INTERNATIONAL RESCUE COMMITTEE

South Sudan Program

FINAL REPORT

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Program Title:	Local Solutions: Conflict Response Initiative in South Sudan.
Location:	Upper Nile and Bahr El Ghazal, South Sudan.
Type of Disaster/Hazard:	Post conflict displacement and return
Period of the Program:	January 1st to December 31st 2006
Reporting Period:	January 1st to December 31st 2006
Program Goal	*The improved social wellbeing of conflict-affected and vulnerable groups from both returnee- and receiving- communities in Southern Sudan through the reduction of mortality and morbidity from disease and the increased capacity of the affected communities to collectively work towards this end.*
Objective 1 – Health	Conflict affected and vulnerable populations from returnee and receiving communities in targeted areas of Bahr el Ghazal and Western Upper Nile have improved access to and increased utilization of curative, preventative and educative health care services for leading causes of morbidity and mortality.
Objective 2 – Capacity Building	Within conflict-affected returnee and receiving communities in targeted areas of Bahr el Ghazal and Western Upper Nile in Southern Sudan: Civil Society Organizations (CSOs) have improved capacity to define, plan and manage interventions in their own communities through strengthened core planning and management capacities and practical experience in the provision of social services; targeted County Health Departments (CHD) have increased capacity to be responsible to better monitor and over-see health service delivery.
Dollar amount received from USAID/OFDA	3,491,386 USD
Number of targeted beneficiaries	384,000

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List of acronyms

CBMIS	Community Based Management Information Systems
CBOs/CSOs	Community Based Organizations/Civil Society Organizations
CHD	County Health Department
CHW	Community Health workers
CSD	Civil Society Development
EPI	Expanded Program of Immunizations
HAN	Hospital Auxiliary Nurses
HEN	Hospital Enrolled Nurses
MCHW	Maternal Child Health Worker
MoH	Ministry of Health
NGO	Non Governmental Organization
PHCC	Primary Health Care Center
PHCU	Primary Health Care Unit
RTC	Regional Training Center
SPLM/A	Sudanese Peoples' Liberation Movement/Army
STD	Sexually Transmitted Diseases
TBA	Traditional Birth Attendants
TT	Tetanus Toxoid
VHC	Village Health Committee
NID	National Immunization Day
SHTP	Sudan Health Transformation Project
WFP	World Food Program

2. Executive Summary

IRC reports completion of its OFDA-supported project, *Local Solutions: Conflict Response Initiative in South Sudan*, implemented from January 1 – December 31, 2006. Overall the program was able to achieve most of its two objectives, both in terms of health and capacity building, despite the unexpected closure of one field site (Marial Bai) and the phasing out of another (Billing). Under the health objective, there was a steady increase in facility utilization throughout the year: IRC-supported health facilities conducted 83,268 consultations and diagnosed 113,794 cases in total, resulting in an annual facility utilization rate of 0.51. IRC also continued to support students at the Regional training centres, training cadres of Community Health Workers in Ganyliel and Billing. In the second quarter of the project 67 (out of a class of 80 students) graduated from the RTC and another 40 enrolled in October 2006. IRC additionally continued to provide support to the Village Health Committees, and, overall 75% of VHC's were 'trained and knowledgeable' by the end of the project.[1]

Under the capacity building objective, IRC worked to improve the capacity both of CSO partners and the Country Health Departments (CHDs). Due to the closure of Marial Bai field site, IRC targeted support to 5 NGO partners in Aweil Town, rather than 3 partners in Aweil East as originally planned. Four of these organizations carried out water, sanitation, and hygiene sub-projects through the project, which contributed to wider community health improvement and together reached an estimated 65,000 persons (direct and indirect beneficiaries). In terms of the Country Health Departments, capacity building has remained a challenge since most CHDs lack the staff to be operational; therefore, opportunities to work with them have remained limited. The project did contribute to State MoH capacity building, particularly through hand over of 6 project facilities to the State MoH following the closure of IRC's Marial Bai office. Through IRC's "Marial Bai Bridge Plan," IRC held a 4-day managerial workshop for the State MoH (and available CHD staff) in Aweil Town, in which participants were able to demonstrate improved knowledge according to the results of pre and post tests carried out as part of the training.

A number of challenges we presented in 2006. The closure of Marial Bai field site during the second quarter of the project reduced the number of health facilities subsequently covered by the program from 32 to 25, of which 19 were managed directly by IRC and 6 successfully managed by the State Ministry of Health for Northern Bahr el Ghazal through a sub-grant. Secondly, despite security problems in Billing, IRC also successfully managed the phase out of the health program in the area, through a hand over of health facilities to Save the Children US. Thirdly, the relocation of the main South Sudan country office from Nairobi to Juba during the course of the project was a challenging process, however all head office program and support staff were in place in Juba by September 2006.

3. Discussion of results by objective

Discussion of results by objective, expected results and indicators is provided below. Analysis of the final quarter of the project (October to December) is combined with the overall performance throughout 2006.

[1] While the target of 100% of VHCs trained and knowledgeable by the end of the project was not quite reached, IRC is satisfied with the attainment of these results given the challenging environment and the time consuming nature of mobilizing and working with such groups.

Objective 1 **Conflict affected and vulnerable populations from returnee and receiving communities in targeted areas of Bahr el Ghazal and Western Upper Nile have improved access to and increased utilization of curative, preventative and educative health care services for leading causes of morbidity and mortality.** **Beneficiaries targeted: 384,000**[2] **Beneficiaries reached: 384,000**[3]	
ER1.1	**Effective curative and preventive primary health care services available for 384,000 people in Aweil East County (BeG), Aweil West and North County (BeG) and Rumbek East (Wullu/Mvolo) County (BeG) through 32 health facilities (6 PHCCs and 26 PHCUs).** [4]

	Indicator	Baseline [5]	Q1	Q2	Q3	Q4	Annual Totals[6]	Annual Target
1.1A	# of consultations each month	12,834 per month	6,877	6,147	6,882	7,102	6,755 per month	19,000 per month
1.1B	% of facilities with the required buffer stock of drugs in place	60%	100%	100%	100%	100%	100%	85%
1.1C	% of children vaccinated 3 times with DPT in their first year	20%[7]	38%	8%	17%	45%	27%	35%
1.1D	% of facilities meeting new OFDA/ MoH minimum service checklists for PHCCs and PHCUs	25%	100%	100%	100%	100%	100%	100%

Additional indicators

	Indicator	Baseline	Q1	Q2	Q3	Q4	Annual Totals	Target
1.1E	Percent of children < 1 fully EPI covered	15%	38%	8%	17%	45%	27%	60%
1.1F	DPT3 coverage of children <1	25%	38%	8%	17%	45%	27%	40%
1.1G	Percent of women of childbearing age who have received TT3 within the program area	21%	11%	18%	44%	33%	26%	75%
1.1H	Average number of antenatal visits per pregnancy (actual ANC visits/estimated pregnant women)	1.0	1.0	0.3	1.0	1.0	0.825	3

[2] The beneficiary target figure of 384,000 was based on the total estimated catchment population of the 32 health facilities (6 PHCCs and 26 PHCUs) supported through the project. In the Aweil counties, due to the population density and high numbers of returnees, the catchment population is estimated at 10,000 people per PHCU and 30,000 per PHCC. In other areas the figure is the same as in the 2005 proposal (4000 per PHCU and 20,000 per PHCC).

[3] **The overall beneficiary population reached that is cited here reflects the estimated catchment population of the 32 health facilities served within the project. During the first quarter of the project, the project served 32 facilities. However, due to the Marial Bai closure, during the subsequent quarters, the reach of the 19 facilities directly managed by IRC had an estimated catchment population of only 194,000. There were 113,794 cases diagnosed at IRC supported health facilities during the duration of the project. Additionally, IRC's CSO partners' projects directly benefited approximately 4,897 people, and indirectly benefited approximately 65,000 people.**

[4] The original target number of facilities within the project was 32 and beneficiary target 384,000. However, with the closure of IRC's Marial Bai office, this was reduced in the subsequent quarters to 19 facilities that are fully supported by IRC with a reach of 194,000, and 6 for Aweil West and North county that are being run by the MoH under the 'Marial Bai Bridge Plan,' for a new target of 25. Thus, 13 facilities in Aweil West and North have had to be cut from the program. In the indicator table results from the 2nd quarter onwards are based on reports from the 19 facilities run by IRC. Reporting on the 6 MoH facilities in Aweil West and North in quarter 3 is contained in Annex 1. Regrettably these reports were not available for the final quarter.

[5] Taken from 3rd Quarter results from IRC's 2005 OFDA-supported programs (when possible, to show the continued improvement of IRC OFDA-supported programming) as 2005 final results were not available as this proposal was prepared

[6] Presented as average of quarterly results throughout the text, for percentages.

[7] Based on IRCs 2005 target for DPT 3 coverage.

1.1I	Percent of pregnant women attending antenatal clinics in USAID-targeted counties who were given two doses of presumptive malarial medication (SP) according to Ministry of Health (GoSS) standard	10%	40%	33%	95%	81%	62.25%	60%
1.1J	Percentage of assisted deliveries by trained health service providers who have Secretariat of Health certificate of training (Maternal Child Health Workers in USAID targeted counties).	1%	1%	9%	3%	4%	4.25%	15%
1.1K	Percent of households with one or more long lasting insecticide treated bed nets in USAID-targeted counties	3%					Not measured; see below & Annex 5 for details	35%
1.1L	Percent of USAID-supported PHCCs offering STI services	55%	100%	100%	100%	100%	100%	80%

In 2006, IRC's primary health care program has continued to focus on the control of communicable disease; immunization; hygiene promotion and general health education; maternal and child care; and the provision of essential clinical services. This was made possible through the team of frontline workers comprised of medical assistants, laboratory technicians, nurses, community health workers, and mother and child health workers, who are largely local Sudanese who have undergone formal training at the regional health training schools in South Sudan. Technical support is provided on a regular basis by the Health Coordinator and program staff.

During the final project period and throughout 2006, progress of these primary health activities continued to be measured using the following indicators:

1.1 A - Over the course of the project, IRC supported health facilities conducted 81,054 consultations and diagnosed 113,794 cases. Over the final quarter, IRC sponsored health facilities conducted 21,361 consultations and diagnosed 25,452 cases.

Support for returnee populations in Northern Bahr-el-Ghazal continued primarily through assistance to facilities operating along the return routes, and the 2 mobile clinics. Operation of the mobile clinics was re-started during the final quarter with the end of the rainy season. Organized returns are planned for the first quarter of 2007; however, the mobile clinics during the final quarter were able to assist with spontaneous returnees throughout Northern Bahr-el Ghazal.

The facility caseload in the final quarter was again predominated by respiratory tract infections, malaria, diarrhea diseases and intestinal parasites.

- Facility Morbidity Caseload see Table 1
- Malaria as a proportion of causes of morbidity decreased by a third from last quarter from 31% to 21%, as expected with the end of the rainy season.
- Malaria treatment coverage with ACT was 80% or 4,320/5,413.

Table 1: Facility Morbidity Caseload Quarter 4

Disease	RTI	Malaria	Diarrhea Disease	Anemia	Intestinal Parasites	Eye Disease	Skin Disease	Trauma	Other	Total
Cases	5,550	5,413	2,842	792	3,504	617	1,402	1,192	4,190	25,452
Percent	22	21	11	3	14	2.5	5.5	4.5	16.5	100%

- Throughout 2006 respiratory tract infections, malaria, diarrhea and internal parasites were the leading causes of morbidity.

Table 2: Facility Morbidity Caseload January – December 2006

Disease	RTI	Malaria	Diarrhea Disease	Anemia	Intestinal Parasites	Eye Disease	Skin Disease	Trauma	Other	Total
Cases	26,046	22,670	13,921	5,494	11,725	4,946	5,656	5,138	18,207	113,794
Percent	23	20	12	5	10	4	5	5	16	100%

At the beginning of the grant period the baseline consultation rate was estimated to be 12,834[8] consultations per month with anticipated consultation of 19,000 per month by the end of the grant. However, during the course of the grant the number of health facilities supported by IRC decreased from 32 to 19. The consultation rate, despite being lower than anticipated, increased through grant period from 6,877 to 7,102 consultations per month with an annual average of 6,755 consultations per month. This increase in consultation rate (despite the absolute decrease in health facilities) is a result of increased local confidence in the services provided by IRC sponsored facilities and, thereby the increase in the utilization by the communities.

1.1 B - All IRC-supported health facilities continued to be provided with essential drugs and equipment kits through in-kind contributions by:

- European Community Humanitarian Office (ECHO) via Pharmaciens Sans Frontieres (PSF)
- Global Funds – Malaria for sector specific program assistance (treated bed nets and malaria drugs)
- UNICEF for vaccines and cold chain equipment

Through these varied sources of drug suppliers in conjunction with IRC's well established logistics-supply chain, all of the health facilities supported by IRC throughout the grant period maintained a buffer stock of drugs and medical supplies.

1.1D & 1.1L - The IRC sponsored primary health care facilities were 100% compliant with the OFDA/MoH minimum service checklist for PHCUs and PHCCs. Additionally, all PHCCs provided prevention and treatment services for sexually transmitted infections (STIs).

1.1C, 1.1E, 1.1F & 1.1G - Routine immunizations in the PHCCs and PHCUs, as well as outreach vaccinations were conducted during the final quarter and included:

- EPI Coverage rates see Table 3[9]
- Note that number of vaccinated children and targets are based under-1 year for BCG, under-5 years for Measles, DPT-1, DPT-3 & OPV; and pregnant woman for TT-1 & TT-3
- DPT-3 for the under 1 age group was 45% (640/1400); more than half of the DPT-3 were given as catch-up immunizations for the under 5 age group.
- The population breakdown based on the following estimates: under-1 population (4%), under-5 population (21%) and pregnant woman (5%).
- During this quarter, UNICEF decentralized the cold-chain to the state-level creating a disruption in the supply chain. Road conditions continued to provide an obstacle during the quarter.

[8] This figure was based on the figure of 41 health facilities that were supported by the IRC health program in 2005. At the beginning of 2006 the number of targeted health facilities had reduced to 32.

[9] There were only 4 health facilities that we were operating in the 4th Quarter in Billing site, due to the handover of 4 (out of 8) of the Wulu facilities to Save the Children US; so the number for Billing will be less, then the original number catchment area populations. The coverage targets are based on population estimates for the catchment areas around the IRC- supported facilities: Malualkon sites (130,000) and Billing sites (10,000) for a total of 140,000

Table 3: EPI Coverage Rates Quarter 4

Vaccine (Antigen)	Measles	BCG	DPT-1	DPT-3	TT-3	OPV (0,1,2,3)
Children Vaccinated	3,022	760	2,186	1,342	590	5,115
Target for the Quarter	7,350	1,400	7,350	7,350	1,750	7,350
Coverage for the Quarter (%)	41%	54%	29%	18%	33%	69%

Table 4: EPI Services Performed January – December 2006

Vaccine (Antigen)	Measles	BCG	DPT-1	DPT-3	TT-3	OPV (0,1,2,3)
Individual Vaccinated	7,756	6,567	9,721	7,671	4,402	17,780

Looking at the overall performance, at the beginning of the grant the baseline percentage of children that received all three doses of DPT before their first birthday was 20%. The goal at the end of one year was to increase that percent to 35%. This target was met during the 1st and 4th quarters with 38% and 45% coverage, respectively. It was more difficult to meet this target during the 2nd and 3rd quarters. These quarters correspond to the rainy season in southern Sudan. Also during the 2nd and 3rd quarter, UNICEF attempted to decentralize the cold chain from Kenya to the 10 states of southern Sudan. This change in the location of the cold chain resulted in a disruption in the availability of antigens in the field. So, limited access to the target population during the rainy season as well as a disruption in consistent supplies contributed to the lower rates during that time and reduced the overall percentage for the year to 27%.

The third dose of DPT is considered the benchmark for measuring whether or not a child is fully immunized in its first 12 months of life. Therefore the percentages for DPT-3 and fully immunized children under one are redundant.

The coverage for TT3 in woman of child-bearing age was 21% at baseline, with the target at the end of the year at 75%. The percentage progressed throughout the course of the grant from 11% to 33% with an annual coverage of 26%. Mothers are generally immunized with Tetanus Toxoid during antenatal visits and during outreach services. Tetanus Toxoid coverage is effected by similar factors as the childhood antigens.

1.1H, 1.1I & 1.1J - The standard antenatal package of services was available at the PHCCs and PHCUs. These services included the intermittent preventive treatment (IPT) of malaria, distribution of long lasting insecticide treated nets (LLITNs), iron-folate supplementation and routine tetanus toxoid (TT) vaccinations. Health education messages for pregnant women included the importance of immunizations, nutrition, hygiene promotion and danger signs in pregnancy.

MCH activities in the 4th quarter included:

- Antenatal service coverage at 81% (1424 actual visits/1750 expected visits);
- IPT coverage for pregnant women attending ANC clinics was 90% or 1284/1424.
- Fe-Folate was provided to 76% of the women attending ANC clinics.
- Traditional Birth Attendants (TBAs) continue to perform a majority of the assisted deliveries, 96% of assisted deliveries, while Maternal and Child Health workers contributed to the remaining 4%.
- ITN distribution includes pregnant woman, children under 5 years and other vulnerable groups; during this quarter with the onset of the dry season only a few nets were distributed.

As part of a comprehensive approach to reproductive health, IRC continued working to establish basic Emergency Obstetric Care (EmOC) centers in southern Sudan throughout 2006. During the 4th quarter, the EmOC facility in Wullu County, Lakes State provided 2 of the 6 basic EmOC services (parenteral antibiotics and parenteral anti-convulsants & anti-hypertensive). The second EmOC center is currently under-construction at the Malualbai PHCC facility (Aweil East county) and is expected to be complete in March 2007. Obtaining and retaining qualified staff remained a challenge during the quarter and limited the service available in the EmOC facility.

Table 5 MCH Services Quarter 4

Service	ANC-1	ANC-2	IPT-1	IPT-2	Fe-Folate	ITN
No. of Pregnant Woman	906	518	801	483	1088	28

Table 6 MCH Services: January – December 2006

Service	ANC-1	ANC-2	IPT-1	IPT-2	Fe-Folate	ITN*
No. of Pregnant Woman	3,318	1,880	2,931	1,750	3,696	6,919

*As stated in the narrative above, ITN distribution includes pregnant woman, children under 5 years and other vulnerable groups

Table 7 Health Worker Assisted Deliveries Quarter 4

Service	TBA	MCHW	CO	Total
No. of Deliveries	384	15	0	399

Table 8 Health Worker Assisted Deliveries: January – December 2006

Service	TBA	MCHW	CO	Total
No. of Deliveries	1,037	38	0	1,075

The target and standard for antenatal visits during pregnancy is three. The baseline number of visits for a pregnant mother was one at the beginning of the grant. The average number of visits during the year was 0.825 showing that in the largely rural areas that IRC sponsors primary health care, the practice of attending antenatal clinic needs to be promoted.

Despite the low number of antenatal visits, those women that did attend received the appropriate malaria prevention. The baseline rate for IPT coverage was 10% with a goal of 60% at the end of the grant. The percentage varied from 33% to 95% during the year with an annual average of 62%.

The percentage of assisted deliveries during the year varied from 1% to 9%, with an annual average of 4%. The baseline percentage was 1% with a target of 15%. This is probably the most telling of all of the reproductive health indicators measured during this year and indicates that within the context of primary health care, reproductive health needs to be a priority in southern Sudan.

1.1K - A quantitative baseline measurement for household coverage of insecticide treated net was determined to be 3% at the beginning of the grant with a target of 35% by the end of the grant. The catchment population changed significantly with the reduction in the number of sites and facilities that IRC sponsored, due to security and population movements. A qualitative focus group discussion was conducted as a preliminary effort to assess the population in IRC's reduced catchment area. Since, quantitative and qualitative data cannot be compared, the coverage of nets at the end of the grant cannot be determined at this time. The results of the qualitative focus group discussion can be found in section ER1.3 and **Annex 5**.

ER1.2	**32[10] health facilities (19 by final quarter) in the targeted communities will collect, analyze, report and act on key health data using a systematic information collection system that is directly linked to existing County Health Departments (CHD).**

	Indicator	Baseline	Q1	Q2	Q3	Q4	Annual Totals	Annual Target
1.2A	% of health facilities providing complete and timely monthly report	80%	100 %	100%	100 %	100 %	100%	100%
1.2B	Quarterly reports on analyzed health trends presented to CHD and FMoH	-	0	0	0	0	0	4

Throughout 2006, the nascent Sudanese Ministry of the Health had limited capacity to receive direct reporting of health statistics at the County Health Department (CHD) level. IRC therefore internally reported health data monthly and maintained records at each health facility throughout the project. Consolidation of the health programs has allowed for a greater focus on the standardization and quality of data collection and analysis through the IRC Health Management Information System (HMIS). The HMIS includes daily patient and drug registries; and monthly reports for morbidity, EPI coverage, and maternal health activities. Through the 'Marial Bai Bridge Plan' operating in Aweil West and North, IRC is has been receiving monthly facility reports on behalf of the MoH for the 6 facilities supported through the 'Marial Bai Bridge Plan'. IRC is working with the MoH so that future reports can be collected and analyzed directly by the Ministry or the CHD.

ER1.3	**Increase health knowledge and key health behaviors in 32 (19 by final quarter) health facility catchment areas through community outreach and health promotion activities.**

	Indicator	Baseline	Q1	Q2	Q3	Q4	Annual Totals	Annual Target
1.3A	Utilization rates at health facilities	0.40	0.40	0.50	0.55	0.58	0.51	0.80
1.3B	Survey carried out as baseline and near end of grant to cover knowledge on three key health indicators: malaria, diarrhea and child vaccinations	-	1 baseline KPC survey completed	1 baseline KPC survey completed	1 baseline KPC survey completed	Qualitative Survey Completed	Qualitative Survey Completed	Qualitative Survey Completed

5. During the 2nd quarter this was revised to include 19 health facilities (2 PHCC and 17 PHCU); a further 3 PHCC and 3 PHCU were supported through the 'Marial Bai Bridge Plan.'

1.3 A - Facility utilization rate for the final quarter was 0.58 (new consultation per person per month), which is a slight increase over the past three quarters. This was due to end of the rainy season and therefore increased access to the facilities.[11]

Over the cause of the project the annual facility utilization rate was 0.51 (consultation per person per year). The World Health Organization recommends a rate of 1.0 (consultation per person per year), and may reflect the difficulties experienced in accessibility to health facilities. However, the utilization rate increased steadily throughout the year from 0.40 to 0.58.

1.3 B - Health education is an essential component of primary health and part of the daily, weekly and monthly activities at all health facilities. Topics in the final quarter focused on the prevention of the major causes of morbidity and mortality in the region, including improved hygiene practices, malaria prevention and the importance of immunizations.

A qualitative health assessment was conducted in the final quarter. It consisted of focus group discussions at each of the health facilities in Aweil East County. A qualitative approach was decided over a quantitative approach for two main reasons: change in operational area with a decrease in facilities/sites and, logistical constraints.

The information collected in the baseline survey at the beginning of the project was in the form of quantitative data and covered a much larger operational area than present at the end of the project. As quantitative surveys take an extensive investment of time, personnel and logistics, and given that the result would have covered a different operations area allowing for only limited comparative analysis, qualitative focus group discussions were conducted to re-assess this new, reduced operational area. Qualitative data collect is the first step in guiding future quantitative data assessments and will help focus efforts for an up-coming baseline survey planned in early 2007 under the APS. As a result qualitative and quantitative data sets cannot be directly compared. The focus group discussions covered the basic health concerns of developing countries in Africa: HIV/AIDS, malaria, and water/sanitation and access to health facilities.

There were a total of ten focus group discussions; each group consisted of approximately 15 individuals. Criteria for inclusion in the focus group discussions were based on individuals visiting the clinic on the interview date; and a willingness to participate in the discussion. The facilitators for the focus group discussions were the health officers that supervise the health activities in that particular area. The exact questions and percentage results are provided in a table in **Annex 5** and below is a brief summary of the results:

Demographics:

- The major ethnic group is Dinka;
- The majority of individuals are married;
- Two-thirds of the individual involved in the group discussion were female;
- More than half identified themselves as Christian;
- The majority of the respondents have no formal education;
- The major occupation identified was farming;
- Most individuals were either never displaced or returnees;

Water, Sanitation & Household Amenities:

- Two-third of individuals get their water from an open well or borehole;
- It takes two-third of the individuals less than 60 minutes to fetch water;
- Majority of individual keep their household's water in a container;
- Over half of the respondents never washed their hands;
- A majority of the respondents used a field or bush as their toilet facility;

11 WHO recommends a utilization rate of 1.0 (consultation per person per year).

Malaria:

- A majority of the participants stated that they had a mosquito net in their home

HIV/AIDS:

- More than half of the individuals had heard of HIV/AIDS;
- Only one individual said that they knew someone that had HIV/AIDS;
- Most the question related to transmissions individuals answered "I don't know";
- Most individuals did know if they would be willing to be tested;

Health Services:

- A majority of the individuals are within a 60 minute walk to a health facility.

ER1.4	**Increased capacity of two regional health training centers (RTCs) based in Billing (Rumbek East County) and Ganyliel (Panyijar County Western Upper Nile State) to provide 80 additional better trained Community Health Care Workers (CHW) and Maternal Child Health Workers (MCHW) for service in Primary Health Care Centers (PHCC) and Primary Health Care Units (PHCU) in Southern Sudan.**

	Indicator	Baseline	Q1	Q2	Q3	Q4	Annual Totals	Annual Target
1.4A	Number of students graduating from RTCs.	84%	80 students enrolled	67 out of 80 enrolled graduated in June (84%)	Classes to resume in October	40 Students Enrolled	37 Students Enrolled (93%)	90%

The 67 graduates of the RTC program in June 2006 returned to their sponsoring agencies and are currently providing health care services at the primary health care unit level. The IRC Regional (Health) Training Center in Billing was closed in July with the start of the phase-out of Billing health facility activities. IRC used support available through the SHTP program to renovate some of the Ganyliel regional training center facilities. 40 students began the 9-month CHW course in October 2006 and are expected to graduate in June 2007.

Guidance from the Ministry of Health is forthcoming regarding the changes in the reproductive health worker curriculum, as the Maternal Child Health Workers (MCHW) position is phased-out and the community mid-wives position is phased-in.

ER1.5	**Community committees (Village Health Committees – VHC) in 32 targeted communities (19 by final quarter) are retrained following technical guidance from the Federal Ministry of Health (FMoH) and utilizing established IRC Civil Society Development (CSD) methodologies for effective management of PHCUs and PHCCs.**

	Indicator	Baseline	Q1	Q2	Q3	Q4	Annual Totals	Annual Target
1.5A	Proportion of VHCs that are trained and knowledgeable on their duties and responsibilities to the health facilities and communities	-	50%	74%	80%	75%	70%	100%
1.5B	Proportion of VHCs that have effectively incorporated learning into constitutions	-	50%	54%	60%	75%	60%	100%
1.5C	Proportion of health facilities whose governing VHCs consult with communities on major decisions	-	25%	42%	56%	75%	50%	80%

These proportions are based on overall targets for the two active sites. It should be noted that during the last quarter, one of the VHCs was in an area handed over to another international NGO. The target number for Billing therefore dropped from 6 to 5 during the last reporting period.

1.5 A - VHC targets did not reach the targeted 100% of VHCs under ER1.5, however positive results were still largely obtained and IRC is satisfied with the attainment of these results given the challenging environment and the time consuming nature of mobilizing and working with such groups.

Area	Target	No. Achieved	% Achieved
Malual Kon	10	7	70%
Billing	5	5	100%
Total	**16**	**12**	**75%**

1.5 B - Most VHCs do not have formal, written constitutions, which is quite an advanced activity for community level groups such as these, particularly given the low levels of literacy. Reporting on those with constitutions would make this indicator appear lower than is the case, as most have incorporated learning into their general principles and practices, as evidenced by their ongoing eagerness to participate in trainings. Learning is also in evidence as an informal process in the Committees, taking place through meetings and discussions, both among themselves and with other community members.

In retrospect, IRC would replace the indicator "Proportion of VHCs that have effectively incorporated learning into constitutions," with "Proportion of VHCs that have effectively incorporated learning into general practices," as the indicator currently implies that each VHC has a constitution. As mentioned above, most VHC members are illiterate and not accustomed to such formal ways of working, but have more locally appropriate systems for management. IRC believes that ensuring that learning is incorporated into the VHCs general practices is sufficient to ensure that learning is an ongoing activity.

1.5 C - Proportion of Health facilities whose governing VHCs consult with communities before making major decisions.

Area	Target	No. Achieved	% Achieved
Malual Kon	10	6	60%
Billing	5	5	100%
Total	**16**	**12**	**75%**

Activities in the targeted areas (Billing and Malual Kon) were hampered during the rainy season. Security in Billing has also been problematic and restricted movement, both for the Committees in meeting with their communities, and for the IRC to monitor the Committees' work. The new Community Development Officer has been extremely pro-active in mobilizing VHCs, which is a time-consuming process under difficult circumstances, and initial training that was completed by the end of the project, met with a high level of enthusiasm and commitment. Ensuring consultation takes place is also a part of the mobilization and training process and most Committees have taken this responsibility on board, the results of which will further be realized in the 2007 'Bridge to Peace and Security' project.

ER1.6	**CSOs: covering the definition of NGOs and Community Based Organizations-CBOs) partners are selected, trained and receive sub-grants to assist in the implementation of activities under Objective 1 utilizing established IRC methodologies for CSD (refer to Objective 2).**

	Indicator	Baseline	Q1	Q2	Q3	Q4	Annual Totals	Annual Target
1.6A	Number of CSOs involved in implementation, monitoring and evaluation of health and health education activities	-	CSO selection in progress	CSO selection in progress	5	4	4	3

Following delays due to site closure, and with the relocation of activities to Aweil Town, five CSO partners were selected in that location during the third quarter to implement projects. This followed receiving initial applications, short-listing, assessment visits, selection and a project re-design process. Although only three partners had been targeted, the amount of interest and qualifying CSOs allowed IRC to add two extra partnerships. Unfortunately, only 4 of the 5 selected partners ultimately received grants and implemented projects, due to internal disputes within the fifth organization. The Kongdai Women Development Agency (KDWA) had aimed to perform latrine construction and hygiene awareness activities in a new school, targeting 150 students and teachers.

The four remaining partners were granted $4,000 each to carry out their projects. As there are no local organizations in the area directly delivering health services, the scope of sub-projects was broadened to include support for hygiene and environmental health promotion activities, with the goal to contribute to wider community health improvement. Through the project, some of these partners developed interest and linkages in further expanding their activities and expertise into health service delivery in the future, although this remains a long-term goal for many.

The projects implemented benefited approximately 65,000 persons (direct and indirect beneficiaries), and included the following specific achievements[12]:

a. **Community Development Society (CDS):** constructed a pit latrine for a school with 800 students and teachers. There were delays in obtaining the necessary materials, and a final wall is yet to be constructed.
b. **Lony Piu Charity Society (LPCS):** trained 97 vulnerable women (such as IDPs, returnees, or female-headed households) as peer educators to conduct household hygiene awareness, particularly those in vulnerable situations. Their outreach promotion activities further benefited approximately 600 community members.
c. **Underground Water Association (UGWA):** rehabilitated 9 hand-pumps in and around Aweil Town, and provided awareness and information to communities about the importance of safe water and correct use of hand-pumps to ensure their longevity. It is estimated that approximately 4,000 people now have access to safe water through these hand-pumps.
d. **Youth Organization for Development and Environment (YODEP):** conducted 3 clean up campaigns in key locations around Aweil Town, e.g. the hospital, the State Assembly and a populated residential area. The community was mobilized to participate in these activities, which promoted sanitation awareness. Indirect beneficiaries include the town's population, which is estimated at 65,000 people. The group had planned to contribute to the reduction of vector-borne diseases by digging water trenches to remove stagnant water, however the season proved to be an obstacle and the group plans to dig more permanent drains in the future. The local authorities were so inspired by the response and result of the clean up days that they have introduced a new policy mandating that Saturday mornings be used for cleaning public areas, such as the market place. Cooperation between YODEP and local authorities are continuing.

[12] This number includes the estimated population of Aweil town benefiting from sub-project d, and does not the total of the individual counts below, in order to avoid double counting of beneficiaries, as many individuals may have benefited from more than one project.

A hand-pump now in use in Koum, near Aweil Town, through the project

A busy hand-pump rehabilitated by UGWA near the central market in Aweil Town

Objective 2 Capacity Building **Within conflict-affected returnee and receiving communities in targeted areas of Bahr el Ghazal and Western Upper Nile in Southern Sudan: Civil Society Organizations (CSOs) have improved capacity to define, plan and manage interventions in their own communities through strengthened core planning and management capacities and practical experience in the provision of social services; targeted County Health Departments (CHD) have increased capacity to be responsible to better monitor and over-see health service deli very.** **Beneficiaries targeted: 384,000** (same beneficiaries targeted as Objective 1) **Beneficiaries reached: 119,194** (same beneficiaries reached as Objective 1)	
ER 2.1	**A target of 3 Sudanese CBOs are selected based on capacity assessments carried out on potential partners identified through a general call for partners process**

	Indicator	Baseline	Q1	Q2	Q3	Q4	Annual Totals	Annual Target
2.1 A	Capacity assessments carried out for all short listed candidates resulting in the selection of 3 CSO partners.		Call for partners issued	2	5	5	5 pre-assessments completed	3 pre-assessments completed

Capacity assessments were carried out with the 5 selected partners in September, with the following aspects analyzed for each organization: strategic direction; structure and governance; internal systems; finance; technical capacity; and, external relations. All partners were identified to have a “nascent” level of development, meaning that they are still emerging and solidifying their structures, but have already made some progress in establishing an identity. This level of CSO has high training and support needs, as is normal for IRC’s local partners in Sudan.

ER2.2	**A target of 3 Sudanese CBOs from conflicted-affected communities in Aweil East, Aweil West and North[13], are better able to plan and manage development interventions through the capacity-building inputs delivered by IRC CSD staff and directly delivering assistance to communities**

	Indicator	Baseline	Q1	Q2	Q3	Q4	Annual Totals	Annual Target
2.2A	Training needs for 3 local partners defined	-	Capacity assessments are pending the short listing of candidates.	Training needs for the 2 CSOs to be defined once the capacity assessments are complete.	4 CSO assess-ments in progress	5 CSOs' training needs assessed	5 CSOs' training needs assessed	3 Strengthening Plans Developed
2.2B	Training needs for 3 local partners completed	-	Capacity assessments are pending the short listing of candidates.	Training needs for the 2 CSOs to be complete once the capacity assessments are complete	In process for 5 partners	5 Partners trained	5 Partners trained	3 Partners trained

2.2 A - Based on the analysis capacity assessments, urgent training needs for each partner were identified, analyzed and documented in a capacity building plan for each organization. The key areas for training included: financial and administration management; project design and management; and community participation. These were identified as priorities both by the CSOs themselves, as well as by IRC to ensure that basic capacity existed for sound sub-project implementation.

2.2 B - Each partner received the following formal training:

1. Financial and Administrative policies and procedures (15 – 18 August)
2. Civil Society and Civic Engagement, including advocacy (19 – 22 October)
3. Community participation (7 – 10 November)
4. Project redesign (18 – 22 December)

- In addition, each partner received additional one-on-one support, both upon request, and/or in response to needs identified by IRC field staff, in:
  1. Project and logical framework design
  2. Budget preparation and monitoring
  3. Report writing (financial and technical)
  4. Specific project-specific assistance as required.

ER 2.3	**4 CHDs assisted to better exert over-sight of health services in the four Counties where IRC implements health activities (Aweil East, West, North and Rumbek East).**

	Indicator	Baseline	Q1	Q2	Q3	Q4	Annual Totals	Annual Target
2.3A	# of CHD offices better equipped to monitor and oversee health service provision in the county	-				1 CHD workshop held	1 CHD workshop held	4

Capacity building of the CHDs has remained a challenge, as most CHDs lack the staff to be operational. However, during the final quarter, IRC engaged a consultant to conduct a training needs

[13] With the closure of Marial Bai field office the location of the partners was changed to Aweil Town

assessment of key staff within the CHD and state hospital. The key training priorities were identified as:

- **Management & Planning**: Management functions and processes; principles of management; strategic planning and project development and management;
- **Interpersonal relations:** Leadership; effective communication
- **Networking & collaboration:** Community participation
- **Intergovernmental linkages.**

The consultant prepared a tailored training program, which was carried on 19 – 21 December for 15 participants from the State Ministry of Health, the County Health Department and the Aweil County Hospital. The overall objective of the training was to improve basic management skills, knowledge and attitudes for effective service delivery in the health sector in Aweil. The participants demonstrated improved knowledge according to the results of pre and post tests carried out as part of the training. Details of the consultants report can be found in **Annex 4**.

ER 2.4	IRC field staff, partner CBOs and government counterparts are trained in key messages on two IRC cross-cutting programming issues: HIV/AIDS and Protection

	Indicator	Baseline	Q1	Q2	Q3	Q4	Annual Totals	Annual Target
2.4A	% of IRC staff trained in core messages on HIV/AIDS and Protection awareness	-				60% trained in protection awareness	60% trained in protection awareness	100%
2.4 B	# of CSO partner staff trained in core messages on HIV/AIDS and Protection awareness	-				2 partners trained in protection in Aweil and 4 on HIV/AIDS awareness in Ganyliel	2 partners trained in protection in Aweil and 4 on HIV/AIDS awareness in Ganyliel	Staff of 3 CBOs trained
2.4 C	# of CHD staff trained in core messages on HIV/AIDS and Protection awareness	-				CHDs are non functional	Not completed due to low level of CHD operations	8 (2 per county)

Protection training was conducted for 60% of IRC staff. Targets were not met in training the County Health department and CSO partners. Protection training of CSO partner staff and CHD staff was limited by later-than-expected identification of CSO partners in Aweil Town and the general absence of CHD staff in Aweil. As the development of civil society and establishment of government services increase, the need for protection training will likewise increase. Through follow-up projects IRC expects to expand the number of beneficiaries under these indicators.

The HIV/AIDS program has been collaborating with the IRC CSD team to train CSO partner groups showing interest in working in HIV/AIDS. IRC has trained CSOs based in Ganyliel and Juba to improve their skills in raising awareness in HIV/AIDS, although it is noted that these are not the same 4 partners in the project that IRC has been working with in Aweil Town.

4. Success stories/constraints/adjustments

i) Success stories

IRC highlights the following project achievements as particularly successful.

- Handover of Billing health facilities – 7 facilities run from IRC's Billing field site were successfully handed over to the Ministry of Health and Save the Children US in December 2006. The final facility in Billing will be handed over to Save US in early April 2007.
- Marial Bai Bridge Plan – in reaction to IRC's sudden departure from Marial Bai, 6 health facilities were successfully supported through a sub-grant to the Northern Bahr el Ghazal MoH for the last 6 months of the project, with positive cooperation from the MoH.
- In Aweil town, the clean up activities of YODEP effectively mobilized the community to clean public spaces. This generated considerable interest and attention of both members of the community, as well as the local authorities, who have now required that Saturday mornings be used for cleaning up public spaces, particularly the market. Cooperation between YODEP and the local authorities are continuing to ensure space is created for rubbish collection, which the authorities will dispose of.
- For most CSO partners involved in the project, this was their first opportunity to gain institutional strengthening training and implement a project with external funding. While each required considerable support and monitoring, each of the four active partners are now able to present accurate financial reports and demonstrate a high level of accountability and transparency.
- Response from health officials trained in basic management skills was extremely positive and there are requests for follow up activities, as this was a recognized "first" for all participants, and essential for their work.
- Transition of IRC's main office for S. Sudan from Nairobi to Juba – throughout 2006, IRC's southern Sudan headquarters was moved from Nairobi to Juba, with the official opening ceremony of the IRC Juba office taking place in October 2006. IRC has also successfully incorporated the former Garrison town of Aweil into its southern programming and is now strategically well placed in the state capital of Northern Bahr el Ghazal, where it has the opportunity to renew its focus in areas experiencing a high influx of returnees.

ii) Constraints and lessons learned

Security and operations

- **Closure of Marial Bai** – the Marial Bai field site was officially closed down in May 2006. Repeated security incidents and threats to the lives of staff members led to IRC's decision to cease program activities in Aweil West County. The closure was communicated to the authorities at county and state level, and to the OFDA South Sudan representative in Nairobi. The Marial Bai field office was a major area of programming under the 'local solutions' project, and the location of 13 of the 32 health facilities supported under this grant. As an intermediate measure, IRC entered into a successful sub-agreement with the Ministry of Health to take over 6 facilities as part of the 'Marial Bai bridge plan.' In Aweil West and North County it is expected that other stakeholders (Cordaid, Diocese of Rumbek and the State Ministry of Health) will take over the running of 6 of the 13 facilities in the two counties by April 2007.

- **Relocation of Billing staff** - Two feuding clans, the Dinka-Agar (who are cattle keepers with access to arms) and the Jur (farmers who are unarmed), were frequently in conflict in this area over cattle, food and pasture during the hunger gap period (January – May 2006). Thus, IRC's Billing staff were temporarily relocated to Rumbek, and carried out activities from that base. As of the end of the project, UNMIS/ UNDSS had not given the security clearance for the area, and some IRC staff were still temporarily relocated.

Program

- A persistent problem for health activities in Southern Sudan is the short implementation period caused by the onset of the rainy season in May/June, lasting through to October. In 2006, the rains came in mid-May, resulting in low accessibility, which therefore affected facility utilization rates.
- As reported, the closure of Marial Bai field site resulted in the reduction in the number of health facilities supported by IRC, and subsequent reduction in the target population for a large part of the project. However, the Marial Bai bridge plan was a good learning process for IRC, especially in terms

of the increased MoH collaboration and capacity building, and the desire for more direct implementation by the CHDs in the future.

- In terms of the 4 CHDs that were to be assisted through the project to better oversee health services in each of the counties, the current capacity of the country health departments is still limited to the extent that there are none/few staff in place, and the departments are not fully functioning. With the closure of Marial Bai, IRC conducted a workshop in Aweil Town, and although the participants were predominantly from the State MoH, one or two County Health Department officials were present. It is hoped that through the course of the 2007 and afterwards IRC will be able to build the capacity of the country level authorities and it is hoped that CHDs will receive better support from the Central and State MoH, as more resources and support become available at local level. Earlier engagement with the State MoH and CHDs for the workshop would have contributed to a stronger result in this area. A start has been made, however, and IRC hopes to follow on this activity with future basic management training, leading to improved health management.
- MoH/CHD capacity building activities were also delayed by the unclear structure of the CHDs, as well as finding a suitable time for all the identified participants, given under-staffing and hectic work schedules. This also led to a limited time available for training. However, given the positive reception of the training, IRC feels that people will be more willing to commit to a longer training in the future.
- Due to the delays caused by changing the program locations, CSO partners were not selected and sub-projects were not finalized until quite late in the year. This inevitably reduced the duration of the sub-grants. However, IRC is very satisfied with sub-project outcomes, both in terms of community impact, as well as strengthened CSO capacity, which will contribute to the program's sustainability.
- Progress in mobilizing, training and ensuring consultative VHCs in both Malual Kon and Billing was constrained by the rains and staff shortage. Many of the locations of the VHCs are quite remote and distant from IRC compounds, and transportation is often limited and even impossible during the rainy season. The Billing Community Development Officer was not recruited until quite late in the year, but then moved quickly to ensure that all targets were met. This occurred once the immediate security threats had passed, however, high levels of concern disrupted the community and resulted in many people leaving the area.
- In terms of training IRC staff, CSO partners and CHD staff on protection and HIV/AIDS issues, delays in the selection of CSO partners and CHD staffing problems meant that some planned activities were not carried out. IRC recognizes that mainstreaming these two issues into existing sectoral programs is necessary, and increased efforts will be made to ensure this is incorporated into the 2007 project.

5. Cost effectiveness

The closure of the Marial Bai field site, the resulting reduction in target health facilities, and constraints to capacity building activities resulted in funds remaining in the program budget at project's end, which are to be returned to OFDA.

6. Other pertinent information

In 2006, IRC underwent a major strategic consolidation of its programs, resulting in a program that is more geographically focused and in a position to grow more strategically. In 2006 this meant prioritizing geographical areas for concentration and the closure of two 'local solutions' project sites, as well as making a renewed investment in program quality. Going into 2007, in the south IRC has decided to focus its programming on Northern Bahr el Ghazal, particularly due to potential high rates of IDP and refugee return in this area. IRC's direction and strategic focus in southern Sudan is now guided by a new strategic plan for 2007-2009, which is the result of a planning process undertaken during the final quarter of the project. In health this will mean a commitment to quality healthcare provision across fewer field sites and target facilities. The majority of the health programming in the next two to three years will be focused on Aweil East and Aweil Center County, confirming IRC's commitment to work in areas where service provision is low and the pressure of returns is highest. IRC remains committed to focusing further on efforts to include cross cutting issues of HIV/AIDS capacity building and gender in all programming aspects.

Annex 1 Q3 Health facility report, MoH Marial Bai Bridge Plan

1. Facility Utilization

Over the third quarter, the health facilities covered under the Marial Bai bridge program conducted 19,609 consultations and diagnosed 24,633 cases, resulting in a facility utilization rate for the quarter of 0.55 (new consultation per person per month), which is consistent with the health facilities in region and attributed to the increase of malaria cases during this quarter.

2. Facility Morbidity Caseload and Treatment

The facility caseload this quarter was predominated by respiratory tract infections, malaria and diarrhea diseases.

- Facility Morbidity Caseload see Table 1
- Malaria as a proportion of causes of morbidity 22% is consistent with this time of year

Table 1: Facility Morbidity Caseload

Disease	RTI	Malaria	Diarrhea Disease	Anemia	Intestinal Parasites	Eye Disease	Skin Disease	Trauma	Other	Total
Cases	4,799	5,421	3,333	1,358	1,934	1,966	1,254	3,093	1,475	24,633
Percent	19.5	22	13.5	5.5	8	8	5	12.5	6	100%

3. Maternal and Child Health (MCH)

The standard antenatal package of services was available at the PHCCs and PHCUs. These services included the intermittent presumptive treatment (IPT) for malaria, distribution of long lasting insecticide treated nets (LLITNs), treatment of anemia with iron-folate and routine tetanus toxoid (TT) vaccinations. Health education messages for pregnant women included the importance of immunizations, nutrition, hygiene promotion and danger signs in pregnancy.

MCH activities this quarter included:

- Total antenatal visits was 2134 and total IPT treatment was 2049
- IPT coverage for pregnant women attending ANC clinics was 96% or 2049/2134.
- Fe-Folate was provided to 95% of the women attending ANC clinics.
- Trained Traditional Birth Attendants (TBAs) conducted 100% of assisted deliveries.

Table 2: MCH Services

Service	ANC-1	ANC-2	IPT-1	IPT-2	Fe-Folate	ITN
No. of Pregnant Woman	1,383	751	1,182	867	2,027	1,348

Table 3: Health Worker Assisted Deliveries

Service	TBA	MHCW	CO	Total
No. of Deliveries	1,180	0	0	1,180

	Field site	Facilty name	Facility type	Payam	County	State
1	Billing	Wullu	PHCC/U *Completed upgrade expected by 2006	Wullu	Mvolo	Lakes
2	Billing	Tilkuc	PHCU	Akot	Rumbek East	Lakes
3	Billing	Nakutmanga	PHCU	Wullu	Mvolo	Lakes
4	Billing	Deteku	PHCU	Wullu	Mvolo	Lakes
5	Billing	Kombi	PHCU	Mvolo	Mvolo	Lakes
6	Billing	Malou	PHCU	Pacong	Rumbek East	Lakes
7	Billing	Cuebelac	PHCU	Pacong	Rumbek East	Lakes
8	Billing	Mabuorduong	PHCU	Akot	Rumbek East	Lakes
9	Malual Kon	Malual bai	PHCC	Malual bai	Aweil East	NBEG
10	Malual Kon	Ameth	PHCU	Maluabai	Aweil East	NBEG
11	Malual Kon	Malualkon	PHCU	Baac	Aweil East	NBEG
12	Malual Kon	Mangaritong	PHCU	Managriton g	Aweil East	NBEG
13	Malual Kon	Mayom Deng Akol	PHCU	Malual East	Aweil North	NBEG
14	Malual Kon	Wargeng	PHCU	Malual East	Aweil West	NBEG
15	Malual Kon	Mariem	PHCU	Mariem East	Aweil East	NBEG
16	Malual Kon	Rumrol	PHCU	Madholi	Aweil East	NBEG
17	Malual Kon	Adoor	PHCU	Malual bai	Aweil West	NBEG
18	Malual Kon	Warwar	PHCU	Baac	Aweil East	NBEG
19	Malual Kon	Jaac	PHCU	Malual East	Aweil North	NBEG

FACILITIES SUPPORTED UNDER THE MARIAL BAI BRIDGE PLAN

	Field site	Facilty name	Facility type	Payam	County	Region
1	Marial Bai	Marial bai	PHCC	Ayat	Aweil West	BEG
2	Marial Bai	Nyamlel	PHCC	Gamjuer	Aweil West	BEG
3	Marial Bai	Gokmachar	PHCC	Malual North	Aweil North	BEG
4	Marial Bai	Aguat	PHCU	Malual West	Aweil West	BEG
5	Marial Bai	Rolgut	PHCU	Malual North	Aweil North	BEG
6	Marial Bai	Nyinboli	PHCU	Aweil West	Aweil West	BEG

The six Marial Bai facilities shaded in light blue are the ones that are assisted through to the end of December 2006 under the bridge plan developed with the Bahr-el-Ghazal State Ministry of Health.

THE INTERNATIONAL RESCUE COMMITTEE SOUTH SUDAN PROGRAM

Local solutions: Conflict Response in South Sudan 2006

A Report on Training of Trainers in Behavior Change Communication

December 2006

IRC South Sudan Health Program

BACKGROUND

The signing, on 9th January 2005, of the Comprehensive Peace Agreement (CPA) between the hitherto embattled Government of Sudan and the Sudan Peoples Liberation Movement/ Army (SPLM/A) marked an end to the Sudanese civil war. Spanning almost 50 years, the long drawn out conflict brought about untold misery with an estimated 2 million people dead and up to 4 million Internally Displaced People (IDP), the highest population in the world.

IRC'S SOUTH SUDAN HEALTH PROGRAM

The CPA has created a window of opportunity for Sudan to heal but with war has come a plethora of related challenges, critical among them the state of health of the citizens. It is with this in mind that IRC, in partnership with the Ministry of Health, started the South Sudan Health Program, which today supports 28 primary health care facilities across South Sudan. As well as providing basic curative and preventive health services, the IRC is committed to helping build the capacity of local health workers to better deal with health issues within their communities.

Map of Sudan

TRAINING OF TRAINERS WORKSHOP

Towards helping build capacity and as part of an on-going exercise to provide training for its health workers in Bahr El Ghazal and Upper Nile regions, IRC coordinated a "Training of Trainers" workshop from December 7th to 12th, 2006 at the Palm Tree hotel in Rumbek involving 9 participants and 2 facilitators. The first part of the workshop focusing on **Survey Techniques** took 3 days and was followed by **Behaviour Change Communication** (BCC) from December 9th to 12th 2006. This report is for the BCC part of the training.

OBJECTIVES

To enable the participants to increase their knowledge, skills and confidence in design, implementation and of BCC strategies for primary health care, reproductive health and the health aspects of HIV/AIDS in post-conflict settings.

METHODOLOGY

The training methodology was designed to be fully participatory with the main role of the consultant being to introduce and elaborate on the selected topics and facilitate group and individual exercises in and out of plenary sessions.

Typically, introductory sessions would begin with a power point presentations (projected slides) by the consultant usually for about 30 minutes, followed by a question and answer period of about 10 to 20 minutes. The group of 9 participants would then be assigned a task and break into working groups of 2 or 3 individuals depending on the nature of the exercise. Each working group would deliberate for 30 to 45 minutes noting all their points on flip chart paper. An individual from each group, with input from other members would present the group's work in a plenary session. This would then be followed by a slide presentation by the consultant and a group discussion to summarize the particular topic/session. Wherever possible groups were formed

Training session (Group work)

of members with varying but complementing skills and experiences. For instance, a group of 3 members would ideally not have 2 individuals from the same sector or duty station.
Each day was concluded with a review of the sessions covered. Day 2 and 3 were started with a brief discussion of matters arising from the previous day.

See Annexes for a breakdown of the 3 day training agenda with guiding notes and a descriptive list of topics in slide form.

PRE AND POST TEST RESULTS

After conducting the pre evaluations at the beginning of the BCC training workshop it became evident that most participants were conversant with their respective areas of work though most were not familiar with the term **Behaviour Change Communication**. The test revealed that the term was only familiar to 33% of the participants but at the end of the training, knowledge had risen to 75%.

However, through plenary discussions it became clear that the marked percentage difference could have risen more from unfamiliarity with the terminology than the concept. When asked during the pre test to describe separately, the words 'behaviour', 'change' and 'communication' in the beginning, interestingly the average percentage went up to 70%, almost the same average derived from the post test results.

Though most did not initially see the relevance of BCC in their areas of expertise, many had made the connection by the end of the workshop. Many participants admitted that they had not made provisions for BCC activities during the planning of their programs but many confessed that this was as a result of not knowing enough about the subject. Others did however say they had planned for BCC activities but specified that they had thought of Information, Education and Communication (IEC) materials but had not earlier known the difference. Pre test indicated that IEC and BCC have been used interchangeably though most (55.5%) were more familiar with the earlier. Post test figures of participants knowledge of BCC rose to 75%.

Participant discussing a poster

Central to discussions on BCC strategies was the selection of the most suitable channels of communicating health messages. Strangely, the pre test indicated that all (100%) of the participants could name at least 3 different ways

clustering channels of communication into 3 main groups, i.e., Mass media, Community networks/traditional media and Interpersonal/group communication. It is thought this could have created confusion in I individual. It is worth noting here that the post test exercise only had 8 of the 9 participants as 1 had fallen ill. This fact will have contributed to the percentage drop.

It was evident from the start to the end that the participants had a very clear understanding of their target communities. After a question relating to target audiences, pre and post results indicated 88.8% and 87.5% of the participants respectively were very clear in their conviction that they represented their communities and hold them in very high regard.

PARTICIPANTS' EVALUATION RESPONSES

At the end of the workshop, the participants were presented with 17 evaluation questions. The evaluation was done jointly for both Survey Techniques and BCC training workshops. Following is a summary of their responses:

Asked in question 1 about overall workshop organization, the average result recorded was **1** out of **5** where 1 represents **'Much better than expected** and **5**, **'Much worse than expected'**.

Comments such as "cleared all doubts about the subject", "The hotel was very nice and the consultancy was very good' and "Well organized from the beginning" were recorded.

When asked in question 2 about the level of participation by participants for the survey techniques and the BCC, participants again returned a **1** verdict for both Survey techniques and Behaviour change communication. However, interestingly and contradictorily, question 4, asking, "How would you rate the participatory approach used by the trainers during the survey techniques training session?" elicited a surprising "Very low" answer represented by 1 out of 5. The seemingly contradictory response is perhaps best explained by the fact that the order of responses, where 1 represented very low and 5 very high were deliberately changed. This is further explained in the fact that the reasons under the answers were:

"The method made each participant feel involved", "All participants had to do something for any given session" and "Good participation". It is clear that this question confused respondents. A similar participant confusion was noted in question 5 and 6. Question 7, with the order reversed again produced a very satisfied (1) for course content with the predominant reason given that participants felt confident to perform in their duties.

Question 8 asked participants to list 3 area/issues they thought the trainers could have done better. Most repeated responses indicated that participants would have liked to see more BCC/IEC materials to be handed out to them, learn more on communication methods, be exposed to more theoretical work and get involved in more sampling work. Asked in question 10 how they would rate the course against others they had attended before, participants

rated it better than most they had attended. Four participants attributed this to the fact that the small groups of participants made it easy for them to get individual attention and added that they would recommend further training in survey techniques and behaviour change communication. It was noted that the training days were few and therefore there was need for further training in the future.

Reviewing IEC materiaals

As a follow-up to question 11, question 12 asked for a list of training areas participants would recommend. Most prominently mentioned areas included questionnaire design/implementation, data collection and analysis, sampling techniques, conducting surveys, behaviour change on HIV/AIDS, development of BCC materials, developing messages, follow-up workshops, etc.

Question 13 revealed that Rumbek as an area for the workshop met with approval with everyone stating that it was “a good environment away from our working one”.

Question 14 to 17 on conference facilities returned the responses such as:

- 2 (Average) for size of conference room, with some saying it was too narrow and squeezed and that a round sitting arrangement would have been preferable
- 1 (Like very much) for hotel accommodation though 4 participants noted that there was often no soap and fresh towels/bath mats/sheets/ as had been promised
- 2 (Like somewhat) the food and drinks offered by the hotel but there was not enough vegetables provided and only one type of juice. It was also noted that food was similar every day and that the ‘ugali’ was not properly cooked
- 4 (Dislike somewhat) for laundry services offered by the hotel because, “Nobody even minded to ask for clothes although the service was paid for” and for 4 people did not receive any while 8 others had delayed service delivery.

The conference room, Palm Tree hotel, Rumbek

PARTICIPANT CAPACITY AND NEEDS

The participants actively and enthusiastically got involved in development of BCC themes and messages and discussed various of their rough prototypes and final real life examples collected form the field. It emerged that all participants felt strongly that there is need for BCC activities to be integrated in project activities and that it is equally important for community members to be involved in all stages of message development and dissemination. This was particularly made clear when discussing change of behaviour in relation to HIV/AIDS. The participants voiced displeasure at the way visual imagery is often used insensitively with disregard to the culture and traditions of local communities.

The conclusion was that BCC messages and themes must be pre-tested with communities extensively during all stages of development and production and that there is need to lobby for a more enabling environment from government and donors to smoothen the process. All participants felt they had acquired sufficient knowledge and confidence to carry out BCC strategies, messages and training within their project areas. They however felt that they required further assistance with the practical and technical aspects of message development and production but insisted that pre-testing and choice of message dissemination were areas best left to them since they were more in touch with their communities' needs and practices. During various discussions, it emerged that most participants took their jobs very seriously and felt they were doing it well.

RECOMMENDATIONS FOR THE FUTURE

As highlighted in the summary of the evaluation process,, m

any participants felt that a lot was required to assist them do their jobs even better. Following are some suggested needs and recommendations as perceived through the workshop.

1. The inability to reach certain communities because of their geographical locations or their traditions such as migration from one area to another was cited as a major bottleneck to disseminating BCC messages. A suggestion was to carefully think out the channel of dissemination and distribution. For instance, it was suggested that posters and discussion cards/flip charts be used at health centres where communities are expected to come by themselves. Similarly channels of message dissemination suitable for migrant communities need to be explored and encouraged.

2. There is a dire need for appropriate and relevant BCC and IEC materials within Southern Sudan. It was suggested that a standardized and systematic way of BCC message development and production be adopted. Towards this a materials production workshop is recommended. This would bring together subject specialists, target community members, stakeholders and production experts. Participants at the IRC BCC workshop would also be involved.

3. There is insufficient local capacity to carry out final production (e.g., design, final artwork, filming, printing etc.) of any BCC materials that are planned and developed. Two possible solutions could be:

    a. On the short term, selected members of the local community with proven aptitude could be trained, possibly in a neighbouring country that has the required facilities and expertise
    b. On the long term, a selected group of trainers could go to Southern Sudan for a given period of time to train staff and establish a health education unit with the required facilities

4. Future programs requiring community outreach would benefit from BCC activities being integrated from the start.

5. Cited as an retrogressive practice of effort duplication, was the development of BCC initiatives by some organizations, without regard to communities (e.g.. no pre-testing) or consultation with other potential partners (e.g., other NGOs). This has brought about a proliferation of generic and inappropriate messages to Southern Sudan.

   To help address this, the formation of a network or consortium of various organizations in Southern Sudan is recommended.
6. Because of its wide reach and proven success in other countries, the use of radio as a channel for message dissemination was highly recommended. However, a reliable radio station does not exist nationwide. There was the suggestion that taped messages could be designed and distributed through “battery-less” radio/cassette players such as ones used by worldwide by UNICEF. This suggestion will be considered after further investigation on its viability.

ANNEXES

BCC Pre-test Evaluation document
BCC Post-test Evaluation document
BCC Content
BCC Group exercises
BCC Facilitation Guide
Workshop Evaluation

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EXECUTIVE SUMMARY

The project involved a Needs Assessment (NA) and the execution of the training intervention for HCW of Northern Bahr El Ghazal State in Aweil town. The entire exercise tool place between ….and 22nd December, 2006.The course was a joint venture between the IRC and the SMoH with funding support from the OFDA.

The NA involved 13 officials from the SMOH both in the headquarters, ACH, the counties and the IRC. The actual training covered the same target group. Fifteen officials attended the courses and were drawn from various levels of the management hierarchy. The issues identified during the NA were management, Leadership, communication, planning and intergovernmental linkages. Subsequently the following topics were identified for the course, management functions and processes, principles of management, leadership effective communication, strategic planning, project development and management, participation and intergovernmental linkages.

Other topics identified during the NA but could not be covered then included procurement, governance, HRM. The last three topics were not included in the training due to the limitation of time. The training took place at the premises of ACH nursing school within the compound of the ACH. Pre and posts tests were administered to gauge the level of entry for purposes of training and also for observation of the areas would receive improvement. The training was appreciated and this was amplified by the participant's commitment during the entire training period without any absence whatsoever. The course was opened by the Director General, SMoH with representation of the IRC by their Aweil office.

A combination of training methodologies were used namely lectures, group work and individual exercises during the learning process.
In planning for future training programmes the following issues were noted which would require to be addressed.

- Focus group discussions during the NA would be more appropriate than a survey;
- There will be a need for translation in both the NA and the training due to language in the short term.
- Participation of the female gender should be encouraged by including conditions for the participation
- The additional topic identified among other should be run as follow up or be part of planned training interventions
- NA and training should be undertaken in another month other than December to avoid disruptions due to the festive nature of the month

The course was a welcome activity in the calendar of the SMoH and was appreciated by all concerned and the choice of Aweil as the venue was indeed praised

ABBREVIATIONS

ACH	Aweil Civil Hospital
CHD's	County Health Department (s)
DG	Director General
GOSS	Government of Southern Sudan
HCW	Health Care Workers
HRM	Human Resource Management
ICSS	Interim Constitution for Southern Sudan
IRC	International Rescue Committee
NA	Needs Assessment
NBGS	Northern Bahr El Ghazal State
PHCC	Primary Health Care Clinic
SMoH	State Ministry of Health

1.0 INTRODUCTION

1.1 Background

With the Assistance of OFDA, the International Rescue Committee (IRC) in the South Sudan Area is geared towards the improved social well- being of conflict –affected and vulnerable groups from both returnees and receiving communities in Southern Sudan through the reduction of mortality and morbidity from disease and the increased capacity of the affected communities to collectively work towards this end. As part of this, the IRC is working with County Health Departments (CHD's) to build their institutional capacity to better exert oversight over health services.
Based on the informal assessments of the CHD needs the IRC is proposing to provide organizational strengthening training in areas such as organizational management, project management, project evaluation, strategic planning, and community participation.

Subsequently and in consultation with the State Ministry of Health (SMoH) a decision was made to undertake a Needs Assessment (NA) on the actual needs and to subsequently undertake and provide training towards institutional strengthening for Health Care Workers (HCW) of the Northern Bahr El Ghazal State (NBGS).
This report covers the period of the NA and up to the training period itself.

2.0 PURPOSE

The purpose of the Needs Assessment (NA) was to determine the training needs of the various cadres of HCW in NBGS and to subsequently mount an appropriate training intervention addressing the identified management training needs of the target group.

The training targeted the SMoH health workers including those of Aweil Civil Hospital (ACH) and CHD's with representation from the IRC managed PHCC.

2.1 Specific Objectives

In order to pursue the overall goal of the proposed training programme appropriately and in line with the proposed program of action the following objectives were targeted:

- To conduct a NA for management training for the health workers
- To design an appropriate training intervention
- To develop training materials for the management training course
- To mount a management training programme
- To make appropriate recommendations

3.0 ACTIVITES

3.1 Needs Assessment

The NA was conducted from 1st – 6th December, 2006. Questionnaires **(**Appendix ii), were administered to the thirteen respondents were easily available and who constituted a good sample of the target population. The questionnaire was supplemented with focus group discussion to check and establish a common understanding of the anticipated management training. These would also ascertain what form and direction that the intended management training for HCW should take.

3.1.1 Training Needs Analysis

The NA questionnaire part B, focused primarily on the capacity of the organization and that of the individual. The questionnaires part B's question 1 and 2 need to be read and interpreted together in order to get a clear picture. The management roles and functions scored 50% rating on a combined scale 1 and 2 (low management skills) at the organizational level, it scored 41% at the individual level on the same combined scale. At the higher end of the scale implying the existence of capacity i.e. combined scales 4 & 5, management roles and functions scored 32% at the organizational level and 24% at the individual level on the same scales. This to a great extent did emphasize the need for management training.

The focus group discussions, additionally (Appendix **x**i**)** pointed towards the need for training in management related topics. This was clearly demonstrated by the responses to the question "What is your assessment on the level of management skills in your organization" among other questions. During the discussions one could deduce the need for training in management related topics. Key telling statement and examples include instances where ,some of the respondents understood capacity building to mean 'the putting up of a building'. Discussions at ACH found an even greater need as all the three medical Doctors had additional management roles and responsibilities bestowed on them namely, management / administrative and finance roles in the Hospital and in SMoH in the absence of the DG. This was despite a lack of understanding of basic management skills as explained by the Doctors and the overseers.

The scores relating to planning are very even at the individual level i.e. low skills (combined scales 1 and 2) and high planning skills (combined scales 4 &5) both scoring 41%.as well as a close tally on PDM at 50% low skill and 49% , for high skill. It is curious when the organizations own capacity on planning skills is given a low rating (no planning skills) by 41% of the respondents despite the existence of high planning skills with its employees as amplified by higher ratings. It is difficulty to visualize an organization with people with planning skills being rated poor in planning abilities. This would indicate lack of understanding either the questionnaire or perhaps an indication of

understanding what planning implies. In the absence of any other explanations would require further a further follow up in subsequent related activities.
The focus group and the pre test too did not indicate the existence of knowledge on planning as captured in the needs analysis. A classic example of lack of planning skills was in that there was no evidence of planning tools like strategic plans, or any other kind in use both in ACH and SMoH.The IRC's officers involve in the informal discussions were more averse to planning as a management tool and were able to indicate the objectives being pursued by IRC without any difficulty.

On the basis of those doubts and based on previous IRC informal assessments and on information derived from the focus group discussions (Appendix ix**)** it was deemed necessary to devote time to the subject of planning during the course.

Communication process was rated with a low scale of between 1- 2(poor communication skills) by 66% of the respondents while only 24 % thought of it as being good combined scales 4 & 5. This aspect was singled out for training due to the higher number of respondents who identified it as a need.

The existence of the need was subsequently confirmed in subsequent events namely the communication process used to get the participants to training was poor and other issues affecting the welfare of the participants remained un attended until they arose during the training session. The issue of the communication process within the SMoH was identified as being poor and requiring improvement.

Leadership was identified as a training need by 50% of the respondents with only 33 % thinking otherwise and 8% could lean either way. Leadership issues were also discussed and examples of lack of and poor leadership skills were brought out. This constituted the basis of including a leadership session in the training programme.

The Inter governmental linkages ratings indicate it as an area which the respondents were not well averse with, 50 % of the 14 respondents scoring it low on scale 1– 2(lack of knowledge) with 16 % rating it high (good knowledge of the subject) on scales 4 – 5. The three subjects the respondents indicated they would wish to learn in order of priority included the following:

No.	Subject	Respondents	%
1.	Management	7	54
2	Planning	6	46
3	Communication	3	31

Other subjects namely procurement, government functions and capacity building each had one respondent each. Communication includes issues relating to record keeping and reporting systems.

It is imperative to note that one could lump the first four topics under the general theme of management as a subject. In some situations the understanding of the term

management is normally very vague because it could be the whole spectrum of the subject and in some cases it could be the mere understanding of the management concepts/principles. The facilitator interpretation is on the latter more than the former. This is further underscored by the fact that all the three identified subjects are all Management subjects.

In addition the subjects indicated below will require training in future endeavours.Their need was indicated during the discussions and also in the NA.These subjects include:

- Government financial regulations;
- Human resource management
- Procurement Management

The topics of procurement as it relates to medical supplies among other office supplies featured very prominently during the focus group with the SMoH.It is note worthy that most government expenditures are incurred during the procurement process.

3.1.2 Identified training needs

The NA primarily focused on the areas which had been singled out during the informal assessment, namely, organizational management, project development and management, strategic planning and community participation. The questionnaire (Appendix ii) that was administered focused both on the perceived existing organizational and individual skills and it was divided into four clusters namely Management and planning, inter – personal relations, networking and collaboration, governance and public finance. An additional area was introduced relating to public finance and governance based on the new emerging role of the state government which is increasingly expected to take over certain responsibilities being undertaken by Non Governmental Organizations. Based on the data analysis it was established that for training to be effective the four clusters should be disaggregated into the following subject areas:

- **Management & Planning**: Management functions and processes. Principles of management, Strategic planning and project development and management
- **Interpersonal relations:** Leadership, Effective communication
- **Networking & collaboration:** Community participation
- **Intergovernmental linkages:** Intergovernmental linkages

The above list is not exhaustive and a number of other potential training areas were identified as mentioned elsewhere in this paper, among them government financial regulations, Human Resource Management (HRM) and procurement among others but could not fit within the planned time frame.

3.2 Course Implementation

The training materials were developed between the 10th and 16th December, 2006 based on the specific subject areas identified and are available under a separate cover and a training curriculum and training agenda were developed (Appendix iv & v) respectively to facilitate the implementation of the training.

The management training course was mounted from the 19th – 21st December, 2006 at the compound of the ACH in Aweil town, Northern Bahr El Ghazal. Pre and post tests were administered analysed and the results tabulated (Annex vi and vii**)**.The training program was preceded by a low key opening ceremony by the Director General (DG,) self introductions were done and each participant were given an opportunity to identify their course expectations. All the subjects were covered as scheduled.

The learning process was facilitated using a variety of training methods among them lectures, discussions, questions and answer sessions, individual and group exercises were undertaken.

3.2.1 Course objective

A course curriculum was developed (Appendix iv) with the overall objective of setting direction towards imparting basic management skills, knowledge and attitudes for effective service delivery in the health sector in the State

3.3 Other activities

A number of meetings to facilitate the planning and execution of the training programme were planned and did take place (Appendix i). Notable among the meetings include meetings between the SMoH DG and his officials, the IRC representatives and the consultant and on a separate occasion the consultant, IRC representative and ACH health workers and led by the ACH Director.

4.0 OUTPUT

The management training for health care workers brought together officials from the SMoH based in Aweil, health workers from both the SMoH and the IRC in the Counties. This opportunity created a forum for interaction and mutual exchange of ideas on issues that affect them as individuals and as HCW. During the planning and execution phase of the training program additional outputs were obtained, namely:

- A total of fourteen meetings were held during the NA which involved thirteen different officials of the target population (appendix i);
- A questionnaire were developed and applied during the NA exercise;
- A training course outline and accompanying materials for training were developed and issued;

- Fifteen Health Care Providers were trained, two from the SMoH, eight from CHD's, two from the IRC and four from ACH;
- Pre and post tests were developed , administered, result analyzed and tabulated (**A**ppendix vi & vii**)**
- Course evaluation instrument was developed , administered and the result analyzed (Appendix viii & ix)

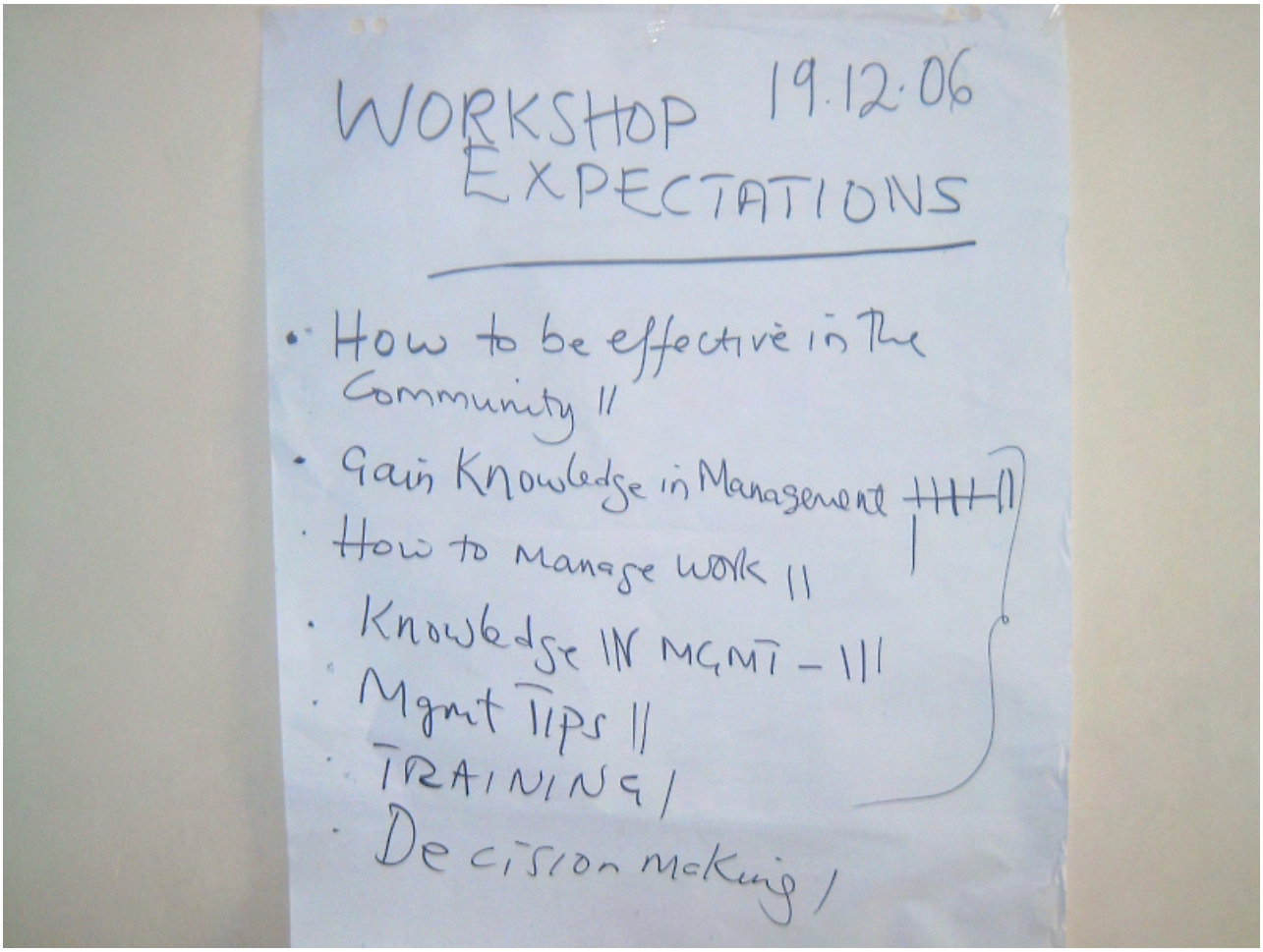
5.0 OUTCOME

The training intervention was timely and was welcomed by all the participants and the SMoH.The mounting of the course in Aweil was a plus on the part of the IRC. It was a 'first' in Aweil in the words of the Director General, SMoH that such a course was conducted in Aweil. He further explained it was one of the few courses that he had attended lately that he followed thoroughly without feeling being rushed.

The course mix was described as being good as all management levels were well represented. It provided an opportunity of bringing together the various management cadres of HCW from the SMoH. It brought the very senior and junior into one classroom without any inhibitions. This gave them an opportunity to meet as a team and to realize the importance of working together.

Picture 1: Participants going through a group work session

Indications from the course evaluation are that the course was relevant and appropriate and that it met the needs of the participants. The course expectations from the participants further reiterated the findings of the NA.



Picture 2: Participants course expectations

During the learning process, a number of questions arose during the various lectures and discussions in the course. Some cluster of questions include the following:

- Why is management different from leadership
- What makes a good leader?
- Are people born leaders?
- Is reporting part of communication process?
- Is infrastructure a part of part of communication?
- What do we do when there no resources?
- Which is better method of participation monetary or in kind?
- Who is senior a Governor or a GOSS Minister

- What is the role of the GOSS Ministry of Health in relationship to of Health the SMoH
- Why GOSS and State Constitution
- Why does the State Constitution have to be taken to GOSS for approval

It was also observed during the training by the facilitator that the training programme was appreciated. More specifically this view was reiterated unsolicited during the closure of by two of the participants.

The post test revealed an improvement in the participants understanding of the subjects This is reflected through an increase in the mean score from 6.5 to 7.95 **(**Appendix vii**).** The percentage gain in marks for most of the participants was over fifty percent. This implies that there was additional knowledge gained.

The best overall subject in terms of performance was communication with a 139 % improvement, followed by Management with 84 % and participation with a 40% improvement. Leadership scored 35% improvement and which perhaps could be described as being the hardest subject to understand.

5.1 Course Evaluation

Majority of the participants 80% expressed satisfaction with the course (Appendix ix) and its relevant to their work. This implies that the lessons learnt could be applied in their day to day work. During the introductory phase of the course participants had identified certain objectives they would have wanted met. This expectations were clustered and displayed
(picture 1).Accordingly therefore 71% of the participants translating into eleven of the respondents indicated that their expectations were met during the course.
The course quality was rated as being very good by 73% (eleven respondents) and the remaining 27% rated the course quality as being good. The most useful subjects were highlighted to be management, leadership and planning.

The courses training methodology involved a combination of group work, individual exercise, lectures and discussions. All the methods were found relevant. However sixty percent felt that Group work was very relevant, fifty percent felt lectures were very relevant while twenty percent were inclined towards exercises being. Other types of methods scores13% and were found not to relevant.

The participants expressed willingness to apply the practices skills and attitudes acquired into their work situation. However a majority of those who responded (33%) indicated that the changes they would introduce would be in management and planning. Another group of respondents (20 %) indicated they would use the skills learnt to improve work performance without specifying in which areas. Others who constituting 6% indicated their improvement would be geared towards improvement in communication while another 6% vouched for improvement on their leadership skills.

Area for improvement	No. of Respondents	%
Changes in management & planning	5	33
Use knowledge in leadership & administration	1	6
Improve planning and communication	1	6
Implement skills to improve work performance	3	20
No response	5	33

May of the participants (33%) did not respond to the second part of question 8 as indicated above on the course evaluation relating to "What changes will you make in your work as result of this training".

The punctuality and commitment by the fifteen HCW who attended the course from day one to three without failure was a strong feedback of their commitment to the learning process.
It is note worthy that there were no female participants in the course.

6.0 LESSONS

The process of undertaking NA and the training in the month of December was perhaps not very appropriate, when everyone involved wanted to clear a role touching on the exercise in order to 'clock off'.
During the planning and implementation phases and the training; a number of unexpected events e.g. unscheduled holidays led to the loss of planned working days and also led to a number of potential participants particularly the Medical Doctors of ACH not to attend the course.
The coordination between the IRC Aweil office and the SMoH on course announcement, dates and venue arrangements did no take off smoothly as anticipated.
The per diem / night out allowances concerns of the participants whose duty station is not within the locality of a course venue need to be addressed. This aspect almost derailed the course.
English language both in the spoken and written form is and remains a problem to some of the HCW.
Training on various aspects of public finance, government organization regulations and procurement. The management of medical supplies and other assets is a subject that should be addressed in subsequent training programmes as well. Other notable subjects requiring further attention include HRM and Government Organization and functions.

7.0 RECOMMENDATIONS

The Need Assessment and execution of training unless a continuing series should not be undertaken during the IRC's end of financial year, which also happens to be a festive season month, and may staffers are about or proceeding on their annual leave. It also happens to be a month whereby other institution that provide additional support services can only confirm availability of such services at very short notices and can be subject to

cancellations and changes at short notices or no notice e.g. World Food Programme (WFP). The facilitator was not picked at airports on two occasions, on one occasion had two wait for one hour before pick up and on the final stretch he was not expected on the officer on the ground until maybe an hour before arrival

Coordination between the IRC Aweil office and the SMoH should be improved in future ventures the communication process, in relationship to the Course announcement, venue, dates and what the respective collaborating institutions will be responsible for or not responsible for.

Training programmes for HCW require an Arabic translator if the impact is to be felt for most of the HCW. Many of the participants will not willingly agree that they are having difficulties and will insist as such despite the handicap. There is a capacity gap as far as English is a medium of the learning process.

During the NA phase a number of training areas were identified which could not be dealt within the planned time. These are important management areas and include the following:

- Procurement of goods (including medical drugs and equipment) etc
- HRM focusing on rules, regulations etc
- Government organization and functions
- Public finance

As discussed elsewhere in the report and in other informal discussions during the assignment, the understanding of both written and spoken English was a major huddle. It is quite possible that many of the respondents did not understand the scoring, despite explanations and translations of the same, although too some of the attempted explanations translations were quite suspect and in a number of situations alternative explanations had to be given. It is recommended that future NA be conducted through focus group discussions and with an informed translator. These strategy should be used at both at NA and the training level . It is worthwhile noting that it has been successfully in used in the training of State Legislative members in six of the Southern Sudan states, Northern Bahr El Ghazal being one of them.

There was no female participant in the course as mentioned elsewhere in this report. This is not with standing the fact that the State Minister for Health is a woman. The absence of female participants may be explained in that women have culturally and educationally been disadvantaged and also that the war may have worsened the situation further This is not based on any factual data collected during the assignment. Those factors however have been known to have a detrimental effect in advancing the cause of women to managerial positions among others in the African context.

It is also worth noting that the Interim Constitution for Southern Sudan ICSS) article 20 subsection 4 (a) has explicitly stated that at least 25 % of all legislative and executive Public Service positions should be held by women. In the short run therefore, representation may be low but may improve in the future with the clauses for affirmative

action being in place. In future training interventions it may be desirable to put a caveat in the target group specification to enable women to be adequately represented in similar training programmes e.g. 30 % must be female participants or for funding purposes that only projects with at least 30% female representation shall be considered.

8.0 CONCLUSION

There are limited management skills among the health care workers in NBGS. This situation was observed during the NA period as well in other interactions with the respondents before and during the course. The analyzed pre and post test data too subsequently confirmed the above stated position.

The pre test was seen as more indicative of group performance rather than that of individuals and that there are many factors influencing performance and expectations of individuals in a course. Some of these factors are a negative influence. Assessment was seen as one motivating factor towards the learning process.

The lack of skilled personnel has additionally placed additional managerial responsibilities on three of the Medical Doctors who play multiple roles namely that of tutors in the Nursing school, administrative and management roles as Hospital Director of Administration and Finance, Director of Medical Services and acting DG respectively. In addition to the above stated responsibilities one of the Medical Doctors normally act as Director General SMoH in the absence of the holder. The situation is no different in the counties. It is notable that none of the Medical Doctors attended the training despite the need.

Many of the participants have not attended any professional and management training courses in well over a decade plus. Due to skills shortage there is a need for skills upgrading and exposure to management and professional training courses for all cadres of staff.

In the long-term there will be need to facilitate the professionals to relinquish some of the non medical roles they are currently performing. Training should be encouraged and made a regular feature of the SMoH.

9.0 APPENDICES

Appendix i: List of Persons met

	Name	Designation	Organization	Date
1	Charles Yenge	Field Manager	IRC, Aweil	1.12.02
2	Dominic Athian	Clinical Officer	IRC, Nyamulel PHCC	1.12.02
3	Dr.Garang Thomas Dhiel	Director General	Aweil Civil Hospital	1.12.02 & 5.12.06
4	Abraham Lual Deng	Office Manager	State Ministry of Health	4.12.06
5	Gabriel Garang	County Medical Officer of Health	State Ministry of Health (Aweil North)	4.12.06
6	Nkit – El din Abdrahu	Clerk	Aweil Civil Hospital	5.12.06
7	Severino Kon Dumo	Hospital Overseer	Aweil Civil Hospital	5.12.06
8	Marko Apai Makuei	Nurse Overseer	Aweil Civil Hospital	5.12.06
9	Mayen Arou Arou	Senior Nurse	Aweil Civil Hospital	5.12.06
10	Abour Gordon Nhial	State Epi Manager	Aweil Civil Hospital	5.12.06
11	Debeek Atak Longar		State Ministry of Health	5.12.06
12	Stephen Urio Tong	Director General	State Ministry of Health	5.12.06
13	Michael Achiriu Lual	Director, Administration & Finance	State Ministry of Health	5.12.06

Appendix ii: Capacity assessment questionnaire

On a scale of 1 – 5 (1 (one) being the lowest and 5 (five) being the highest) in sections B,C and D give a rating with a tick (√) for each of the statements given in the appropriate box.

Part A: Personal Details

1. Sex: M [ ] F [ ] Age
2. Educational Qualification
3. Professional qualification / Training
4. Designation (Job Title) /Organization
5. Current Job responsibilities (Starting with major to minor)

Part B: Organizational and strategic management

1) What is your overall assessment of the CHD's /MoH organizational capacity in terms of:

Management roles & functions..

1	2	3	4	5

Goal setting

1	2	3	4	5

Leadership

1	2	3	4	5

Communication processes

1	2	3	4	5

Stakeholder participation

1	2	3	4	5

2) How would you rate your skills as a CHD / SMoH official in the following areas:

Management skills

1	2	3	4	5

Planning skills

1	2	3	4	5

Interpersonal skills

1	2	3	4	5

Project development & management skills

1	2	3	4	5

Part C: Organizational networking

3) What is your assessment of the relationship between CHD's / SMoH officials with beneficiaries and other health care providers in terms of :

Networking / collaboration

1	2	3	4	5

Communication processes

1	2	3	4	5

Participation/involvement

1	2	3	4	5

Part D: Government Organization and Functions

4) What is your knowledge & understanding of the government set up and functions:

1	2	3	4	5

Governance structure

Inter governmental linkages

1	2	3	4	5

Government financial processes

1	2	3	4	5

Human resource management

1	2	3	4	5

Part E: Other

4) What are the three management training subjects in order of priority that you would like to learn/ enhance most?
5) What are the key support services that you need most in the performance of your work?
6) Identify some key challenges you have to deal with as an employee

Thank You

Appendix iii : Analysis of the training needs

Profile of the participants

The potential participants to the course had an average age of 42 years of age the youngest at 30 and the oldest with 65 years respectively. The educational level for most were senior school certificate, with an additional professional qualification at certificate, diploma and degree level. A majority of them had diplomas predominantly.

Qualification	**No. of Participants**	**Age Distribution**
Certificate	5	32 - 65
Diploma	6	30 – 43
Degree	2	33 - 65
Total	13	

Candidates were asked to give ratings 1-5 for each of the statements (1 indicates a lowest rating and therefore the greatest need, while 5 would denote excellent knowledge and the least need for any intervention).

Part B: Organizational and Strategic Management

Question 1. What is your overall assessment of the CHD's/SMOH organizational capacity in terms of:

Management roles & functions

Scale	No. of Respondents	%
1	3	25%
2	3	25%
3	2	16%
4	2	16%
5	2	16%

Fifty percent of the respondents gave a rating of 1-2 for management roles & functions with only 32 % of the 12 respondents indicating confidence in the roles and functions of their organizations.

Goal Setting

Scale	No. of Respondents	%
1	5	33%
2	1	8%
3	3	25%
4	1	8%
5	2	16%

41 percent of the respondents gave a rating of 1-2 for goal setting . 49 percent rated it between 3-5

Leadership

Scale	No. of Respondents	%
1	3	25%
2	3	25%
3	1	8%
4	0	0%
5	4	33%

Fifty percent of the respondents gave a rating of 1-2 for Leaders. While only 33% gave a rating in scales 1 - 5

Communication processes

Scale	No. of Respondents	%
1	4	33%
2	3	25%
3	2	16%
4	0	0%
5	3	25%

Majority of the respondents, Fifty eight percent, rated highly communication process.

Stakeholder participation

Scale	No. of Respondents	%
1	4	33%
2	2	16%
3	1	8%
4	4	33%
5	1	8%

Forty nine percent gave stakeholder participation a rating of 1-2

2. Question two: How would you rate your skills as a CHD/SMoH official in

Management skills

Scale	No. of Respondents	%
1	2	16%
2	3	25%
3	4	33%
4	1	8%
5	2	16%

41% of the course participants gave a low rating of between 1 – 2 in terms of their knowledge in management skills and 24% rated highly their knowledge while 33% more or less would be considered being on the border line.

Planning Skills

Scale	No. of Respondents	%
1	3	25%
2	2	16%
3	2	16%
4	4	33%
5	1	8%

39 % gave a low rating i.e. scale 1- 2 meaning they recognize that the y are weak on planning skills, while 38% scored on the higher scale 4 – 5 indicating they have planning skills.

Interpersonal skills

Scale	No. of Respondents	%
1	3	25%
2	1	8%
3	3	25%
4	3	25%
5.	2	16%

41% of the respondents indicated weakness of good inter – personal skills while well over 51% scored a higher rating scale of 4-5 indicating good or excellent skills in interpersonal relations.

Project development & management(PDM) skills

Scale	No. of Respondents	%
1	6	42%
2	1	8%
3	3	25%
4	4	33%
5.	2	16%

Rating on the lack / knowledge of PDM skills in the organization scored 50% and 49% respectively while 25% rated it more or lesson the middle ground

Part C: Organizational Networking

Question 3. What is your assessment of the relationship between CHD's / SMoH officials with beneficiaries and other health care providers in terms of:

Networking /Collaboration

Scale	No. of Respondents	%
1	4	33%
2	1	8%
3	4	33%
4	0	0
5.	3	25%

The rating of the networking / collaboration aspect of the organization was rated evenly with 41% indicated a low score, with 33% appearing not so sure while 25 % gave excellent score, meaning there is no organization problems on that aspect.

Communication Processes

Scale	No. of Respondents	%
1	4	33%
2	4	33%
3	1	8%
4	2	16%
5.	1	8%

66% indicated there is a need for improvement on their organizations communication skills due to the low rating on the scale, while only 24 % thought of it being good or so.

Participation/Involvement

Scale	No. of Respondents	%
1	4	33%
2	2	16%
3	2	16%
4	2	16%
5.	2	16%

49% gave a low rating while 32% gave the subject a high rating with 16% being a middle ground again the scores are very close, separated with minimal scores

Part D: Government Organisation and Functions

Governance structure

Scale	No. of Respondents	%
1	1	8%
2	4	33%
3	3	25%
4	4	33%
5.	0	0

A score of 41% between scales 1- 2 indicted need for training in the subject area, despite the equally not so high or low score of 33% indicating knowledge in the subject.

Inter governmental linkages

Scale	No. of Respondents	%
1	3	25%
2	3	25%
3	3	25%
4	1	8%
5.	1	8%

50 % of the 14 respondents who answered the question indicated need for training in the area due to low rating of scales 1- 2 with only 16% thinking otherwise

Government Financial Processes

Scale	No. of Respondents	%
1	4	33%
2	3	25%
3	3	25%
4	1	8%
5.	0	0

There is need for exposing the HCW with government financial regulations as figures indicate 58% indicating a need with only 8 % indicating some degree of confidence in the subject area.

Human Resource Management (HRM)

Scale	No. of Respondents	%
1	4	33%
2	1	8%
3	4	33%
4	1	8%
5.	2	16%

The scores indicated a relative training need with 41% indicating so with low rating of the subject knowledge and a slightly low number represented by 24% of the 12 respondents who filled the questionnaire

Appendix iv: Curriculum for the Management Training

Overall Course Aim

The training programmes overall aim is to impart basic management skills, knowledge and attitudes for effective service delivery in the health sector in the State

Target Group

The training programme target groups are the health care providers with a supervisory responsibility in the SMoH and the County Departments of Health.

Course Objectives

The cours**es** objective is to:

- Inculcate and enhance the management skills of the health care providers
- Emphasize the role and importance of planning and the roles of various players and actors in the development process
- Facilitate a better understanding of the inter - government linkages in the various levels

Course Content

- Management functions and processes
- Leadership
- Strategic Planning
- Effective Communication
- Community Participation
- Inter Government Linkages

Methodology

- Lecturrets
- Group and individual exercises
- Discussions

Evaluation

End of event

Management functions and processes

Specific objective

By the end of the session participant should be able:

- Explain and relate to their work the basic concepts of management
- Identify basic functions and principles of management that they perform/ought to be performing
- Identify and apply the principles of management

Content:
Concept of management
Functions of management
Principles of management

Leadership

Specific Objective:

At the end of the session participant should be able to:

- Describe the main leadership styles;
- State leadership functions;
- Develop basic leadership skills relevant to their job

Content:
What leadership is
Leadership and management
Leadership Styles
Leadership functions

Strategic Planning

Specific Objective

By the end of the session participants should be able to:

- Understand and explain the importance of setting organizational direction at the SMoH and CHD's levels
- Formulate basic goals, objectives and strategies in health care work and planning
- State the importance of assessing organizational performance

Content:
Setting organizational direction
Strategic management model
Strategic planning processes

Effective Communication

Specific Objective

At the end of the session Participants should be able to:

- Understand the meaning and importance of effective communication
- Identify various channels for communication
- Be aware of the various communication barriers

Content:
Communication process
Various types of Communication
Communication barriers
Making communication effective

Participation

By the end of the session, Participants should be able to:

- Be able to define 'community'
- Discuss the importance of participation for sustainability
- Enhance community participation to resolve issues/problems and derive benefit of working with community structures to develop their communities

Content:
Understanding participation
Participation as a strategy

Intergovernmental Linkages

By the end of the session, Participants should be able to:

- Understand the organization and functions of the Government of Southern Sudan
- Explain the various level of government and their linkages
- Visualize the position of the Health sector in the overall government framework

Content:
Government organization and functions
The structure of government (Devolution and decentralization)
Government functions
Inter governmental linkages

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5. Stephen R.R., Organizational theory Structure, Design and Application, 3rd Edition
6. Vroom V. ITR, Management and Motivation, Penguin Books Ltd, 1970

Appendix v: Training Agenda

Management Training Course for Health Care Workers

Northern Bahr El Ghazal State

19th – 21st December, 2006

Day	Time	Subject
Tuesday (19 .12 . 06)	8.30 am – 10.30am	Course Opening, Briefing & Introductions, Pre - test
	10.30 – 11.00 am	**Tea Break**
	11..00 – 1.00 pm	Introduction to Management functions & Principles
	1.00 pm – 2.00 pm	**Lunch Break**
	2.00 – 4.00 pm	Strategic Planning
Wednesday (20.12.06)	8.30 am – 10.30am	Project Management Cycle
	10.30 – 11.00 am	**Tea Break**
	11..00 – 10.00pm	Effective Leadership
	1.00 pm – 2.30 pm	**Lunch Break**
	2.00 – 4.00 pm	Effective Communication
Wednesday (21.12.06)	9.00 am – 10.30am	Community Participation
	10.30 – 11.00 am	**Tea Break**
	11..00 – 1..00pm	Inter Governmental Linkages
	1.00 pm – 2.00 pm	**Lunch Break**
	2.00pm – 4.00 pm	Post –test ,Course Evaluation & Closure

Facilitator: David Njoka

Implementing Agencies:
IRC South Sudan Programme and the NBG State Ministry of Health

Appendix vi: Pre and Post tests for course

A: Pre / post test questions

Management & Planning

1 What do you understand by the term management?
2 Why do we need to manage?
3 Identify three functions of management
4 Why do we plan?
5 Identify two different types of plans
6 What is a project? Identify one project you are aware in your work station.
7 Why do we need to prioritize needs

Leadership

8 Who is a leader ?
9 Is a manager a leader? Explain your answer.
10 Identify four qualities of a leader

Communication

11 What is communication?
12 Select three barriers to effective communication from the following:
- Office, Noise, language, telephone, channel, weather

13 State two ways in which we can ensure effective communication

Participation

14 What does the term 'community' mean?
15 What is community participation and what are the Benefits its benefits

B: Answers

Management

1 .Management is the process of getting results, it is the team responsible for an organization, it is working with people
2. We need to manage so as to get things done properly, to coordinate activities, to ensure order, to ensure proper use of resources
3 .Functions include: planning, organizing, staffing, directing/leading evaluation
4. We plan in order to: set direction, know where we are going, maximize use of resources, to know what are our priorities, not to get lost or confused
5 .Different types of plans include: Strategic, tactical, operational. Others may state: daily plan, work plan action etc.

Leadership

6. A leader can be: a person in position of authority a formal or informal situation, a person who exhumes responsibility etc one could also identify a politician, clergy, minister or Governor as an example etc
7. Yes a manager is a leader as he or she is in position of responsibility and occupies a formal position.
8. Qualities of a leader include: honesty, courage, visionary, patience,

Communication

9. Communication: is shared understanding, creating mutual understanding, and exchange of ideas, involves sending and receiving messages
10. Barriers to effective communication include: noise, language, status, body language,
11. How to ensure effective communication: have the receiver in mind, simple language, use appropriate channel, ensure understanding, be a good listener, be empathetic

Participation

12 Group of people- Geographically as a location (i.e. city, town or village) this is when a community is defined through physical location or precise boundaries understood and accepted by others. Common cultural heritage (i.e. tribe, tradition, language, values, customs, etc.) Shared beliefs or interests (i.e. religious, business (traders, investors, farmers, etc.))

13 Community participation means groups/communities with shared needs actively taking part in identification of their needs, making decisions and plans to meet these needs. Community involvement in project identification, planning, implementation and monitoring and evaluation

14 Helping each other Gaining new skills and knowledge Sharing of resources Participating in decision making.

Appendix vii: Pre and post test results

	Name	Management & plan		leadership		communication		participation		Total	
		Pre	**post**	**pre**	**Post**	**pre**	**post**	**pre**	**post**	**pre**	**post**
1	Stephen Urio Tong	2	8.5	1.5	7	0.5	1	1	1.5	5	8
2	William Aken Dut	3.5	4	0.5	2	1	1	0	1	5	8
3	Benson Opothmalo Ger	2	2	5	3	1	3	0	0	8	8
4	Dominic Athian Dut	8.5	10	5.5	7	1	6	2	3	17	26
5	Tito Marieu Marieu	1	2.5	1	3	1	0.5	0	0	3	6
6	Dun Chuor Aketch	2	3	0	0	0	1	0	0	2	4
7	Marko Apai Mokuei	1.5	4	0.5	0	0	1	0	0	2	5
8	Gabriel Garang Lual	5.5	9	2.5	5	1	5	1	2	10	21
9	Santino Akok Ngor	4.5	11	2	5	1.5	6	2	2	10	24
10	Zacharia Mayuol Deng	4	6	3	4	4.5	4	1.5	2	13	16
11	Daniel Yel Chan	1	4	1	1	0	0	1	0	3	5
12	John Angelo Akwar	2.5	2	0.5	0	0	0	0	0	3	2
13	Victor Wot Akok	3	9	4.5	5	1.5	3	1	3	10	20
14	Angelo Deng Lual	0	1	0	0	0	0	0	0	0	1
15	Albert Arian Mawian	4	7	5	2	1	2	3	3	13	14
16	Morris Jong Aru									1	NA
17	Abdin Moh Kohalil									7	NA
18	Severino Ken Dulmo									2	NA
19	Dr. Jamal Zakalh									15	NA
20	Dr.Garang Thomas									12	NA
	Total	45	83	32.5	44	14	33.5	12.5	17.5	104	178
	Marks gained	38		11.5		19.5		5		74	
	% gained	84%		35%		139%		40%		71%	
	Mean	3	5.5	2.2	2.9	0.9	2.2	0.8	1.2	6.9	11.9

The best overall subject in terms of performance was communication with a 139 % improvement, followed by Management with 84 % and participation with a 40% improvement. Leadership scored 35% improvement and which perhaps could be described as being the hardest subject to understand.

NB

There are more people who did the pre test than the post test. This was due to Doctors in ACH who attended the preliminaries of the course but later left due to the Aids day organization and celebrations. Secondary the daily attendance list for day one indicates a higher number due to the same group and nursing officer trainees who erroneous got into the training room and were later identified and left.

Appendix viii: Management Training Evaluation Questionnaire

Now that you have finished the management training course you are kindly requested to summarize your experience by completing this questionnaire. This questionnaire will be used for:

- reporting to the donor organization (International Rescue Committee);

Your information will be handled discretely. The results of the questionnaires will be used only in compiled form.

1. Was the course an appropriate and useful to your work experience?

   a. Yes, perfectly
   b. Yes, reasonably well
   c. Yes, but only to some extent
   d. No

2. Were your expectations fulfilled?

   a. Yes, fully
   b. Yes, to a large extent
   c. Yes, but only to some extent
   d. No, hardly at all
   e. No, absolutely not

3. What is your overall opinion of the quality of the course you followed?

   a. Very good
   b. Good
   c. Fair
   d. Poor
   e. Very poor

4. What do you consider as the most relevant and useful aspects of the course you have just completed?

   a. Almost all subjects
   b. Learning from the lecturer and participants
   c. Learning elements: group discussion, individual assignment, group assignment
   d. Course quality: lecturer, materials, English language

5. Which elements of the course did you consider <u>not</u> very useful?

   a. None/nothing
   b. Some subjects/materials/assignments
   c. Course arrangement: lecturer, material, study load,
   d. Only one subject

e. Others, please explain …….

6. How would you rate the overall quality of the course? Was it well taught?

   a. Very good
   b. Good
   c. Fair
   d. Poor
   e. Very poor

7. What kind of teaching methods were used and which methods did you find most effective/ relevant? (Please rate each method that was used).

0 Group work assignment	0 very relevant	0 relevant	0 not relevant	0 waste of time
0 Lectures	0 very relevant	0 relevant	0 not relevant	0 waste of time
0 Exercises	0 very relevant	0 relevant	0 not relevant	0 waste of time

0 Other method, namely …….

8. The duration of the course you followed was:

   a. Just right
   b. Too short
   c. Far too short

9. Do you expect to put into practice the techniques, skills and attitudes you acquired in the Course?

   a. Yes
   b. Partly
   c. No

THANK YOU VERY MUCH FOR YOUR TIME AND EFFORT

APPENDIX ix: Course evaluation analysis

1. **Question No.1:** Was the course appropriate and useful to your work experience?

		No. of Respondents	%
a.	Yes Perfectly	12	80%
b.	Yes Reasonably well	1	7%
c.	Yes but only to an extent	2	13%
d.	Not Really	0	0%
e.	Not at all	0	0%

Eighty percent of the respondents were of the view that the course was both useful and appropriate to their work experience. Seven percent responded that the course was reasonably well whereas thirteen percent felt that that the training was useful to some extent.

2. Question No. 2: Were your expectations fulfilled?

		No. of Respondents	%
a.	Yes Fully	6	40%
b.	Yes to a large extent	5	33%
c.	Yes but only to some extent	3	20%
d.	Not Really	1	7%
e.	No absolutely not	0	0%

Seventy seven percent of the respondents felt that their expectations were either fully or to a large extent filled. Twenty percent were of the opinion that their expectations were to some extent fulfilled while the expectations of the other seven percent were not really fulfilled.

3. **Question No. 3:** What is your overall opinion of the quality of the course you followed?

		No. of Respondents	%
a.	Very Good	11	73%
b.	Good	4	27%
c.	Fair	0	0%
d.	Poor	0	0%
e.	Very Poor	0	0%

All the respondents felt that the course was worthwhile since seventy three percent were of the opinion that the course was very good whilst twenty seven thought that the course was good.

4. **Question No. 4:** What do you consider the most relevant and useful aspects of the course you have just completed?

			No. of Respondents	%
a.	Almost all subjects		2	13%
b.	Learning from the lecturer and participants		4	27%
c.	Learning elements: group discussion, individual assignments, group assignment.		6	40%
d.	Course quality: lecturer, materials, English language		0	0%
e.	Most Useful subject	Management	1	7%
		Management & Leadership	1	7%
		Planning	1	7%

Forty percent of the respondents were of the opinion that the Learning elements were the most relevant and useful. Twenty seven percent of them felt that learning from the lecturer and participants were useful whilst thirteen percent believed that all subjects were useful and relevant. The most useful subjects were highlighted to be Management, Management and Leadership and Planning

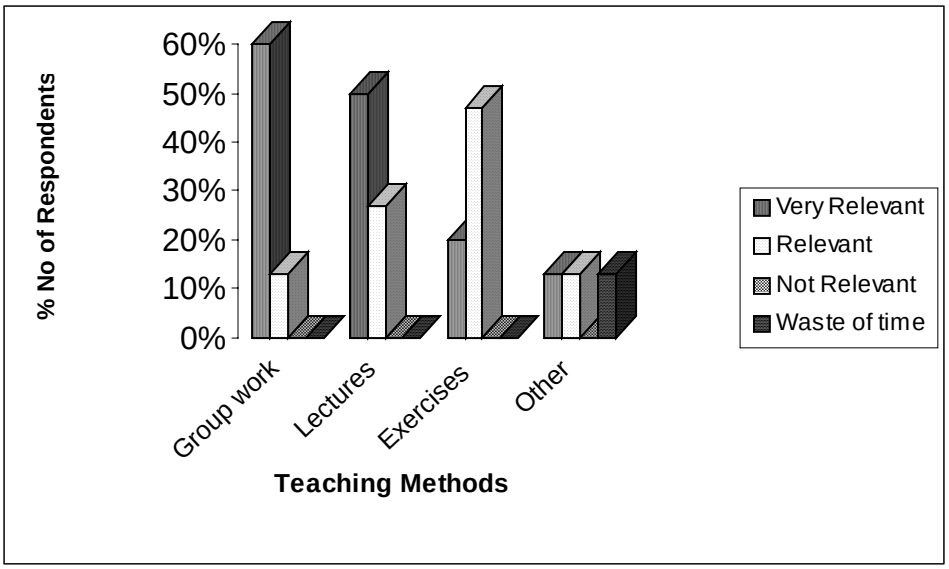
6. **Question no. 5:** Which elements of the course did you consider not very useful

			No. of Respondents	%
a.	None/Nothing		6	40%
b.	Some subjects/materials/assignments		2	13%
c.	Course arrangement: lecturer, material, study load		2	13%
d.	Only one subject		2	13%
e.	Others	Poor Accommodation	1	7%
		Poor Accommodation & Transport	1	7%

Poor planning on the aspects of accommodation and transport were pointed as the elements of the course that were not considered very useful. However forty percent felt that there was nothing that was not useful, with a further thirty nine percent feeling that either a subject/s, assignments, materials and course arrangement was not very useful

6. **Question no. 6:** What kinds of teaching methods were used and which methods did you find most effective/ relevant

	Very Relevant	Relevant	Not Relevant	Waste of Time
Group work	14	2	0	0
Lectures	8	4	0	0
Exercises	3	7	0	0
Other	2	2	0	2



From the table and bar graph above, it is clear that no method was found irrelevant. However sixty percent felt the group work was very relevant, fifty percent felt lectures were very relevant, twenty percent were inclined towards exercises being very relevant and thirteen felt other methods were irrelevant.

7. Question no. 7: The duration of the course was

		No. of Respondents	%
a.	Just Right	10	67%
b.	Too Short	3	20%
c.	Too Long	1	7%

Sixty-seven percent of the respondents stated that the course duration was just right whilst twenty percent felt that the course was too short and another seven percent felt that the course was too long.

8. Question no. 8: Do You Expect to put in practice the techniques, skills and attitudes you acquired in the Course

		No. of Respondents	%
a.	Yes	10	67%
b.	Partly	3	20%
c.	No	1	7%

Ten of the respondents stated that they would utilize the techniques, skills and attitude acquired during the course, three of them felt that they would partly utilize while, one felt that he would not utilize the skills learned.

Appendix x: Exercises

Exercise 1: Can You Follow Directions

You are advised to work as rapidly as you can but read everything carefully before doing anything.

1. Write your first name in the right hand corner of this sheet
2. Write the name of the Minister for Health, in the Northern Bahal El Ghazal State
3. Multiply 2001 by 201. Work behind this sheet
4. Divide 16 by 160. Work behind this sheet
5. Draw six circles below the name of the Minister for Health
6. How many men are in this session?
7. Write the name of your immediate neighbour in class.
8. Shout your names loudly
9. Say loudly – "I have"
10. Stand up and take a deep bow
11. Who is the Secretary General for Northern Bahar El Ghazal State
12. Who succeeded Mandela as President of the Republic of South Africa
13. If you have reached this point, say loudly "I am the first person to reach this point, I am the leader in following instructions"
14. How many of us come from around Nyamalel?
15. Put x in each of the circles you drew in number 5 above
16. Now that you have read this far, do only sentence one
17. Do not give this test away by comment or otherwise
18. Why does communication breakdown occur?
19. What can be done to avoid communication breakdown?
20. What role do listening play in the communication process?

Results

Not a single participant was able to get the anticipated answer right or the correct position i.e. to answer only question. Meaning none of them was able to identify what was required. The verification is that the only mark on the sheet of paper would be their first names on the right side of the answer sheet. Any additional mark would be the indication that one never followed the instructions.

Observations participants and trainer

Practically all of them went though the paces doing as each sentence requested but not what the instructions implied. One observation is the degree of honesty doing the exercise as many people ordinarily discover the error and ignore the rest of the exercise which should be the right thing to do.
Of course after the answer was revealed it became quite clear to the participants through their comments that one needs to read and understand before replying to any communication oral or written. That instructions need to be simple and concise or clear.

It is notable in the exercise that the word “work as rapidly “prompts one to do like wise, behavioural wise.
It should be noted that one needs to be keen in following instructions and secondly to avoid information overload as in the exercise

Exercise 2: The chairs game

The participants are dived into three groups. Each group is given a specific task on where to take the chairs they are using in the classroom. The game can be played for five or so minutes and requires a big room for maximum effect.
In this case the participants were divided into three groups of five people each. Group one instructions were that they take all the chairs to the back of the class. Group two were to take all the chairs to the front of the class. The third group instructions were to take all the chairs outside the classroom
The lessons learnt from the game is that where there are conflicting interests nothing can get done.Secondry the so called conflicting interests can be turned into mutual interests beneficial to all and therefore working together would achieve their specific interests, needs and wants of working together while achieving their goals
The exercise was used during the effective leadership subject and also can be used with slight modifications in conflict resolution subjects to show how conflict goals can be transformed into super ordinate goals.

Results

The exercise attained 80% of the indeed impact bringing out different objectives that can exist in a community or organization. The different objectives can be harmonized into uniform objectives i.e. putting the chairs according to the specific instructions i.e. at the front of the class, at the back of the class and outside the classroom door. The chairs were carried meticulously to the targeted locations. One notable, though unintended outcome was the interpretation of the instruction “put the chairs in the back of the class” which in the exercise was interpreted to mean physically outside the classroom building and at the back of the building.

Observations participants and trainer

One of the team members in the team of “put all the chairs at the back of the classroom” actually took two chairs in the correct place in the back of the classroom. However he later joined the rest of his team in ferrying the chairs outside and in the back of the building. Second observation one would have expected one or two of the participants to challenge the status quo and therefore provide leadership into some agreed objective or seek further guidance. This is where the remaining 20% could have been attained. Hence the need to emphasize that people need to think outside the box in work or assignments they may be pursuing. This would also have been easily picked up because as the game went on it appeared that the groups were passing on chairs to each other in the following order, in front of the class to outside the classroom door and to the back of the classroom building.Ulitmately all the chairs ended in the back of the classroom building and two of the teams had no output to show.
The participant who had put the first chairs in correct position at the back of the classroom explained that he thought he was wrong and the others were right and hence

just joined the rest. The position is no group strategized on the way forward and no discussions were held despite being prompted to do so.
The participants observed they could have agreed mutually to share the chairs and therefore all of them attain the desired goal but did not.

Exercise 3: The string game

The game can be played s by a full class of participants with at least some of them playing an observers role. During the game each person is expected to hold on to their end of the string until the end of the game. Ten minutes are adequate to play the game and another ten for de briefing after the exercise.
The game requires only a thick string ball. The participants are expected to toss the 'ball' to the people they 'like' while still holding part of the string. The observers can further be divided into two groups, one to note and observe the behaviour of the ones who have already been identified and the ball tossed to them and the others to observe on the who group who are yet to be identified as 'friends'. Remember as the game progresses on there are fewer people who are to are to receive the ball and the choices become fewer and expectations of being the one to receive the next toss raises anxiety levels until the last person is incorporated.
The second part of the game begins with all the participants stretching their part of the string to make an observable visible pattern. Randomly the different ends of the string can be dropped to distort the pattern.

The **participants** share their feelings and observation during the game process. The observers give their feedback to the group. The participants make his comments for debriefing purposes
The exercise highlights issues of community participation and how different members of the communities can contribute. It also illustrates what happens different when different actors or players withdraw support the pattern or unity collapses.
The exercise was used during the class on community participation, but can also be used on leadership or team building courses.
Results
The results accruing from the exercise was that working together 'brings good things' as opposed to working alone for individuals as well as organizations. Secondly, individuals and organizations have a sense of belonging and need to identify and to be identified in pursuing societal or community goals. Finally when people stop pulling in the same direction (dropped end of the string) 'things' don't work well for anybody.
The fully stretched out string roll indicated ones, while parts of it were dropped it portrayed disunity and lack of team spirit. Participation and involvement is not desirable but can be also sought out as the participants who had not gotten a part of the string thought and felt.

Observations participants and trainer

The following are a summary of the observations made by the participants after the end of the game:

- I was happy to be first one to receive the string

- The network created by the string being held tightly on several ends created a good thing.
- It was nice to have the string being thrown to me.
- I felt nice to be identified.
- I was worried that nobody would involve me in the game.
- Loose string indicated lack of togetherness and individuals on their own
- I would have loved to be a part of the game (participant playing observation role)

Exercise 4 : Intergovernmental linkages group work

The participants were divided into three working groups and given the following for their discussions and presentations in the plenary. The questions are followed by the respective groups outputs and the lecturer's presentation on the topic of intergovernmental linkages which each one got a copy in addition to the training notes.

Questions for Discussion

1 What is government?
2 How is the government of southern Sudan structured?
3 What are the linkages between various levels of government?
4 What are the functions of government in various levels?

Participants output

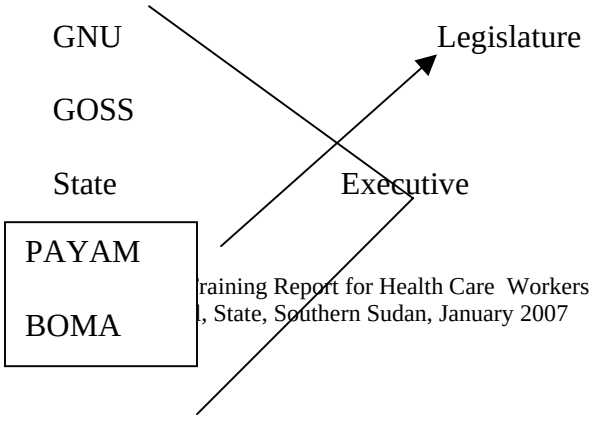
Group one
It is the organization responsible for the management of public affairs in a political unit (state, country, Payam, Boma etc.)
it derives its mandate or authority from the citizens.

Group two
Government is an organization that has power, laws, & authority to guard people

Group three
The government is a recognized system by the international set by the people govern them according to the constitution base on their environment

2: How is the government of Southern Sudan structured?

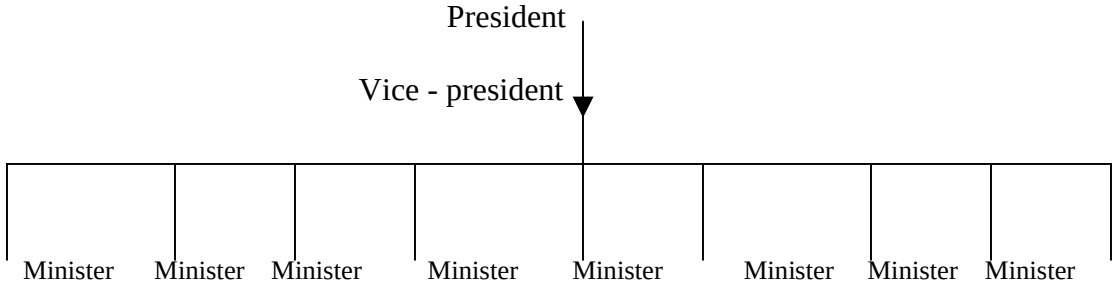
Group 1



Judiciary *checks and balances*

Group 2
- Goss
- States
- Counties
- Payams
- Bomas

Group 3



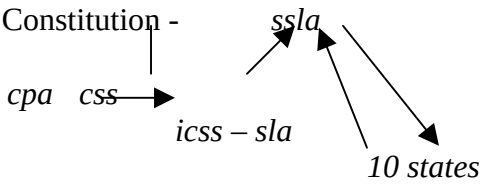
3: What are the linkages between various levels of government?

Group 1

Devolution	-	democracy
Power of GNU		separation of powers
Power of GOSS		transparency
Power of state		
Concurrent powers		
Decentralization	-	GNU
		GOSS
		State
		County

Group 2

- Services
- Development projects
- Constitution - *ssla*



Group 3
The various level of government are linked they share the following
1. The same resources

2. Constitution
3. One leadership
4. Plan together

4 What are the functions of government in various levels?

Group 1:
Security - *security* *police*

Development
Health
Water
Airport
International relations

Group 2:
- Planning
- Organizing
- Staffing
- Leading
- Policy making
- Solve conflict
- coordination
- capacity building
- international relations

Group 3:

1. Maintain law and order
2. Manages resources
3. Link the nation to other nations/ international organization
4. Development
5. Defends

Results

The participants work output is captured verbatim as it was presented in the plenary above. The presenter gave an additional handout to supplement what was available in the notes and is appended below their output.

Observations

The participants need additional training on the organization and structure of government. This should also be seen in the context of understanding the various governance instruments formulated within the advent of the CPA and resulting in various State constitutions. The sharing of powers between the various levels is not clear to some and even the relationship between Goss's Ministry of Health and SMoH is vague.

Lecture Notes
Inter government linkages
Introduction
Governments mandate to execute is derived the law and the legitimacy bestowed on it by the populace ie both constitutional and statutory.
Thus the government is a creation of the constitution. The business of government therefore must be transacted within the framework of the constitution.
The government employees are bound by law just as it binds individuals and corporate entities.
Adherence to the rule of law and to the ethos of the Civil Service is the cardinal principle that public servants vigorously guard and observe

The aim of government

The major aim of government is to provide a sense of direction in public affairs, and to guide the management of such public affairs through formulation of public policies.
The broad functions of government are two fold Security and development.

Characteristics of Public administration

Is co-operative group effort in a public setting
Covers all three branches – executive, legislative and judicial and their interrelationships.
Has an important role in the formulation of public policy and is thus a part of the political process
Is different in significant ways from private administration
Is closely associated with numerous private groups and individuals in providing services to the community

Ministerial responsibilities

Ministries are responsible for planning and implementing their own programmes. More specifically they are responsible for:
Identification of problems which require action;
Identification of ways of addressing these problems
Formulation of financial plans; and
Coordination of ministerial activities

Devolution of Powers

The following principles shall guide the devolution and exercise of powers:
Affirmation of the need for norms and standards of governance and management at the state and local government levels that reflect the unity of Southern Sudan while recognizing the diversity of its people.
Acknowledgement of the role of the GOSS and the states in the promotion of the welfare of the people and protection of their human rights and fundamental freedoms
Recognition of the need for the involvement and participation of all people of Southern Sudan at all levels of governments as an expression of unity, and

Devolution of Powers

Pursuit of good governance through:
Democracy
Separation of powers
Transparency
Accountability and respect for the rule of law to enhance peace, socio-economic development and political stability.

The GOSS Shall:

Exercise its competences in accordance with the Comprehensive Peace Agreement (CPA) and Interim National Constitution
Respect the powers devolved to the states and local government

Intergovernmental Linkages

In the administration of the decentralized system of governance in Southern Sudan, the following principles of inter-governmental linkages shall be observed:
The linkage between the NG and the states in Southern Sudan shall be through the GOSS and the local government shall be through the government of the relevant state
In their relationships with each other or with other government organs, all levels of government, particularly Southern Sudan and state governments, shall observe the following:
Respect each others powers and competences and collaborate in the taste of governing and assist each other in fulfilling their respective constitutional obligations

Intergovernmental Linkages

Government organs at all levels in Southern Sudan shall perform their functions and exercise their powers so as:
Not to encroach on or assume powers or functions conferred upon any other level except as provided for by this constitution.
To promote co-operation by rendering assistance and support to other levels of government
To promote open communication and co-ordination between all levels of government
To adhere to procedures of inter-governmental interaction and comity
To respect the status and institutions of other levels of government
To promote amicable settlement of disputes before attempting litigation
Any two or more states in Southern Sudan may agree on mechanisms or arrangements to enhance inter-state co-ordination and co-operation

Appendix ix: Focus Group Discussions

Two different focus group discussions were held during the needs assessment. One of the sessions involved SMoH, Director General, SMoH Director for Finance and Administration, Officer responsible for Epidemiology in the state and the Office Manager In attendance during the discussions were the IRC's Aweil Field Manager, PHCC Coordinator and one of the County Medical Officer of Health.

In the second key focus group discussions were held between the consultant and the Director of the ACH, one of the medical officers of Health, three of the hospital overseers and one clerical cum records officer. IRC was represented by the IRC Aweil Field manager.
These discussions were largely structured in the line of the NA questions and the included the following questions and a summary of the responses:

What is your assessment on the level of management skills in your organization?

- Our management skills are the infancy level
- We are just beginning to learn.
- We are having skilled people management and professional areas
- There is a heavy workload

Describe the leadership roles and skills in your organization?

- Some people do not know where to report
- The reporting relationship is not clear or is ignored by County Medical officers
- The is no direction in many of the activities
- Some people are overburdened

How do you determine the direction of your organization?

- The is no referral system anymore
- There are no treatment guidelines
- Disease prevention activities are not there
- It is not clear what role Goss should play in SMoH

How would you rate the overall communication process in your organization?

- There are no meetings
- No clear communication
- Information is personalized
- Poor records management
- Poor management of medical reports
- Reporting system not clear

What is your understanding of the linkages between various level of government and their functions?

- Only sure of the CPA
- Different levels
- It is not clear what Goss and SMoH should do in terms of health
- Too many constutions for one to understand
- Why should the state constitution be approved by GOSS
- It has to do with peace and security

Picture 2: Group photograph - Management Training Course for Health Workers for Nothern Bahr Ghazal Workers 19 – 21 December, 2006

<u>Annex 5</u> Details of KAP Survey

Focus Group Discussion Overview

A qualitative health assessment was conducted in the final quarter of the 'local solutions' program. It consisted of focus group discussion at each of the health facilities in Aweil East County. A qualitative approach was decided over a quantitative approach for two main reasons: change in operational area with a decrease in facilities/sites and logistical constraints.

The information collected in the baseline survey at the beginning of the project was quantitative data and covered a much larger operation area than present at the end of the project. As quantitative surveys take an extensive investment of time, personnel and logistics, and given that the result would have covered a different operations area allowing for limited comparative analysis, a qualitative focus group discussions was conducted to re-assess this new, reduced operational area. Qualitative data collection is the first step in guiding future quantitative data assessments and will help focus efforts for an up-coming baseline survey planned in early 2007. As a result qualitative and quantitative data sets cannot be directly compared. The focus group discussions covered the basic health concerns of developing countries in Africa: HIV/AIDs, malaria, and water/sanitation and access to health facilities.

There were a total of ten focus group discussions; each group consisted of approximately 15 individuals. Criteria for inclusion in the focus group discussion were based on individuals visiting the clinic on the interview date; and a willingness to participate in the discussion. The facilitators for the focus group discussions were health officers that supervise the health activities in that particular area.

Demographics

Total Number of Participants	143
Female Participants	64% (91)
Male Participants	36% (52)

Age	
Percentage Who Knew Their Age	19% (28)
Age Range	14-57 years

Marital Status	
Married	96% (137)
Single	3% (4)
Widowed	0.5% (1)
Divorced	0.5% (1)

Ethnicity	
Dinka	99.5% (142)
Rizigi	0.5% (1)

Religion	
Christian	53% (77)
No Religion	44.5% (63)
Muslim	1.5% (3)

Education Level	
Never Attended School	84% (120)
Primary School Incomplete	14% (19)

Primary School Complete	1.5% (3)
Secondary School Complete	0.5% (1)

Occupation	
Farmer	81% (114)
Trader/Business	2% (4)
Soldier	1% (2)
Other	16% (23)

Residential Status	
Never Displaced	60% (86)
Returnees	39% (55)
Internal Displacement	1% (2)

Water, Sanitation and Household Amenities

Main Source of Drinking Water	
Open Well, Public	34% (48)
Cover Well/Borehole, Public	1% (2)
Pond/Lake	13.5 (19)
River/Stream	13.5% (19)
Spring	6% (9)
Cover Well/Borehole, Private	1% (2)

Time Spent Fetching Water	
<5 minutes	17% (24)
5-30 minutes	48% (69)
30-60 minutes	20% (29)
60-120 minutes	9% (12)
>120 minutes	6% (9)

Storage of Drinking Water	
Container (Bucket, Jerry Car and Jerkin)	86% (123)
Other	14% (20)

Do you have a specific place in you home for hand washing?	
Yes	44% (64)
No	56% (79)

When Do you wash your hands?	
Never	54% (77)
Before food preparation	21% (30)
After defecation	0.5% (1)
Other	24.5% (35)

What kin of toilet facility do you use?	
Pit latrine	7% (10)
No facility (field/bush)	93% (133)
Does you household have a radio?	
Yes	34% (48)
No	66% (95)

If you have a radio, how often do you listen to it?	
Daily	71% (34)
Never	29% (14)

Malaria

Does your household have a mosquito-net?	
Yes	81% (116)
No	19% (27)

HIV/AIDS

Have you ever heard of HIV/AIDS?	
Yes	56.5% (81)
No	43.5% (62)

Do you know anyone with HIV/AIDS?	
Yes	0.5% (1)
No	99.5% (142)

Is there anything a person can do to prevent getting HIV/AIDS?	
Yes	10.5% (18)
No	7% (10)
Don't Know	82.5% (118)

Can a person get HIV/AIDS from a mosquito or other insect bite?	
Yes	8% (12)
No	5% (7)
Don't Know	87% (124)

Can a person get HIV/AIDS from sharing food?	
Yes	3.5% (5)
No	5% (7)
Don't Know	91.5% (131)

Is it possible for a healthy looking person to have HIV/AIDS?	
Yes	0.5% (1)
No	5.5% (8)
Don't Know	94% (134)

Can HIV/AIDS be transmitted from a mother to a child?	
Yes	5% (7)
No	1.5% (3)
Don't Know	93.5% (133)

If a member of your household got infected with HIV, would you want it to remain a secret?	
Yes	0% (0)
No	8% (11)

Don't Know	92% (132)

If a member of you family got infected with HIV, would you be willing to take care of them in your own house?	
Yes	1.5% (3)
No	5.5% (8)
Don't Know	93% (132)

Would you be willing to get a HIV test if it were available?	
Yes	8% (11)
No	1% (2)
Don't Know	91% (130)

Health Services

How long does it take for you to get to the nearest clinic	
<30 minute walk	25% (36)
30-60 minute walk	46% (66)
>60 minute walk	29% (41)