Annual Review - Summary Sheet

This Summary Sheet captures the headlines on programme performance, agreed actions and learning over the course of the review period. It should be attached to all subsequent reviews to build a complete picture of actions and learning throughout the life of the programme.

Title: Integrated Community Case Management (ICCM) South Sudan		
Programme Value: £31m		**Review Date: 29 March 2015**
Programme Code: 202841	**Start Date: 01/04/2013**	**End Date: 31/03/2016**

Summary of Programme Performance

Year	**2013/14**	**2014/15**	**2015/16**					
Programme Score	**B**	**A**						
Risk Rating	**High**	**High**						

Summary of progress and lessons learnt since last review

Years of conflict causing destruction of settlements and infrastructure, as well as the displacement of millions of people, have made South Sudan one of the most underdeveloped countries in the world. With high demand and limited access to the few remaining health facilities, community initiatives have played a key in role bridging the healthcare gap and making services directly available to people at the community level.

The DFID Integrated Case Management Programme (ICCM) was initiated in April 2013 to complement the Global Fund home management of malaria for children under 5 years of age, by allowing treatment of additional childhood illnesses including pneumonia, diarrhoea and severe acute malnutrition by community based distributors at the household level. This is the 2nd year Annual Review (AR) of the three-year programme, which is currently being implemented in 26 counties in 9 of the 10 states of South Sudan.

Year one of implementation was fairly stable until fighting broke out in Juba in December 2013 spreading quickly to the rest of the country. Throughout year two the security situation continued to be unstable. All quarterly reports for these periods document incidences of migration of people including Community Based Distributors (CBDs) and restrictions of movements due to insecurity. Furthermore, flooding in the July-September 2014 period hampered prompt delivery of drugs, supportive supervision activities, and timely collection of reports.

Because of the multitude of challenges experienced in the first year of implementation, and as recommended by the first annual review in April 2014, the programme's Log Frame (LF) was revised in October 2014. A new output and a few output indicators were added, some output indicators revised and targets at the outcome level adjusted.

Despite a difficult operating environment, the programme was able to expand geographically as well as scale up the nutrition component in Year 2. There has been considerable progress against all three outputs of the programme from Year 1, catching up well on some key results that lagged behind significantly. The outcomes achieved to date show that the programme is on track to achieve the results expected at the end of the programme. The programme needs to make better efforts to improve monitoring as well as internal coordination, sharing and learning.

A. Introduction and Context

DevTracker Link to Business Case:	http://devtracker.dfid.gov.uk/projects/GB-1-202841/documents/
DevTracker Link to Log frame:	http://devtracker.dfid.gov.uk/projects/GB-1-202841/documents/

Outline of the programme

After years of conflict, South Sudan gained independence in July 2011. As the world's newest nation, it is also one of the poorest, with just over half (51%) of its population of 8.3 million living below the national poverty line[1]. Because of the high levels of poverty and the long history of conflict and violence, the health needs of the population are vast and cannot be met by the basic and fragile health system. For example, of the 1,147 functional Health Facilities in the country; 23.3% (347) require minor renovation, 18.4% (274) need major renovation and 32.9% (490) need to be rebuilt[2]. Exacerbated by the destruction of health facilities during the conflict and the severe shortages of qualified health care workers in the country, utilisation rates of health care are extremely low (estimated at 0.2 contacts with health service persons per year)[1].

Because of the high number of unreported deaths, accurate mortality data for the country is difficult to find. However, according to the South Sudan Countdown Report, approximately 40,000 children under five years of age die every year. 18% of these deaths are due to pneumonia, 6% to malaria, and 11% to diarrhoea. Additionally malnutrition is the underlying cause of approximately half of these deaths[3]. It is in response to this reality that the ICCM programme was established. In a country where only 44% of the population live within 5km radius from a functional health facility and where availability of health care providers and medication is limited, the integrated case management of the top three illnesses at the community level is *critical* to saving lives[4].

The ICCM Programme is a three-year, £31m, DFID funded programme currently completing its second year of implementation. Population Services International (PSI) is the principal recipient (PR) of the fund; the International Rescue Committee (IRC) is the technical lead; Malaria Consortium (MC), Save the Children International (STC) and BRAC, the sub-recipients (SRs), make up the consortium of partners running programme implementation in 26 counties in 9 of the 10 states of South Sudan.

With leadership from the Ministry of Health (MoH), the aim of the ICCM programme is to reduce deaths of children under 5 years of age by providing access to health care at the community level through a cadre of community based distributors (CBDs). These CBDs work as volunteers and are trained to provide treatment of malaria, diarrhoea, pneumonia and severe acute malnutrition, and receive supervision support and medical supplies from supervisors. Procurement and supply chain management functions parallel to the national system with a Programme Management Unit (PMU) in PSI centrally managing operations, but executed in terms of delivery of programme commodities to the field offices by individual SRs.

Through cost sharing and mutual collaboration efforts the ICCM programme is designed to complement the Home Management of Malaria (HMM) programme, funded by the Global Fund. Because HMM has the restricted mandate of tackling malaria, DFID funding allows the HMM programme to be expanded so that community based distributors are also trained to treat pneumonia, diarrhoea and severe acute malnutrition for children under five years of age. Furthermore, ICCM also complements the DFID supported Health Pool Fund, established to support the South Sudan Health Sector Development Plan (2012-2016) in strengthening primary health care at facility level.

At the start of the programme the security situation in South Sudan was fairly stable; however after 9 months of implementation fighting erupted in Juba in mid-December 2013. From Juba the fighting

[1] ICCM Business Case, February 2013
[2] The Basic Package of Health and Nutrition Services in Primary Health Care, 2011 MOH

[3] South Sudan 2014 Countdown Report data reported from 2012
[4] Health Facility Mapping, Ministry of Health, Republic of South Sudan 2011

subsequently spread to Central Equatoria, Jonglei, Unity, and Upper Nile States, all areas where the programme was being implemented. Because of the fighting, programme areas witnessed migration of people, repatriation of staff and closure of offices, which caused disruption in implementation. From April 2014 to December 2014, the security situation continued to be unstable. All quarterly reports for this period document incidences of migration of people (including community based distributors) and restrictions of movements due to insecurity. Furthermore, flooding in the July-September 2014 period restricted prompt delivery of drugs, supportive supervision activities and timely collection of reports.

In February 2014, in response to the conflict, a 6 month interim strategy was developed in line with DFID's request for one. The strategy proposed continuing support of previous ICCM activities in areas unaffected by the conflict, whilst establishing linkages with humanitarian and relief partners to provide training and commodities to support ICCM activities in eight States namely Jonglei, Warrap, Unity, Upper Nile, Lakes, Eastern Equatoria, Western Equatoria and Central Equatoria. The strategy was approved by DFID in March 2014.

The intended impact of the programme is a reduction in morbidity and mortality of children under five year from malaria, pneumonia, diarrhoea and severe acute malnutrition in selected intervention areas. The expected three-year results of the programme are:

- 2.1 million children treated for malaria with ACTs (Artemisin Combination Therapy)
- 600,000 children treated for pneumonia with antibiotics (Amoxicillin)
- 700,000 children treated for diarrhoea with Oral Rehydration Solution (ORS) and Zinc
- 12,000 children treated for Severe Acute Malnutrition (SAM)

B: PERFORMANCE AND CONCLUSIONS

Annual outcome assessment

The intended outcomes of the ICCM programme are to increase appropriate case management of malaria, diarrhoea, pneumonia and SAM among children under five years.

The achievement of outcomes has been compared and analysed in two ways:

1. End of Year 2 cumulative achievement against the end of Year 2 cumulative targets, and
2. End of Year 2 cumulative achievement against end of the programme (i.e. Year 3) targets

A simple traffic light method is used to visually inform the reader on the degree of achievement of result (red – has not met expectation substantially, yellow – has not met expectations moderately and green - has met or exceeded expectation).

1. Expectation to reach end of Year 2 cumulative programme targets

The table below describes cumulative targets to be achieved by the end of the second year of implementation (March 2015) alongside cumulative achievements by the end of December 2014, i.e. three months short of two years of programme implementation. It must be emphasised that achievement figures *do not* provide a complete picture of Year 2 cumulative results. The data from the last quarter (January-March 2015) of implementation were not available due to: 1) early commencement of the Year 2 Annual Review process and 2) delays in reporting. To factor this limitation, a proportional approach has been taken to make the comparison. By breaking the Year 2 (ending March 2015) target into 8 quarters, it is assumed that the target for the end of December 2014 (7 quarters) would be 87.5% of Year 2 target. It is very possible however that overall achievement could turn out to be higher or lower based on results coming in for the final quarter in Year 2. This occurrence is very likely in a country so volatile to unpredictable conditions such as conflict, insecurity and natural disaster.

Indicator	Target End of Year 2 (Cumulative, April 2013-March 2015)	Achievement (Cumulative, April 2013-**Dec 2014**)	Percentage Achieved
Outcome Indicator (OC1):	1,391,054	1,410,222	101%

Number of children under five with fever receiving ACT (Artemisin Combination Therapy) treatment, through ICCM, according to National guidelines			
Outcome Indicator (OC 2): Number of children under five with symptoms of pneumonia receiving antibiotic treatment, through ICCM, according to National guidelines	363,597	353,486	97%
Outcome Indicator (OC 3): Number of children under five with diarrhoea receiving (Oral rehydration Salt) ORS + zinc through ICCM according to National guidelines	484,604	465,548	96%
Outcome Indicator (OC 4): Number of children under with SAM receiving treatment through ICCM, according to Integrated Management of Acute Malnutrition (IMAM) guidelines	8,714	14,447	166%

From the percentage achievements given in the table, above we can see that all outcome indicators have already or are well on track to meet the Year 2 targets. This is a significant progress since the first Annual Review, when the programme lagged behind substantially in all outcome indicators. However, this progress has to be noted with a caveat that all targets (for Year 2 and Year 3) have been revised downwards significantly following the first annual review in order to adjust to the new realities (more difficult, insecure and uncertain circumstances) since the conflict that broke out in December 2013.

2. Expectations to reach end of programme targets

When considering whether the outcome indicators are on track to achieve the end of programme targets, it is clear from looking at the table below that all four outcome indicators are well on track to meet their March 2016 target.

These projections are based on the same rationale mentioned earlier. In a 12 Quarter programme (equivalent to three years) it is assumed that in 7 quarters of implementation, 58% of achievements should have been met by the end of quarter seven. All indicators are therefore on track.

Indicator	Cumulative Target (April 2013-March 2016)	Cumulative Achievement (April 2013-**Dec 2014**)	Percentage Achieved
Outcome Indicator (OC1): Number of children under five with fever receiving ACT treatment, through ICCM, according to National guidelines	2,100,334	1,410,222	67%
Outcome Indicator (OC 2): Number of children under five with symptoms of pneumonia receiving antibiotic treatment, through ICCM, according to National guidelines	605,958	353,486	58%
Outcome Indicator (OC 3): Number of children under five with diarrhoea receiving ORS + zinc through ICCM according to National guidelines	719,289	465,548	65%
Outcome Indicator (OC 4): Number of children under with SAM receiving treatment through ICCM, according to IMAM guidelines	12,796	14,447	113%

The only outcome indicator which has already surpassed the end of programme targets is OC 4. Increased expansion of programme coverage, sensitization meetings and an increase in numbers of Out-patient Therapeutic Programme (OTP) sites able to treat malnutrition cases, have impacted positively on the number of SAM cases receiving treatment. However, it may have been difficult to set

targets based on Year 1 achievements as the nutrition component of the programme began implementation roll-out in a staggered approach. Therefore, it may have made it difficult to set cumulative programme targets based on sporadic achievements in year 1.

Overall output score and description

Overall Output Score is **A**, calculated using the ARIES project score calculator using individual output scores and weightages. This is a highly significant progress from the first annual review, which was scored at B, particularly given that, though five new indicators were added, targets of the already existing output indicators were not reduced following the first annual review.

Output 1: Increase access to appropriate case management
Score: A; Weightage: 40%
Four out of 6 indicators meeting and exceeding expected results, one falling short and one not judged owing to the lack of target

Output 2: Improved quality of service provision by community based distributors (CBDs) & community nutrition workers (CNWs)
Score: B; Weightage: 40%
Five out of 7 indicators meeting or exceeding expected results, two falling significantly short

Output 3: Increased demand for utilization of severe acute malnutrition (SAM) services
Score: A+; Weightage: 20%
New output indicator added and already achieving expected results

Key lessons

Increased country ownership
Due to the emergency situation and poor infrastructure of the country, Year 1 of the programme focused heavily on making sure that services were being accessed by those most in need. As the programme regains momentum and continues learning from implementation it is important for sustainability that support and coordination is maintained with the National MoH, State, and County government structures.

Since the first year of implementation the programme has worked hard at improving national linkages with the Government of the Republic of South Sudan, working hand in hand with the National Ministry of Health (MoH) on a number of strategic documents. Throughout this collaboration the National ICCM training manual (including job aids, trainers guide and participants guide) was developed and recently launched in collaboration with the MoH Primary Health Care Directorate. The ICCM programme also contributed to the drafting of the ICCM Implementation Strategy document for South Sudan, which is led by the MoH. Furthermore the Global Fund Concept Note for Malaria has been presented in Geneva to request for follow-on malaria funding from the Global Fund. All Sub Recipients (SR) have been recommended by the Malaria TWG to continue as implementing partners and therefore cost sharing with DFID will continue.

Evidence of collaboration and partnership is evident in Year 2 of the programme. However more can be done in Year 3 to strengthen the national system and create ownership of the programme from the National MoH down to the county health department. Support in coordination, monitoring & evaluation (M& E) and supply chain management could be provided to gradually build in elements critical for incremental government leadership and programme sustainability.

Improved ICCM consortium coordination
As the ICCM programme is implemented by five different SRs, the programme faces differences in implementation approaches, which have at times challenged smooth running of activities. For example Malaria Consortium faced challenges with the drop out of many supervisors because IRC, also working in the same state, was paying supervisors a higher incentive than what MC was paying. This caused challenges for the overall programme cohesion and impacted negatively on programme achievements.

Another noted difference is in the cooperation and involvement of the County Health Department (CHD) and State MoH. During field visit observations, it was noted that there is no clear standardised operating

procedures or best practices applied across the board for all ICCM SRs in respect to report sharing and involvement of CHDs in ICCM implementation. As there is currently no specific governmental position assigned to oversee community health activities in the state and county level, this responsibility falls on an already overburdened Public Health Officer. This could be another lost opportunity to work and strengthen the national system.

Networking and creating linkages
During meetings at the National MoH it was discovered that a new strategy for community work, the "Boma Health Initiative', was being discussed for the country. Unfortunately the ICCM team were not involved in the drafting of this strategy so they were not able to provide technical insight. The discussion and development of this initiative is something that DFID will need to monitor more closely as it may challenge implementation and direction of the programme in the future.

A meeting with the HPF brought to attention possible linkages which could be created at community level. Currently HPF role at the CHD level to support the setting up of Village Health Committees could be used as an advantage to strengthen the CHD capacity on ICCM issues.

Procurement and Supplies Management
In terms of programme success it is essential that the procurement and distribution of goods is done in an efficient and timely manner. Procurement and supply chain management is fundamental to the life of the project and more needs to be done to minimise delays especially from the central level to the field. Specifically in the rainy season, when stock-outs are experienced in the main warehouse, these delays are multiplied by the time stocks reach CBDs.

Instability
The effect of conflict has substantially disrupted ICCM activities by delaying and obstructing re-stocking, trainings, reporting, monitoring and supervision visits. This instability has impacted greatly on programme activities and outcome and output achievements. In areas worst affected by the conflict, CBD and supervisor have been displaced or have left the programme. Some sites have become unreachable due to the threat of violence making it difficult for CBDs to be re-stocked and continue providing treatment to those in need.

Similarly to threat of violence, flooding has also posed instability in programme implementation. Specifically in the July-September period floods have disrupted access and restocking of supplies for CBDs.

As an interim strategy, after the December 2013 conflict, programme priorities were adapted to support immediate needs of internally displaced population. This was done, by supporting other humanitarian and relief partners expand ICCM services whilst continuing support in areas unaffected by the conflict. Overall however, outcome level targets were revised downwards to reflect above-mentioned challenges and disruptions encountered in the later part of the first and initial months of the second year of implementation.

Recommendations
- DFID to consider the implications of the Boma Health Initiative and what this will mean to the ICCM programme - (Responsibility: DFID Health Adviser, by May 2015)
- Explore further linkages and support, which ICCM could have with the Health Pooled Fund. (Responsibility: IRC by May 2015, with support from DFID Health Adviser)
- Revise targets on number of children under 5 with SAM receiving treatment through ICCM, taking into account past trends and plans for future Outpatient Therapeutic Programme (OTP) site expansion plans (Responsibility: PSI by April 2015)
- Disaggregate information on children receiving SAM treatment by new and returning cases to help identify if other measures and linkages to food security need to be explored. (Responsibility: PSI to start the discussion with partners in April 2015)

Has the log frame been updated since the last review?
The log frame (LF) has been revised in response to recommendations made in the previous AR and was approved by DFID in October 2014. Some targets were revised and indicators added. Furthermore risk

and impact weight percentage have been revised for all three outputs to accommodate the inclusion of a new output indicator.

Targets for outcome level indicators were revised to take into consideration implementation challenges received straight after the December 2013 violence as well as making use of actual programme achievements to create more accurate and realistic targets for the programme. In the revised LF a whole new output was added: Output 3 – "Increased demand for utilisation of SAM services". Furthermore, in terms of indicators, 5 new output indicators were added to the revised LF. Four indicators were added to reflect momentum build in the nutritional component of the programme, which was delayed in start-up in Year 1. Furthermore two other indicators were added to monitor quality: "support through supervision" and "completeness and timeliness of reporting".

Summary of changes made were as follows:

- Output 1 new indicator:
  - Number of children U5 screened for acute malnutrition (AM) using mid upper arm circumference (MUAC) / bilateral pitting oedema[5]
  - New impact weight: 40%
- Output 2 new indicators:
  - Percentage of CBDs supervised at least once per quarter
  - Proportion of CBDs providing complete and timely reports
  - Percentage of trained CNWs passing core competence tests
  - New impact weight: 40%
- NEW Output 3: Increase demand and utilisation of services
  - New indicator: Percentage of CNW/Vs conducting sensitization sessions on AM screening and treatment
  - Impact weight: 20%
  - Risk rate: High

- Outcome indicators:
  - Year 2 and Year 3 targets reduced for all outcome indicators

There are areas in the logframe as well as its use that need to be addressed to improve monitoring:

- The M&E team of ICCM programme has received some feedback regarding the logframe and advice from DFID to remove baseline results (from projects prior to DFID funding) from overall achievements, however more has to be done to simplify the data reporting.

- The selection of indicators chosen is fairly simplistic and does not accommodate for a wide enough scope of measurement in monitoring programme progress. For example Output 1 indicators, which weigh 40% of the project, mostly monitor access of supplies at the community level. There are no indicators however that review supply chain management or indicators that reflect on the impact of stock-outs in relation to the magnitude of service provision being lost. E.g. Percentage of clients needing malaria, pneumonia, diarrhoea or severe acute malnutrition treatment who were sent away without medication due to drugs supply stock-outs by CBDs/CNWs.

- Indicator language needs to be uniform across all programme documents. For example, the LF Outcome indicator 1 reads Number of children under five with fever receiving ACT treatment through ICCM according to National guidelines. The same indicator in the quarterly report reads Number fever episodes treated with first line antimalarial medicine at community level. Output and Outcome indicators should also be clearly demarcated and numbered in the quarterly report.

- All current quarterly reports do not have standalone results for the quarter but instead have cumulated results from the start of the programme. To allow for trends to be made evident, quarterly achievements should firstly be reported as standalone results for that

[5] Acute malnutrition is diagnosed and graded by measuring MUAC of a child and checking specific kind of swelling (oedema) in the leg

quarter, alongside annual achievements. Another column to reflect against cumulative programme targets should then be added.

- Indicator definitions need to be more detailed. For example: Number of stock-out events of Amoxicillin for more than 1 week during the quarter. The indicator definition should also explain by whom the stock out is being experienced and at what level.

Recommendations

- It may not be possible in the third and the final year of implementation to make major amendments to the log frame. However adjustment of targets and addition of a few more output indicators, as discussed above as well as in relevant output sections, needs to be considered.

- Develop an M&E Plan which describes the Log frame, programme indicators with definitions, impact weight rational, programme monitoring tools, methodology of data collection, flow of information and reporting, implementers roles and responsibilities, data quality assurance methods, and data management system. (Responsible: PSI by May 2015, with support from DFID Statistics and Health Advisers)

- Quarterly report format to report on both quarterly and cumulative achievements for the programme (Responsible: PSI from Year 2's Quarter 4 report)

Summary of all recommendations given in this report, grouped by responsible agency, is given in **Annex A**.

C: DETAILED OUTPUT SCORING

Output Title	*Increased access to appropriate case management*		
Output number per LF	1	**Output Score**	***A***
Risk:	*High*	Impact weighting (%):	40%
Risk revised since last AR?	*Yes*	Impact weighting % revised since last AR?	*Yes*

One of the most vital preconditions to programme implementation and success falls upon the continuous availability of drugs and commodities at household and community level.

Interpretation of the stock-out (out of stock) indicators

To better understand indicator on percentages of stock-out event, one has to comprehend that the definition for stock-out of supplies is the unavailability (stock-out) of a particular drug by CBD over a period of more than one week. For the case of stock-out of Plumpy Nuts, the timeframe has been extended to two weeks. To help with the interpretation, when looking at OP1 for example, the target suggests an acceptability of under 15% of stock-out events over the course of the year. The programme managed to achieve a 6% stock-out in the April-December 2014 timeframe. This means a 94% success in maintaining desired stock levels instead of 85% success (acceptable low), i.e. having reached 110% of the target.

Indicators	Target (April 2014-March 2015)	Achievement (April 2014-Dec 2014)	% Achieved against targets
Output Indicator (OP 1.1) Percentage of stock-out events of ACTs for children under the age of five, for more than a week during the reporting quarter	15%	6%	110%
Output Indicator (OP 1.2) Percentage of stock-out events of Amoxicillin for children under the age of five, for more than a week during the reporting quarter	20%	13%	108%
Output Indicator (OP 1.3) Percentage of stock-out events of ORS for children under the age of five, for more than a week during the reporting quarter	20%	6%	118%
Output Indicator (OP 1.4) Percentage of stock-out events of Zinc for children under the age of five, for more than a week during the reporting quarter	20%	7%	117%
Output Indicator (OP 1.5) Percentage of stock-out events of treatment (plumpy nuts) for malnutrition in OTPs for children under the age of five, for more than two weeks during the reporting quarter	20%	36%	81%
Output Indicator (OP 1.6) Number of children U5 screened for acute malnutrition (AM) using Mid Upper Arm Circumference (MUAC)/bilateral pitting oedema	TBD by end of March 2015	203,492	

Key Points

- Similar to the previous year of implementation the project met and exceeded the targets ensuring access to ACT, Amoxicillin, ORS and Zinc commodities in remote and hard to reach areas. Targets were exceeded for 4 out of the 6 indicators. The reasons why the output has not been scored higher than an A, are mainly three:
  1) Q6 (July-Sept 2014) and Q7 (Oct-Dec 2014) were exceptionally challenged with heavy rains, and in some cases the reporting of insecurity in Rumbek East, Rumbek Centre and Cuibet, made it difficult for SRs at times to replenish ACT, ORS and Zinc.
  2) In the case of Amoxicillin the main warehouse experienced stock-out of the drug in all three quarters (April-June, July-Sep, Oct-Dec 2014). In Q6 for example the main warehouse experienced stock outs in July 2014 and was only restocked by October 2014. Furthermore, anecdotal accounts from field visits indicate that Q8 has also experienced the same problem.
  3) The stock-outs for Plumpy Nuts[6] are much higher than the targets, so the achievement falls substantially short of the target for OP 1.5 indicator. For the second year running there is a caveat arising mainly due to problem with delays in receiving supplies of Plumpy Nuts from UNICEF. In both Quarter 5 and 7, SRs implementing treatment for SAM experienced delays in receiving supplies.

- For OP 1.6, the results for this indicator began to be collected in Q6 only. As PSI only began initiating the nutrition component in December 2014, and as Save the Children did not submit reports on this indicator for Q7, the programme has found it difficult to propose realistic targets.

[6] Plumpy Nuts is a packaged and precooked therapeutic food used to treat cases of SAM. The ICCM partners have separate arrangements with UNICEF to provide Plumpy Nuts. UNICEF, through their own resources, supplies almost all Plumpy Nuts in the country for partners implementing SAM treatment. The cost of the commodities is hence not budgeted under the programme.

- Storage - Seasonal variation in access to supplies is still a major challenge for many SRs especially before the rains and during the flooding. In the case of Plumpy Nuts distribution, where a larger amount of supplies is needed, there have been reports of lack of appropriate storage facilities closer to the communities.

- Differences among partners in storage and distribution of commodities - The first annual review mentions best practices in strengthening the national pharmaceutical distribution and monitoring system. During this annual review's field visit, however, different storage and distribution practices were noted varying greatly from SR to SR. It was noted that while some SRs may be strengthening the national system not all are applying this practice and may be exclusively adopting a parallel system

- Forecasting and buffering - The same amount of drugs are being procured in the wet and in the dry seasons. Anecdotal accounts of seasonal variation in caseload has been reported which currently is not being factored into the forecasting equation. For example if malaria is highest during the rainy season and CBDs experience delays in re-stocking, it may mean that a lot more children will be left without treatment.

- Procurement of drugs and commodities is done by PMU only. Delays in distribution of drugs starts with stock-out experienced at the main warehouse. As SRs are then responsible for their own transportation this may also cause further delays in moving commodities out, sometimes at a time when the rains have already started. Stock-out of commodities from the main warehouse can cause a standstill in programme implementation.

- Procurement of Plumpy Nuts is currently managed by UNICEF, which involves a separate procurement system than ACT, Amoxicillin, ORS and Zinc commodities. When UNICEF has delays then the whole programme suffers.

Summary of responses to issues raised in previous annual reviews (where relevant)

Action items raised in last Annual Review:

1. Ensure the supply of Amoxicillin is delivered down to counties as soon as possible.
    - This year saw an improvement; however shortages are still being experienced.

2. PSI to strengthen procurement mechanisms, learning from the first years' experience, to ensure that increased needs are managed quickly and efficiently to avoid any gaps in services. This means working out quantities needed and preparing a procurement plan and budget and moving ahead with the procurement and distribution of the additional supplies (if needed, using fast track mechanisms) while putting in place strategies to mitigate the loss of drugs and commodities.
    - PSI (PMU) is applying long term framework agreements (LTFA) to ensure needs are managed quickly and efficiently, eliminating gaps. The support department is also working to anticipate procurement needs based on the programme log frames and marketing plans to ensure that suppliers are identified ahead of time. For commodities and drugs, the warehousing and Logistics departments are tracking consumption and providing the departments with information on actual consumption data that is used to manage the procurement process.

Recommendations

- Set realistic targets for OP1.6 by making use of trends and achievements so far (Responsibility: PSI April 2015)
- Identify trends in malaria, pneumonia, diarrhoea and severe acute malnutrition caseloads based on seasonality and adjust drugs/commodities forecasting projections to accommodate for seasonal variation in case load (Responsibility: PSI April 2015)
- Discuss in the next ICCM internal (consortium) meeting (Responsibility: PSI by April 2015):
    - Pre-positioning by forecasting for longer periods of time
    - Possibility of purchasing storage facilities (e.g. containers) to be taken in areas worst affected by the flooding

- Possibilities of PMU to also purchase plumpy nuts as a means to reduce shortages of supplies, as expansion of the nutrition component grows
- Possibility of PMU to fully procure and transport supplies to the field offices directly, to avoid further delays in transportation from Juba to the field

- Explore ways to strengthen the national pharmaceutical distribution and monitoring system – document positive cases of cooperation between ICCM and County Health Department (CHD) and learn from best practices. (Responsibility IRC by June 2015)

Output Title	*Improved quality of service provision by CBDs & CNWs*		
Output number per LF	2	**Output Score**	***B***
Risk:	*High*	Impact weighting (%):	40%
Risk revised since last AR?	*No*	Impact weighting % revised since last AR?	*Yes*

A fundamental component key to increasing availability of services relies heavily on training of community based distributors (CBDs) and community nutrition workers (CNWs). Furthermore refresher training, reporting and supervision measures are mechanisms set in place to improve the quality of service provision.

Indicators	Target (April 2014-March 2015)	Achievement (April 2014-Dec 2014)	% Achieved against targets
Output Indicator (OP 2.1) Percentage of community based distributors (CBDs) supervised at least once per quarter	90%	89%	99%
Output Indicator (OP 2.2) Percentage of community nutrition workers (CNWs) supervised at least once per quarter	90%	100%	111%
Output Indicator (OP 2.3) Proportion of community based distributors (CBDs) providing complete and timely reports	90%	73%	81%
Output Indicator (OP 2.4) Number of CBD trained to appropriately identify SAM, and treat fever, pneumonia and diarrhoea in children under five, including refresher training	9,083	12,520	138%
Output Indicator (OP 2.5) Number of CNWs trained to appropriately treat SAM	2,187	1,401	64%
Output Indicator (OP 2.6) Percentage of trained CBDs passing core competence tests	75%	100%	133%
Output Indicator (OP 2.7) Percentage of trained CNWs passing core competence tests	75%	100%	133%

Key Points

There has been a lot of improvement in respect of this output indicator since Year 1 of the project.

In this annual review, 4 out of 7 indicator targets have been met and exceeded moderately with another indicator missing the target only by a 1% margin (OP 2.1 reaching 99% of the target). OP 2.1 may meet the target by the end of the Year 2. In essence it has been considered that 5 out of the 7 targets are considered met, most, of which exceeded expectations. A key shortcoming identified in the first annual

review was poor achievement of targets on CBD training (OP 2.4), and this was argued to be a critical factor resulting in poor achievement of outcome indicators. In this review, it's notable that the programme has already exceeded the Year 2 targets three months before the end of Year 2.

However, two indicators fall short of target, one of them significantly below expectation, and are not likely to be met even by the end of Year 2 (discussed below). Hence an output score of B is given to this indicator. It is a clear improvement from Year 1 when this output was scored a C.

A few points to be noted while considering the achievements under this output:

1) Indicators may be too simplistic and easy to achieve for an impact weight of 40%
2) OP 2.4 Training is a catch up from the previous year, so a lot of the trainings which were scheduled to happen in Year 1 happened in Year 2 maybe at the cost of other activities. This conclusion was made during the field visit when programme staff reported being stretched thinly during training activities and sometimes even delaying picking up reports. This concluding statement is also backed by results of OP 2.3 (less than expected reporting).
3) A 100% passing rate for both CBD and CNW training raises some questions on the level of testing

The challenge reflected in submission of reports is made clear in OP 2.3 not meeting its target as submission delays are reported in all Q5-Q7 reports. Challenges described include inaccessibility to collect reports due to: flooding, insecurity, frequent movement of CBD failing to submit, and overstretching of staff busy with other activities such as training. For example Save the Children data for Q7 is still pending PMU verification because of delayed consolidation of the field level data into the central databases system. Reports have to be collected manually and so data consolidation experiences delays at all levels: from the supervisor level, to field staff and then to the PMU M&E Unit. This evidence of lack of full data has to be taken into consideration while interpreting achievements or lack thereof of programme results.

After the December 2013 conflict there have been tremendous efforts to catch up with training gaps in previous quarters and clear momentum by most SRs in starting the nutrition component of the programme. The catch up in training gap explains why OP 2.4 has substantially exceeded the target. There have also been tremendous improvements to OP 2.6 with an achievement of 133% compared to 80% achievement the previous year.

Training of CNWs is still lagging behind significantly though targets have now been set for OP 2.5 as per recommendations made in the last annual review. The reason for this delay includes slow preparation of measures needed to be in place before training can occur. These include completion of a SMART (Standardized Monitoring and Assessment of Relief and Transition) survey, selection of CNWs candidates and setting up of OTP sites which have to be ready by the time CNWs complete their training. PSI, due to these delays, has yet to begin any training on CNWs. There is a possibility that Year 2 targets for this indicator may not be met, but completion of the expansion plan at the end of March 2015 will ensure cumulated target at the end of Year 3 will be met. Another challenge observed in this regard is the different levels of technical capacity between different SRs, which may have contributed to delays in implementation.

Summary of responses to issues raised in previous annual reviews (where relevant)

The first annual review suggested that training targets be revised in response to disruptions caused by the December 2013 conflict. SRs training activities were revised/ expedited; however the targets for CBD training (OP 2.4) were not changed. From the reporting, it is not possible to know the proportion of new and refresher training for CBDs. Key indicators and targets on the nutrition component were discussed, revised and included in the revised log frame, which was shared with DFID in October 2014. Furthermore, 3 new quality indicators have been added (OP 2.1, 2.3 and 2.7) to assess programme achievements, all of which began being collected in Q6.

Recommendations

- Disaggregate between training numbers to report on new and refresher training separately (Responsibility: PSI)
- Report on participants disaggregated by sex (Responsibility: PSI from the next quarterly report)

Output Title	*Increased demand for utilization of SAM services*		
Output number per LF	3	**Output Score**	***A+***
Risk:	*High*	Impact weighting (%):	20%
Risk revised since last AR?	*N/A*	Impact weighting % revised since last AR?	*N/A*

Sensitization is important to educate community members on health issues surrounding nutrition and hygiene, improve awareness of SAM, and subsequently improve demand creation and utilization of services.

Indicator(s)	Target (April 2014-March 2015)	Achievement (April 2014-Dec 2014)	% Achieved against targets
Output Indicator 3.1 Percentage of CNWs conducting sensitization sessions on AM screening and treatment	75%	100%	133%

Key Points
This indicator has met and exceeded the target. As this is the only indicator under output 3, this output has been scored an A+. However the following caveats need to be noted while interpreting the achievement:

1) For an impact weight of 20%, the weight given to one indicator is too high, especially considering the simplicity of the indicator. The programme needs to consider adding more, as well as more stretching, indicators in Year 3
2) This indicator started being collected in Year 2; however reports describe complications in keeping records of sensitization meetings – data quality should be improved as implementation continues

Summary of responses to issues raised in previous annual reviews (where relevant)
This output indicator has been newly added to the log frame and was not reported on in the last annual review.

Recommendations

- Observe trends in this indicator closely and decide if revisions of sensitization targets are needed once all SRs have begun nutrition implementation (Responsibility: PSI by April 2015)
- Collect information on number of people reached through sensitization meetings as well as disaggregating attendance numbers by sex (Responsibility: PSI by April 2015)
- Add more, and more stretching, indicators to this output indicator and share with DFID for approval (Responsibility: PSI by April 2015)

D: VALUE FOR MONEY & FINANCIAL PERFORMANCE

Key cost drivers and performance
The main cost drivers are commodities and the supply chain management, training, incentives to CBDs and their supervisors, supportive supervision and monitoring. They remain largely unchanged. However incidences of conflict and flooding have had a negative impact on effectiveness in implementation, timeliness and cost, in terms of delivering supplies but also on follow up and implementation of activities.

PSI procures drugs and essential commodities for all partners, which contributes towards achieving economy of scale as well as quality and consistency. If delays are experienced in the main warehouse in Juba then this may cause delays in transportation, which is heavily dependent and susceptible to environmental factors and conflict. An extreme example is using MC who experienced delays in receiving commodities from UNICEF. This delay caused transportation to take place during the rainy

season, which forced trucks to be on the road for 6 weeks instead of an average of 6 days. There have also been reports of smaller scale delays due to shortages of supplies in the main ICCM warehouse.

Another area, which could cut down cost, time and improve quality and consistency further, that the ICCM programme should consider, is PSI taking on the full responsibility of also delivering supplies to the field office. Currently the lack of this shift in responsibility increases delays in transportation.

Assessment of whether the programme continues to represent value for money
The previous Annual Review as well as the Business Case identifies the project to be very cost effective at an estimated cost of £16.5 per disability adjusted life year (DALY) saved (using a WHO methodology that compares the cost of an intervention in a country with Gross Domestic Product (GDP) of that country). However this did not include the impact of those treated for severe acute malnutrition. Research was done to calculate the impact of treating severe acute malnutrition but the results are still awaited. On the other hand, the results for malaria, diarrhoea and pneumonia, which factored into the cost-effective estimation at BC stage, have been revised downwards. These would balance out the net effect to some degree; however it needs a rigorous cost-effectiveness calculation.

As noted in the BC, the model used had calculated that even with an increase in costs by four times and decrease in expected results to one-fourth, the project interventions would remain cost effective as per the WHO methodology. Additionally, as noted above, PSI continues to procure drugs and commodities for all partners, achieving economy of scale as well as quality and consistency. The achievement of results at both output and outcome levels has seen a marked improvement from Year 1.

Given all these, the overall judgment is that the project continues to offer value for money. However, it is acknowledged that the expertise of the reviewer was very limited in making a thorough VfM assessment. It would be appropriate to include resources and expertise for a comprehensive and independent analysis of VFM to be conducted in respect of economy, efficiency, and cost effectiveness, benchmarked against similar programmes in the next review.

Quality of financial management
In response to recommendations made in the last Annual Review PMU now submits quarterly reports with a financial update of the sub-award. Annual audits for this year have also all been submitted to DFID and SRs have also submitted fixed asset list to PMU. ICCM was also included in a recent DFID Internal Audit, the report of which is still awaited. Other financial management activities, which have taken place this year to strengthen quality, include the following: the Programme Management Unit Finance and Compliance Manager conducted on-site financial verification visit looking at financial issues and made recommendations to SRs on how to make improvements and rectify mistakes. Mistakes rectified include: correctly reporting expenditure for the right donor : DFID vs. Global Fund, separating spending made before the project starting date, correctly reporting expenditure in the correct budget category and identification of funds being unsupported. With support from PMU, budget realigning has been done, and a new budget has been shared with DFID. It was apparent that the PMU finance team were not fully clear on the financial compliance protocols of DFID for ICCM, which is an Accountable Grant (E.g. protocol to follow for prior approval of expenditure, process to follow to change budget line expenditure, etc.). They expect having more clarity and receive relevant guidance from DFID on those.

Recommendation
- DFID to provide PMU clear guidelines on ICCM finance compliance/protocols. (Responsibility: DFID Deputy Programme Manager, April 2015)

Date of last narrative financial report	Covering up to 31 Dec 2014, submitted on 15 Feb 2015
Date of last audited annual statement	Covering up to 31 Mar 2014, submitted on 28 Oct 2014

E: RISK

Overall risk rating: High

Overview of programme risk
The first annual review revised the risk rating from medium in the Business Case to high. The Annual Risk Assessment Report updated in December 2014 by PMU provides a risk rating which takes into consideration geographical location, activities, staff requirements (national and international), logistic support required, and security requirements for each SR. The Report however does not provide a concrete recommendation on whether the risk rating should be changed. It is noted that since the later part of quarter two of Year 2 the risk environment has eased somewhat, however it can vary widely by state and county.

In this project, the risks which affect the successful delivery of expected results include:
- conflict and civil unrest,
- security threats to both civilians and programme staff,
- prolonged flooding,
- Inflation,
- frequent staff turnover due to internal displacement

The programme has continued to witness sporadic incidences of violence especially in Unity, Upper Nile and Jonglei. Even in relatively stable states, such as Lakes, cattle raids and inter-clan violence have impacted on programme implementation. The SRs experiencing high risk are IRC and Save the Children; however PSI, MC and BRAC are working in areas rated as medium risk area. In Upper Nile Save the Children will be phasing out (as part of their broader strategy not to work in that region marred by conflict), as GOAL will be taking over as the lead partner for the State.

Prolonged flooding causes challenges in carrying out supportive supervision, collecting reports and delivery of programme commodities as well as safe delivery of supplies. In quarter 6 for example casual labourers had to be hired in some counties to carry supplies manually in very risky terrain.

The institutional risk associated with frequent staff turnover is also very closely linked to inflation. Staff benefit packages have very much stayed the same even if inflation has doubled in the past year causing high staff attrition. Furthermore with such high variation in exchange rate and high inflation, the cost of goods and services have almost doubled by the end of the year and can impact on programme financing.

Based on these, it is judged that the risk continues to remain high for the programme.

F: COMMERCIAL CONSIDERATIONS

Delivery against planned timeframe
The programme has improved spending allocation in comparison to the previous year. In Year one (April 2013-March 2014) £5,430,722 of the £8,455,669 allocated funds were spent for the year (64%). While in Year two, considering only three quarters of expenditure, the programme has already spent 60% of its budget for Year 2. In terms of overall spending (from April 2013 to December 2014), as reported in February 2015, the ICCM programme has spent 49% of the overall £30,391,898 (this includes spending of the core programme budget and the overall management fees budget for the three years). The burn rate has increased considerably in Year 2, however there is still a likelihood of underspend by the end of the programme (March 2016).

Recommendation
- DFID should review the spend and make a decision accordingly (possibly a no cost extension) by the end of September 2015.

Performance of partnerships
Through informal interviews with different SR programme staff, it was observed that overall the consortium is working in close partnership with each other. However there are still areas that need further improvement.

- Misunderstanding between staff regarding the role of PSI/PMU, the managerial lead agency, and IRC, the technical lead agency. This will be beneficial to understand and avoid high turnover of staff, including managers.
- Sharing of information and inclusion of all SRs in certain levels of decisions
- Improved Coordination role by PMU
- Different implementation approaches between SRs – It was noted in the field visit and through communication with different SRs that implementation approaches with the ICCM programme vary greatly from partner to partner. Some of the differences noted include: payments of supervisors, reporting structure of CBD supervisors and delivery and storage of supplies

Recommendations

- The monthly meetings amongst Managerial staff of consortium members are not sufficient to coordinate all technical aspects. Create a forum for different ICCM unit members to meet e.g. ICCM M&E internal meeting. It is important for DFID to attend some ICCM internal meeting (Responsibility: PMU)
- Revisit and discuss partnership Memorandum of Understanding amongst consortium members. (Responsibility: DFID and PMU)
- Document best implementation approaches and best practices to formulate clear implementation guidelines for a unified ICCM system – (Responsibility: IRC April 2015)
- Improve coordination role of PMU (Responsibility: PMU)

Asset monitoring and control
Some assets including programme commodities were lost in the weeks following the outbreak of violence in December 2013. PSI promptly reported the loss to DFID and provided follow up updates also. The lost assets are in the process of being written off by DFID HQ. The programme has put in place more regular measures to update on the assets and any loss. All SRs maintain and update an assets inventory, so does the PMU for the whole programme. The audit of the SRs also included a check on the assets, without any significant qualification made in the reports.

G: CONDITIONALITY

Update on partnership principles (if relevant)
Not applicable. This is an Accountable Grant with a not-for-profit organization

H: MONITORING & EVALUATION

Evidence and evaluation
There are no changes in evidence that would have implications for the programme. However there have been changes made to targets of programme outcomes (discussed above).

Programme monitoring
Programme monitoring by DFID has been limited in Year 2, largely due to limited capacity and adverse security situation. No filed visit was undertaken, and the monitoring was done largely through the review of programme reports and direct interaction with programme team in Juba. Similarly, monitoring by the PMU of programme implemented by SRs in different counties has also been limited in Year 2.

It was observed during the field visit made by the reviewer that the programme uses quite a complicated system of reporting which in turn can affect data quality. The current system, database and processes used to generate reports are very time consuming and open to error. Furthermore it is also risky for a programme, implemented in such a fragile and volatile country to only be able to report findings on a quarterly basis, as large amounts of data could be lost at one go.

Disaggregation of data
As identified in the previous annual review, gender disaggregated data is being collected at the client level but this detail of information in not transferred to quarterly reports received by the programme. It has been confirmed however that the District Health Information System (DHIS) database has recently been updated to allow for the capturing of sex disaggregated data beginning April 2015. The ICCM Technical Working Group (TWG) is also reviewing CBD registers and supervisor summary sheets to ensure sex disaggregated data are being captured at all level. This only pertains at outcome level because there is almost no client data captured at output level.

Evaluation and Research activities

- A Malaria Rapid Diagnostic Test (RDT)[7] pilot, mentioned also in the previous Annual Review has just started (3rd week of March 2015). The pilot will end at the close of April 2015 and is being rolled out and supervised by the MC in Aweil. 240 CBD have been trained to administer the RDT at household level to confirm malaria cases before dispensing treatment. The delay experienced in rolling out the RDT pilot is due to the outbreak of the Ebola virus, which made the MoH halt the exercise as part of its precautionary measures to mitigate any potential outbreak in the country.
- In April-May 2015 IRC together with Save the Children are planning to formally document in a series of case studies, their success in being able to continue sustaining programme implementation and treatment to clients even under conflict situation.
- MC – have undertaken a Knowledge Attitude and Practice (KAP) survey to better understand knowledge, attitude and practices surrounding hygiene, nutrition, malaria and pneumonia in the communities. This was done to inform a Behaviour Change Communication (BCC) strategy which they are currently helping to draft in Aweil West and Aweil Center
- In June 2014 MC conducted qualitative research to formally document referral linkages between community and health facility levels. This was done as a learning exercise to recommend changes in programme implementation.
- Pre- and post-harvest SMART surveys have been conducted in selected counties.

It has not been clear however to what extent findings or plans of these research activities were shared with the wider ICCM programme. Anecdotal accounts from both the MoH and programme staff indicated a gap in knowledge in regard to research going on under the ICCM programme.

Recommendations

- Increase site visits to directly monitor programme implementation (Responsibility: DFID and PMU)
- Share in formal meetings, as part of the research dissemination strategy, results, information and documentation of pilots, surveys, and research being undertaken under the ICCM programme with ICCM consortium/ programme staff, the MOH and all development partners through scheduled session at the ICCM TWG meeting and during training and supervision. (Responsibility: IRC)
- Improve ICCM system of reporting by working with the MOH to strengthen the national Health Information system to accommodate, for the first time, reporting on community health initiative (Responsibility: PMU)

The review process
The annual review was undertaken by one independent consultant (Giulia Besana) who worked in country from the 19th to the 27th of March 2015. The review included 2 field visits and a total of 34 interviews with different stakeholders (Annex B list the people interviewed). Interview notes were also shared with the DFID office in Juba.

[7] RDT is a simple test kit to detect malaria (using a drop of blood from a pricked finger) that can be used at community level by volunteers with some basic training. ICCM programme follows a syndromic approach, where a child presenting with fever is given malaria drugs based on a simple clinical assessment. The use of RDT can help diagnose with more certainty and avoid unnecessary treatment. The purpose of the pilot is to see the operational feasibility and effectiveness in South Sudan's context.

ANNEX A

SUMMARY OF RECOMMENDATIONS	
PMU	1. Establish more frequent ICCM internal group meetings not only amongst managerial staff of the consortium members but also creating a forum for different ICCM technical unit members to meet e.g. ICCM M&E internal meeting. It is important for DFID to attend some ICCM internal meetings. 2. Revisit and discuss partnership Memorandum of Understanding amongst consortium members. 3. Improve coordination role of Project Management Unit (PMU) in PSI M&E 4. Revise OC 4 targets (number of U5 with SAM receiving treatment through ICCM) to reflect learning from Year 2 implementation 5. Disaggregate children receiving SAM treatment by new and returning cases 6. Set targets for OP1.6 by making use of trends and achievements so far 7. Disaggregate the number of CBDs/CNWs trained to report on new and refresher training separately 8. Report on participants and beneficiaries disaggregated by sex 9. Observe trends and decide if revisions of sensitization targets are needed once all SRs have begun nutrition implementation. Disaggregate the participants by sex 10. Add more, as well as more stretching, indicators for output 3 in Year 3 11. Cover both quarterly and cumulative achievements for the programme in the quarterly reports 12. Develop an M&E Plan which describes the Log frame, programme indicators with definitions, impact weight rational, programme monitoring tools, methodology of data collection, flow of information and reporting, implementers roles and responsibilities, data quality assurance methods, and data management system 13. Identify trends in malaria, pneumonia, diarrhoea and severe acute malnutrition caseloads based on seasonality and adjust drugs/ commodities forecasting projections to accommodate for seasonal variation in case load 14. Improve ICCM system of reporting by working with the MOH to strengthen the national Health Information System to accommodate, for the first time, reporting on community health initiative 15. Increase site visits to directly monitor programme implementation 16. Discuss in the next ICCM internal (consortium) meeting (Responsibility: PSI by April 2015): a. Pre-positioning by forecasting for longer periods of time b. Possibility of purchasing storage facilities (e.g. containers) to be taken in areas worst affected by the flooding c. Possibilities of PMU to also purchase plumpy nuts as a means to reduce shortages of supplies, as expansion of the nutrition component grows d. Possibility of PMU to fully procure and transport supplies to the field offices directly, to avoid further delays in transportation from Juba to the field

DFID	1. Attend ICCM internal meetings 2. Intervene and find out more regarding the direction of the Boma Health Initiative and what this will mean to the ICCM programme 3. In terms of success of SAM treatment it may be interesting to analyse the disaggregation of children receiving SAM treatment by new and returning cases. This would be important to identify if other measure and linkages to food security will need to be explored 4. Review the spend and make a decision accordingly (possibly a no cost extension) by the end of September 2015 5. Provide clarity on programme specific finance compliance guidelines to PMU to guide finance implementation practices 6. Increase site visits to directly monitor programme implementation
PMU/IRC	1. Explore further linkages and support, which ICCM could have with the Health Pooled Fund 2. Explore ways to strengthen the national pharmaceutical distribution and monitoring system – document positive cases of cooperation between ICCM and CHD and learn from best practices 3. Document best implementation approaches and best practices to formulate clear implementation guidelines for a unified ICCM system 4. Share in formal meetings, as part of the research dissemination strategy, results, information and documentation of pilots, surveys, and research being undertaken under the ICCM programme with ICCM consortium/ programme staff, the MOH and all development partners through scheduled session at the ICCM TWG meeting and during training and supervision

Annex B

List of people interviewed as part of the Review process (34 interviews)

NAME		POSITION
National level		
Dr. John Rumunu		Director General Preventive Medicine
Dr. Robert Lobor		Child Health Point Person, Primary Health Care Directorate
Dr. Richard Laku		Director General of Policy and Planning
Dr. Damianos Odeh		Team Leader, Health Pooled Fund South Sudan
Consortium partners		
PMU	Sasi Luxmana	PMU Programme Manger
	Gumah Tiah	M&E Manager
PSI	Hussein Ahmed	Country Director
Save the Children	Dr Simon Mbwile	Health Technical Adviser
International Rescue Committee	Katja Ericson	ICCM Coordinator,
	Caroline Lai	Grants Coordinator
Malaria Consortium	Patrick Mwangi	Country Technical Coordinator
BRACC	Dr. Wadembere Ibrahim	Programme Manager Health,
	Bilwa Das Saha	Project Manager
Mundri Field visit - with PSI		
Joy and Simon		Community Based Distributors (CBD)
Mande		CBD Supervisor
Esther		PSI ICCM Field Officer
Otim		PSI ICCM Field Officer
Mary Lucy		PSI ICCM Field Coordinator
Severino Lado		ICCM Programme Manager
Charles Wura		Boma Chief
Kennedy Jadela		Storekeeper
Aweil Field visit – with MC		
Dominic Athiam Dutu		Director General State MOH
Zacharia Mayoul		County Medical Officer – CHD, Aweil Center
Dominic Deng		County Medical Officer – CHD, Aweil West
Luka		CBD trained in MUAC
Deng Aleu		CBD Supervisor
Theresa		CBD piloting RDT
William Gerang		CBD Supervisor – supervising CBD piloting RDT
John Aleu		Community Nutrition Worker
James Atak		ICCM Field Officer
Moses		MC Programme Officer Nutrition
Deng Lual		MC ICCM Programme Officer
Philip Makuei		ICCM Project Officer
Dennis Oyunge		MC M&E Manager
Fatuma Ajwang		Nutrition Programme Manager
Wedwil PHCUnit		Health Facility in charge

Smart Guide

The Annual Review is part of a continuous process of review and improvement throughout the programme cycle. At each formal review, the performance and on-going relevance of the programme are assessed with decisions taken by the spending team as to whether the programme should continue, be reset or stopped.

The Annual Review includes specific, time-bound recommendations for action, consistent with the key findings. These actions – which in the case of poor performance will include improvement measures – are elaborated in further detail in delivery plans. Teams should refer to the Smart Rules quality standards for annual reviews.

The Annual Review assesses and rates outputs using the following rating scale. ARIES and the separate programme scoring calculation sheet will calculate the overall output score taking account of the weightings and individual outputs scores

Description	Scale
Outputs substantially exceeded expectation	A++
Outputs moderately exceeded expectation	A+
Outputs met expectation	A
Outputs moderately did not meet expectation	B
Outputs substantially did not meet expectation	C

Teams should refer to the considerations below as a guide to completing the annual review template.

Summary Sheet

Complete the summary sheet with highlights of progress, lessons learnt and action on previous recommendations

Introduction and Context

Briefly outline the programme, expected results and contribution to the overall Operational Plan and DFID's international development objectives (including corporate results targets). Where the context supporting the intervention has changed from that outlined in the original programme documents explain what this will mean for UK support

B: Performance and conclusions

Annual Outcome Assessment

Brief assessment of whether we expect to achieve the outcome by the end of the programme

Overall Output Score and Description

Progress against the milestones and results achieved that were expected as at the time of this review.

Key lessons

Any key lessons you and your partners have learned from this programme
Have assumptions changed since design? Would you do differently if re-designing this programme?
How will you and your partners share the lessons learned more widely in your team, across DFID and externally

Key actions

Any further information on actions (not covered in Summary Sheet) including timelines for completion and team member responsible

Has the logframe been updated since the last review? What/if any are the key changes and what does this mean for the programme?

C: Detailed Output Scoring

Output

Set out the Output, Output Score

Score

Enter a rating using the rating scale A++ to C.

Impact Weighting (%)

Enter the %age number which cannot be less than 10%.

The figure here should match the Impact Weight currently shown on the logframe (and which will need to be entered on ARIES as part of loading the Annual Review for approval).

Revised since last Annual Review (Y/N).

Risk Rating

Risk Rating: Low/Medium/High

Enter Low, Medium or High

The Risk Rating here should match the Risk currently shown on the logframe (and which will need to be entered on ARIES as part of loading the Annual Review for approval).

Where the Risk for this Output been revised since the last review (or since inception, if this is the first review) or if the review identifies that it needs revision explain why, referring to section B Risk Assessmen

Key points

Summary of response to iprogrammessues raised in previous annual reviews (where relevant)

Recommendations

Repeat above for each Output.

D Value for Money and Financial Performance

Key cost drivers and performance

Consider the specific costs and cost drivers identified in the Business Case
Have there been changes from those identified in previous reviews or at programme approval. If so, why?

VfM performance compared to the original VfM proposition in the business case? Performance against vfm measures and any trigger points that were identified to track through the programme

Assessment of whether the programme continues to represent value for money?

Overall view on whether the programme is good value for money. If not, why, and what actions need to be taken?

Quality of Financial Management

Consider our best estimate of future costs against the current approved budget and forecasting profile
Have narrative and financial reporting requirements been adhered to. Include details of last report
Have auditing requirements been met. Include details of last report

E Risk

Output Risk Rating: L/M/H

Enter Low, Medium or High, taken from the overall Output risk score calculated in ARIES

Overview of Programme Risk

What are the changes to the overall risk environment/ context and why?

Review the key risks that affect the successful delivery of the expected results.

Are there any different or new mitigating actions that will be required to address these risks and whether the existing mitigating actions are directly addressing the identifiable risks?

Any additional checks and controls are required to ensure that UK funds are not lost, for example to fraud or corruption.

Outstanding actions from risk assessment

Describe outstanding actions from Due Diligence/ Fiduciary Risk Assessment/ Programme risk matrix
Describe follow up actions from departmental anti-corruption strategies to which Business Case assumptions and risk tolerances stand

F: Commercial Considerations

Delivery against planned timeframe. Y/N

Compare actual progress against the approved timescales in the Business Case. If timescales are off track provide an explanation including what this means for the cost of the programme and any remedial action.

Performance of partnership

How well are formal partnerships/ contracts working
Are we learning and applying lessons from partner experience
How could DFID be a more effective partner

Asset monitoring and control

Level of confidence in the management of programme assets, including information any monitoring or spot checks

G: Conditionality

Update on Partnership Principles and specific conditions.

For programmes for where it has been decided (when the programme was approved or at the last Annual Review) to use the PPs for management and monitoring, provide details on:

a. Were there any concerns about the four Partnership Principles over the past year, including on human rights?

b. If yes, what were they?

c. Did you notify the government of our concerns?

d. If Yes, what was the government response? Did it take remedial actions? If yes, explain how.

e. If No, was disbursement suspended during the review period? Date suspended (dd/mm/yyyy)

f. What were the consequences?

For all programmes, you should make a judgement on what role, if any, the Partnership Principles should play in the management and monitoring of the programme going forward. This applies even if when the BC was approved for this programme the PPs were not intended to play a role. Your decision may depend on the extent to which the delivery mechanism used by the programme works with the partner government and uses their systems.

H: Monitoring and Evaluation

Evidence and evaluation

Changes in evidence and implications for the programme
Where an evaluation is planned what progress has been made
How is the Theory of Change and the assumptions used in the programme design working out in practice in this programme? Are modifications to the programme design required?
Is there any new evidence available which challenges the programme design or rationale? How does the evidence from the implementation of this programme contribute to the wider evidence base? How is evidence disaggregated by sex and age, and by other variables?

Where an evaluation is planned set out what progress has been made.

Monitoring process throughout the review period.

Direct feedback you have had from stakeholders, including beneficiaries
Monitoring activities throughout review period (field visits, reviews, engagement etc)
The Annual Review process