Sudan. SC has substantially contributed to the local NGOs capacity through various individual and organizational centered approaches which include: counterpart mentorship, on the job coaching, operational facilitation, planning together, training and logistics support. More emphasis was laid on community mobilization (CAC), Partnership Defined Quality (PDQ) and BEHAVE focused behavior change trainings. These were mainstreamed into communities in all aspects of health care management, through an institutionalized participatory framework that promotes sustainability.

Due to various contextual and operational complexities, the project performance was adversely affected by high flight costs, a long span of adverse weather, logistical and transport limitations, accompanied by the limited local capacity. The agency and partners have managed to overcome some of these challenges. The lessons learnt and the approaches employed forms a basis for more effective programming.

This dual approach to program implementation strategy (direct and through partnership) has contributed, in many ways, to the improvement of the health status of the southern Sudanese people and the realization of SC mission of creating real, lasting and positive change to the lives of children and women in need. The agency through this program demonstrates its commitment to supporting the GOSS in implementing the comprehensive peace agreement.

II. PROGRAM OVERVIEW

The project focused primarily on creating capacity of Local NGOs to support health services and at the same time ensuring high quality-high impact services are available to the communities. This was done in line with the Government of South Sudan's (GoSS) Ministry of Health (MoH) (formerly Secretariat of Health (SoH)) guidelines and USAID's past Interim Strategic Plan for Sudan (ISPS) SO 7 that focused on increasing the use of health, water and sanitation services and practices. There has been several capacity building approaches and strategies applied to uplift the organizational and programming skills of the local NGOs to manage and support provision of these services while developing their potential for sustaining such health projects. These high impact services formed the curative and preventive components of the project and included: treatment of ARI, malaria prevention and treatment, diarrheal disease control, distribution of LLITNs, provision of antenatal care, delivery services and EPI. The project was also involved in the improvement of hygiene through health education and in providing syndromic management of sexually transmitted infections (STIs), including HIV/AIDS awareness. The mode of implementation was county-specific with the indigenous NGOs implementing differing activities in specific counties as a result of the level of capacity and existing unmet needs. SC seeks to ensure that the local NGOs' organizational and institutional structure is strengthened at the operational and management levels and build capacities for sustainability as part of a suitable exit strategy.

III. PROGRAM GOAL AND OBJECTIVES

The project had one main strategic objective, with results oriented strategies and specific interventions. Each intermediate result (IR) incorporated certain aspects of capacity building.

Goal:

Improve health and nutrition status of women and children in the impact areas.

Strategic Objective:

Increase use of primary health care services and adoption of key preventive and promotive services and practices.

Intermediate results:

The following results and strategies are linked to the strategic objective:

IR1: Increased availability of and accessibility to primary health care services.

- 1) Increased number of PHCCs and fixed PHCUs providing comprehensive primary health care services
- 2) Increased outreach services and mobile health teams
- 3) Established /improved referral systems
- 4) Distribution of long lasting Insecticide Treated Nets (LLITNs)

IR2: Improved quality of maternal and child health services

- 1) Established county quality assurance teams
- 2) Improved health service providers', skills in the delivery of selected primary health care
- 1) Services
- 2) Improved community health workers skills in delivery of selected primary health care
- 3) services.
- 4) Improvement of infection prevention practices at all service delivery points
- 5) Strengthened supervisory system
- 3) Needed resources made available

IR3: Increased demand for primary health care services and adoption of key preventive and promotive health practices.

- 1) Implemented behavior change intervention (BCC) strategy to improve care seeking and adoption of key preventive and promotive health practices.
- 2) Developed and produced identified BCI and counseling materials.
- 3) Trained health workers to promote preventive and promotive practices at facilities and in the communities
- 4) Community participation, ownership and gender integration

IR4: Strengthened Sudanese NGO, and County health department and community capacity for sustainable primary health care services.

- 1) Improved Sudanese NGO's and CHDs' managerial and health project implementation capacity
- 2) Improved the managerial skills of Village Health and Development, and Health Management Committee members
- 3) Improved Sudanese NGOs' and CHDs' skills in disaster preparedness.

IV. DESCRIPTION OF DATA

The project data requirements largely depended on health facility service statistics. Only one population-based baseline survey was conducted, which was in Maiwut County. Therefore, the data collected from the facilities has mainly formed the basis of this and several other reports. Overall, the data gathering capacities of the project had some regional differences with Nuba region exhibiting higher capacity as a result of more qualified regional staff compared to the local staff in Upper Nile. Due to the vastness of the impact area, the Knowledge Practices and Coverage baseline survey conducted in Eastern Upper Nile can only be used as proxy for the findings related to various variables. In addition, an end line survey was not budgeted for, and no significant changes from the baseline values are expected because of the limitations related to a short implementation time frame resulting from weather related delays.

V. TARGET POPULATION AND BENEFICIARIES

The characteristics of the population in the impact areas are highly variable due to the dynamics of various demographic processes and various temporal changes. The rate of population movement as a result of IDPs and returnees and seasonal migrations, potentially complicate estimations of populations particularly that of coverage in all impact areas. Furthermore, this is exacerbated by the lack of census data or reliable monographs where such estimations can be based. Therefore, the project relies on estimates of population derived from National Immunization Days or other secondary sources. This may result in an underestimation of coverage, because uptake of immunization during the national immunization days may not necessarily provide accurate figures due to selectivity.

Table 1: FLASH Project Targets and Beneficiaries

Region	County	Total Estimated Pop In 2004	Targeted project beneficiaries	Beneficiaries reached by Flash
Eastern Upper Nile	Tonga(Manyo)	196,313	23,557	405 *
	Luak piny	136,875	16,425	8000**
	Maban	157,380	18,886	16,000
	Maiwut	228,126	52,411	82,106
	Akobo	92,768	29,565	12,000**
	Longchuk	105,134	17,500	4000**
	Ulang	100,000	20,000	0***
	Nyirol	50,000	8,000	0***
	Ayod	259,308	75,000	16,000**
	Subtotal	1,325,904	261,344	138,151
Nuba Mountains	Rashad	107,111	113,538	115,000
	Lagawa	67,327	12,110	4,000
	Kadguli	183,456	0	65,117
	Subtotal	357,894	125,648	184,117
	Total	1,1693,56	386,992	322,368

* The signing of the sub-grant coincided with flooding which restricted distribution of project materials and access. The beneficiaries comprise of health committees and community members trained on health issues

** Service provision was delayed and affected by long rainy season

*** These major focus for these counties during this period was construction. Provision of services commenced after the end of the reporting period.

N/B Setting of the targets did not factor in, the pace of construction, and signing of subgrant agreements, thus the observed deviations of beneficiaries from targets

VI. RESULTS

A salient feature of FLASH is the initiation of primary health care services in extremely underserved areas of Nuba and Eastern Upper Nile where services were completely non-existent. In Nuba Mountains FLASH was scaled up the primary health care program initiated in the year 2001. Therefore, the status of the project in two regions varied in several ways, with EUN struggling to initiate basic services in an intricate environment while in Nuba Mountains scaling up and LINGO capacity building combined with enhancing community mobilization occupied an integral part of the project. Consequently, achievements of the project in Nuba from the output point of view eclipsed Eastern Upper Nile, since Nuba Mountains had some basic infrastructure for service provision while Eastern Upper Nile was struggling to rebuild these within a backdrop of challenges.

Table 2. FLASH Indicators and Outputs

Intermediate Results/ Objective	Impact/ Process Indicator	Jan 1 – Sept 30, 2005	4 th Quarter Oct- Dec 2005	Annual Jan-Dec 2005
SO: Increased use of primary health care services and adoption of key preventive and promotive services and practices.	# of children received DPT3	1,286	262	1,548
	# of deliveries assisted by trained CHWs	789	432	1,221
	# of women vaccinated with TT2	4,632	1,792	6,424
	#LLITNs distributed to households with pregnant women and or/ children under 5 years	1,620	0	1,620
	% of PHCUs providing 4 out of 7 high impact services	*100	*100	*100
	# of women attending antenatal care clinics	3,756	1,528	5,264
	# of children <5 treated for fever	5,979	3,344	9,323
IR1: Increased accessibility and availability of PHC care services and adoption of key preventive and promotive services and practices	# of fully staffed and equipped PHCU/C	41	41	41
	% of PHCU providing at least 4 of 7 high impact services	100	100	100
	Overall facility attendance	117,773	68,792	186,565
IR3: Increased demand for PHC services and support for preventive and promotive services	Operational health management committees per county		8	8
	# of trained Community health workers	13	23	36
IR4: Strengthened Sudanese NGO, and County health department and community capacity for sustainable primary health care services	Presence of county planning system		Established in one County	Functional in two counties
	# Sudanese health professionals recruited per county	18	0	18

* The proportion is sometimes variable due to drug shortages.

VII. ACHIEVEMENTS

IR 1: Increased availability of and accessibility to primary health care services and adoption of key preventive and promotive services and practices

There were regional differences in access and utilization rates of various primary health care services originating from pre-existing and contextual factors. The pace and performance of FLASH largely paralleled these variations. In Nuba Mountains, services were scaled up through a network of pre-existing health facility infrastructure, while the project struggled to initiate/establish services in most regions of Upper Nile. However, despite these challenges, SC and various LNGO partners established 19 Primary Health Care Units in Eastern Upper Nile and extended mobile services to several outreach areas with special emphasis on the health needs of returnees and IDPs. The achievements in this aspect can be attested to by the facility attendance of 187,000 people, an increased attendance of 82,000 people, resulting from improved coverage. Although one of the key interventions was to develop a referral system, the possibility of this in Eastern Upper Nile was jeopardized by the lack of next level referral centres. In Nuba Mountains the nascent referral system was improved because there actually existed a hierarchy of referral levels. But the limitations of transport and inadequate drug supplies hindered the functioning of this referral system.

**82,000 MORE
CLIENTS
VISITED
HEALTH
FACILITIES
SUPPORTED BY
SC/US AND
PARTNER NGOS
OVER THE LAST
12 MONTHS**

IR2: Improved quality of maternal and child health services

The urgent need to have better qualified health staff to deliver high quality services has continually reinforced throughout the project. SC has continued to provide technical support to the health workers through refresher trainings, and mentoring health staff to ensure that service delivery is up to standard. Additionally, SC has maintained recommended treatment and diagnosis protocols in the facilities and trained health workers on these guidelines, to promote safe practices at the facility levels. Health workers have also benefited from other trainings meant to improve their capacity through Partnership Defined Quality (PDQ) training that aims to promote the internalization of sound approaches in the delivery of high quality services. The delivery of quality services has however been affected by pre-existing low coverage rates which the project had to sort out first. Therefore, a focus on quality service delivery has received attention towards desirable coverage, and the capacity to provide such high quality services built, pending regional wide universal coverage plans. SC in partnership with SRDA conducted training for traditional birth attendants (TBAs) to promote safe and clean deliveries and expanded ANC services at the community level. The provision of EPI, and post natal care services has also been notable in the project implementation period.

IR3: Increased demand for primary health care services and adoption of key preventive and promotive health practices.

The impact areas are high demand zones partly due to pre-existing health problems and low health unit facility coverage. These deficiencies are exacerbated by the lack of preventive and promotive health practices within communities despite the absence of a functional health system. In response to this, the project has employed a community mobilization strategy based on the 'Community Action Cycle' that has been in use by SC in several developing countries including those in transition. Community core groups have been revitalized to reinforce the activities of the health management committees, while community participation has remained a cornerstone for mainstreaming the community into the system and with this, promoted the utilization of services satisfactorily.

At the facility level, routine health education has had a substantial contribution to enlightening the communities on the need to adopt promotive and preventive practices and influence household and community level factors for better health. Since there is some significant uniformity in the distribution of the facilities where these sessions have been ongoing, the impact of this is somehow comparable to the overall BCI strategy for the whole region. However, demand emanating from unmet need for

some primary health care services continues to be high. In the coming year, the net effects of implementing the BCI strategy will require equal attention in terms of service delivery, so need to ensuring that drugs and any service delivery inputs are available to meet these increasing needs.

IR4: Strengthened Sudanese NGO, and County Health Department and community capacity for sustainable primary health care services

Building the capacity of local NGOs has been holistic right from the initial capacity assessments. Several capacity building approaches have been used, ranging from mentorship, training and on the job coaching. Several training activities for various health cadres and professionals of the local NGOs have been conducted over the reporting period. Immediately after the capacity assessment of all the organizations, training on finance, administration and logistics ensued. This set the pace of mentorship and on the job coaching and several follow up activities that have been crucial in backstopping various roles of these organizations in various aspects of the project. Additional emphasis was laid on equipping the health workers with the right skills for quality service delivery and management. With this arrangement capacity building has been extended to technical areas through facility, community and managerial based training approaches.

***ONE YEAR DOWN
THE LINE, THE
PARTNER NGOS ARE
SHOWING EVOLVING
SIGNS OF
INDEPENDENCE AS
THEY TAKE OVER,
SOME KEY
RESPONSIBILITIES***

Although the County Health Department (CHD) is supposed to be the focal point for the oversight of all health activities, the capacity of the CHD to lead the grass root village health development committees and undertake other roles as mandated by the Ministry of Health, was

limited.

Partner NGOs leadership underwent the ‘BEHAVE and Partnership Defined Quality’ trainings that are meant to institutionalize behavior change through response to community perceptions that influenced behavior, in a proven framework. This, combined with other approaches, has driven capacity building in the envisaged direction and built the foundation of for future programs in this sector.

VIII. OVERALL PROGRAM PERFORMANCE

Regional differences in implementation resulted in different results. Therefore, performance can only be disaggregated by regions to reflect the effects of such differences. Whereas in Nuba Mountains, SC has been providing health services and concurrently building permanent infrastructure. Over the past few years, Eastern Upper Nile was a case of total neglect with a few dilapidated buildings unsuitable for service provision with major repairs being done. Similarly SC struggled with complex logistics in the rainy season in order to establish a make shift regional office and staff compound in Pagak. Despite all this, Eastern Upper Nile, service provision has been initiated in areas where it has never existed. Routine services and outreach services have been established in 5 counties with notable rehabilitation done for four PHCUs and one PHCC in compliance with MoH standards. Over the period SC and partners were also proactive in containing measles outbreaks in Dajo and Maiwut through case management and covering buffer zones and migratory corridors, while immunization was hastened within these regions. Therefore the FLASH program has immensely contributed to the improvement of the health status of the population in Eastern Upper Nile amidst the existing challenges and laid a firm foundation for scaling up activities.

In Nuba Mountains more efforts were focused on preparing NRRDO a local NGO to take over the management of PHCUs in Rashad County, while coverage plans for Lagawa County were implemented. Since access rates in Nuba Mountains have recorded a positive trend over the first 5 years of SC interventions, additional attention was accorded to the service quality improvement, community mobilization and partnerships and the use of the BEHAVE framework in initiating and

reinforcing behavior change, community participation, and sustainability. During the third quarter of this period, five more facilities were added to SC list by MSF Holland on their withdrawal from Kadguli. Although this was not factored in the proposed coverage, it significantly impacted on the project expenditure and presented additional demands and challenges.

Overall, FLASH project has been a success in several ways. For the population of both regions change of their health status is evident. Similarly, the local NGOs' capacity is better than before. In turn, the SC mission of creating real and lasting positive change to the lives of children and women in need, was largely achieved.

IX. SUCCESS STORY

“The Healing of Kigile”

Kigile Payam is located in Maiwut County. Considering distances, Kigile is not far-off, but nevertheless, it took a minimum of three hours of daring navigation to get there by road. The International Rescue Committee was the first organization to attempt the provision of primary health care services in Maiwut County, but did not explore the frontiers of Kigile. SC started provision of PHC services in 2005 at Pagak and thereafter at Turu Payam, while the target populations at Kigile were the last to be reached due to its hard to reach location. Marginalization due in part to ethnic discrimination had greatly impacted on Kigile. Relief to Kigile hardly ever reached its intended recipients due to the fact that every relief effort had some other significant diversion, and this created an imbalance between the volumes of relief and the total population in need of it. This was even more so, especially with the inward movement of returnees from the indigenous Burun tribe into their beloved homeland. On their return, the returnees experienced a lack of basic services whose presence could have instilled in them a sense of being and belonging to their land of origin. Within a short period of time, dilapidated cone shaped huts were renovated while a myriad of new ones could be seen cropping up. Ironically, the population increased in Kigile, an area which lacked food security had no basic services, infrastructure and suffered phenomenally, high rates of morbidity and malnutrition.

Such was the scenario in Kigile in May 2005. The fact that that the road was not cleared of mines was of concern to the SC program manager, community mobilizer and the entire health staff including LNGO partner staff. Throughout the entire stretch of the journey from Pagak to Kigile, members of the SC Health team kept on guessing in silence and determination, as the vehicle waded through mud, thickets of tall grass and woodlands predominated by the world's most dangerous vipers and other wild animals. A glimmer of hope was followed by a feeling of despair when the team set their eyes on the first old and frail woman who directed the team to a small enclosure. Within minutes the enclosure was full of women, children and men of similar frailty. Although everybody's appearance reflected a state of undernourishment, sickness and despair, each of them afforded the visitors a smile on seeing them offload drugs and other medical supplies from the vehicle. With this came the realization that aid was at last, within their vicinity.

Scores of people ranging from toddlers, youth and the old people had been suffering from all kinds of disease and malnutrition. The magnitude of disease prompted the health team to limit the quick one-time dispensing of drugs since it became apparent that each and everybody was craving for some. Children were wheezing with acute respiratory infections, some were dehydrated by diarrhea, middle aged people were dizzy with malaria, and old men and women manifested all kinds of illness ranging from anemia to general weakness. SC finally left some of the health staff in Kigile and went back to marshal more resources and advocate for the alleviation of the alarming conditions in Kigile, to all NGOs including those organizations that spearhead food drops. After all this, “the healing of Kigile” had begun.

Since that visit, GARDOS and SC Health team have been providing PHC services to the population at Kigile. They can now be marked on the map of Maiwut County as one of the impact areas where health service responsiveness is quite high. Kigile's situation is a replica of the perennial problems

that had been prevalent in most regions in the Eastern Upper Nile in times before SC intervened through the FLASH project funded by OFDA/USAID. Furthermore, this sheds some light on the unseen and worrying situations that are present throughout Upper Nile..

X. CONSTRAINTS

a) Inadequacy of Drugs

The persistence of an inadequate drug supply for the project's needs is almost two years old now. During the reporting period, UNICEF continued to provide drugs at the health facilities. However, because UNICEF has not adopted the mandate to provide curative services and essential drugs for PHCCs, these drugs remain inadequate in quantity and type. More so, the Upper Nile had to contend with a high disease burden and soaring client numbers whose demand for curative services surpassed the drug supply. The PHCU kits supplied by UNICEF were not comprehensive and were not responsive to some illnesses which required broad spectrum treatment regimens. Referral to the PHCC levels was incapacitated by such limitations since the drug supply at the centres was not significantly different. Through SC private funds, a proportion of this shortage was to some extent offset, and greater advocacy efforts for improving the drug supplies have been put in place. Out of donation of 298 kits, MEDAIR supplied 20 kits while UNICEF and PSF contributed 210 and 68 respectively.

b) Logistical Constraints

The dollar cost of delivering services has been overwhelmingly high and the implementation time needed has been longer than anticipated, particularly in Eastern Upper Nile. Exorbitant flight costs and resulting cargo service charges in moving supplies/equipment from Lokichogio have in a way jeopardized the cost effectiveness. In addition, although Eastern Upper Nile is logistically strategic for procurement related activities, a poor infrastructure has left the distribution of materials and drugs to NGO partners and has added to the high costs of WFP flights. Other options for such services have been unavailable but as trade opens up from the North and other Southern towns, it is expected that cargo and other transport costs will continue to decline. However, before relocation to Juba, transporting staff to the field remains an unavoidably high cost due to the WFP flight costs.

c) Limited local capacity

Implementation of several project activities has suffered from several setbacks related to the low capacity of sub grantees and local staff in general. Although capacity building is a critical component of this project, the baseline levels of capacity for South Sudanese were on the lower side. This had several implications for the operational and technical aspects of the project and translated into a much slower pace than anticipated in the project time lines. Several approaches to improve on this have been employed, but the pace of skills uptake and project implementation time could not match. Therefore, capacity dependent initiatives in a way deviated from the anticipated performance.

XI. COST EFFECTIVENESS

The project budgeted for **240,000** beneficiaries and has been within a **322,268** beneficiary, coverage level. This translates into **\$10.8** spent per person. Putting into consideration several exorbitant costs incurred for transportation, other logistical requirements, coupled with other exclusive costs for establishing new facilities and facilitating sub grants, it is apparent that the project has operated at a high level of cost effectiveness. After incurring such costs for establishing systems and streamlining logistics, the project has laid a firm foundation for a more effective second phase in Eastern Upper Nile

X. Period of Implementation:

SC requested a no-cost extension until 28 February 2006 because it believed it would have sufficient funds to run the project until that date. In the event however, exorbitant logistical costs and other challenges caused SC to end the program on 31 December 2005.