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: Health Partnership Scheme		
Programme Value: £30m		**Review Date:** July 2015
Programme Code: 202208	**Start Date:** July 2011	**End Date:** June 2017

Summary of Programme Performance

Year	2012	2013	2014	2015
Programme Score	A	A+	A++	A
Risk Rating	L	L	L	L

Summary of progress and lessons learnt since last review

The Health Partnership Scheme (HPS) uses the expertise of UK health professionals and health institutions to build capacity of their counterparts in 26 developing countries (including 17 DFID focal countries). It is also intended that the HPS will bring benefits back to their UK institutions. The Programme continues to perform well in terms of programme delivery and achievement of the majority of agreed milestones, which were amended last year to be more stretching. There are many examples of the contribution the Programme is making to more effective and efficient health systems (expected outcome).

Since the HPS began four years ago, almost 39,000 training courses or other educational opportunities have been provided to developing country health workers, with women accounting for over half of the participants and the vast majority (91%) of tested trainees showing improved skills or performance. 133 developing country institutions have improved medical equipment, ICT or health information management systems; and partnerships have contributed towards the development, review or update of 410 national and institutional strategies and professional standards. These successes have been due to good project management of the scheme by DFID's implementing partner; strong partnerships between UK institutions and their counterparts in developing countires; and over 48,000 of UK health professional days spent volunteering.

The HPS is based on a partnership principle, where both the UK and developing countries contribute to the outputs and also benefit from the work. Participant feedback shows that project management is largely equitable, with Ugandan partners (visited by DFID as part of the annual review process) reporting good relationships with their UK counterparts and experiencing substantial benefits from the relationship. All UK partners contacted by DFID believe that their partnership brings benefits back to the UK, with the majority of UK volunteers surveyed reporting that their experience led to improvement in at least one skill area.

As the first phase of funding comes to an end, and a new set of grants begin (many building on previous work achieved through the HPS), there is an opportunity to build on the successes of the Programme's achievements to date and take forward learning from the last four years. This includes increasing the level of support to grant applicants/holders and looking at new ways to overcome previous data collection challenges.

An external evaluation of the Programme due this year will look in more depth at the benefits of the Scheme and further test the assumptions outlined in the business case. Although many participants demonstrate improved performance after educational opportunities, it will be important to continue to work with grant holders to ensure that methods of assessment are in place, not only immediately after training but also at three months, and that measures are valid. Many partnerships report that they reach rural and vulnerable populations, including women, which was validated during DFID's recent visit to Uganda. This will be further explored during the external evaluation.

Summary of recommendations for the next year

- DFID and Tropical Health Education Trust (THET) to review and agree milestones for 2016 and 2017, by Sept 2015.
- DFID and THET to amend milestones for Output 4 indicators so that they report to the end of April 2016, in order to align with the milestone dates for the rest of the programme's outputs, by Sept 2015.
- DFID and THET to agree method to consistently measure timely and appropriate provision of technical assistance to grant holders/stakeholders over the next two years, by Oct 2015.
- DFID and THET to agree best method to collect information on the populations served through the parnterships, by Sept 2015.
- THET to collect data to enable disaggregation of volunteer time by UK volunteering time and overseas volunteering time, for reporting by Sept 2015.
- THET to continue to support partnerships to collect good quality data on improved skills/performance post training, including reviewing grant holders' evaluation strategies and advising on how proposed methods can be improved.
- THET to look at options for providing a basic resource and advice pack for long term volunteers, to be ready by Oct 2015.
- THET to ensure that all partnerships use UK Aid branding on project materials.
- THET to ensure that all organisations receiving DFID funds have in place robust fraud and bribery prevention policies, and procurement policies; and are aware of, and adhere, to them.
- THET to continue to work to better understand the value for money offered by HPS. THET to build on pilot work, standardising data collection in order to analyse the cost per health worker trained, comparing costs to alternative approaches where feasible. THET to also assess the value of volunteering time leveraged, providing data on the cost savings that the health partnership approach achieves through the use of volunteers, compared to using paid staff/consultants. By Sept 2015.
- DFID and THET to explore the feasibility of assessing the VfM of strengthening institutions, strategies and professional standards through the use of case studies. By Dec 2015.
- THET and DFID to identify the best way to measure the benefits brought back to the UK from the HPS by Sept 2015.
- THET to increase the number of people who complete the returned volunteers survey by April 2016.
- DFID to work with external evaluators to build a stronger picture of what what works and what does not work in the current programme's approach, and test the assumptions on which the programme is based.

A. Introduction and Context (1 page)

DevTracker Link to Business Case:	N/A: HPS pre-dates DFID business cases
DevTracker Link to Logframe:	*To add*

Outline of the programme

The Health Partnership Scheme (HPS) supports partnerships between UK health institutions and those in low income countries, aiming to:

- Improve health services in developing countries through sharing skills and capacity development.
- Bring benefits back to the UK through volunteer NHS staff returning with stronger skills.

The scheme has two main components: grants for partnership projects, which use the expertise of UK health professionals and health institutions to build capacity of their counterparts in developing countries; and activities to support and develop the health partnership community in the UK and overseas.

The anticipated impact of the HPS will be more effective and efficient health service provision (with a special interest in MDGs 4, 5 & 6, as well as rural and underserved populations). The outcome is expected to be more effective and efficient health systems, with an emphasis on strengthening the health workforce in participating countries and the UK.

A strong health workforce is an essential component of a functioning health system. Improving access to better basic services requires skilled and motivated health workers, in the right place at the right time.

DFID invests significant resources in human resources for health in partner countries. The HPS complements other DFID health initiatives by using UK expertise to strengthen health worker training, professional institutions and standards. The HPS aims to make the most of high quality UK health professionals and the international reputation of the UK's health institutions. In 2006-7, Lord Crisp led a review of the UK contribution to health in developing countries, culminating in the publication of the *Global Health Partnerships Report* in early 2007. The recommendations of this report fed into the development of the International Health Links Programme and, subsequently, the HPS. The HPS was launched in June 2011, with Tropical Health and Education Trust (THET) as the implementing partner.

The original HPS grant provided £20 million over four years (July 2011 – June 2015). In April 2014, two cost extensions of the HPS were announced: £10 million to extend the programme to 2017, and £200,000 to fund a pilot medical electives programme overseas (15 students will take part in the scheme this summer). The projects cover a range of health issues, including maternal, newborn and child health.

The majority of data in this review is cumulative, reporting on the original HPS partnerships since 2011. Where figures are presented for this review period only, the data comes from 36 health partnerships: 21 of which ended their projects during the review period and 15 partnerships which are still running.[1] 45 of the original partnerships finished their projects before the start of this review period. Data for this review period covers May 2014 to April 2015, with the exception of Output 4 which reports from July 2014 to June 2015: this will be changed for next year's review, with all outputs reporting against milestones for April 2016. The new grants, as part of the two year extension of the programme, are not included in this report as the majority have only just begun. Data from all of the new partnerships, plus the original grants that are currently still running, will be included in next year's review.

B: PERFORMANCE AND CONCLUSIONS (1-2 pages)

Annual outcome assessment

The Programme's expected outcome is 'more effective and efficient health systems, with an emphasis on the performance of the health workforce in participating countries and the UK', with good evidence that the Programme is achieving this. The Programme has consistently show strong progress against outcome indicators 2 and 3, relating to improving policies, systems and medical equipment. However, it has been more difficult to collect evidence for outcome indicators 1 and 4, relating to improved performance of developing country and UK health workers. In this review period, THET have worked hard to overcome this challenge.

The expected impact of the programme is more effective and efficient health service provision, with a special interest in MDG 4,5,6, and rural and under-served populations. Whilst the first part of the expected impact clearly links to the programme's expect outcome, there are no indicators which measure whether the programme is reaching rural and under-served populations. This has been measured to some degree by the fact that programmes are asked whether they are serving rural populations in their reporting template (47% report that they are), but very little additional information is systematically collected on populations reached. For some partnerships, it is difficult for them to accurately assess this. For example, the College of Surgery of East Central and Southern Africa (COSESCA) has delivered surgical training to doctors from a number of different countries (MCP26) which makes it difficult for them to report on what proportion of patients seen by their trainees come from under-served populations. For other partnerships, it is much clearer that they are reaching rural populations (for example, in Uganda, one partnership (LPIP6) has trained 360 community health promoters in village health teams to improve rural health, and another (D26) plans to train 320 Ugandan health workers from rural health centres in emergency obstetric skills). All seven Ugandan partnerships visited by DFID as part of the annual review process were predominantly targeting and reaching underserved and rural populations. THET will be collecting more detailed information on the populations served by the new partnerships through revising their reporting template, and the planned external evaluation will also assess the degree to which the HPS is reaching under-served groups.

Below outlines the performance of the HPS against the programme's outcome indicators.

[1] Four of the volunteering grants were linked to the LPIP grants and are therefore reported as part of the LPIP grants in this review.

Outcome 1. Developing country health workers demonstrating improved performance, at least 3 months after education or training.

Since the start of the HPS, 9,863 (out of 14,193 tested) developing country health workers have demonstrated improved performance at least three months following education or training, against a milestone of 10,400. Many partnerships have struggled to measure performance at least three months after training but THET have worked with them to overcome identified challenges. It is important to note that some partnerships have looked at samples of health workers, rather than at all of the health workers they trained, without reporting the sizes of those samples; so the number given here as tested may be an overstatement. THET are working closely with the new grant holders to plan data collection for this metric to ensure that this data is collected and of quality.

Example: MCP26: 36 surgeons spent between one and six months on paediatric orthopaedic clinical fellowships, where they performed over 1,100 operations. Their trainers assessed that 91% of trainees gained an appropriate or above average level of clinical knowledge. All the surgeons found the placements relevant to their clinical practice and said that their management of children's musculoskeletal impairment had significantly changed since the placement.

Outcome 2. Participating institutions demonstrating implementation of improved policies/curricula

114 participating institutions have demonstrated implementation of improved policies and curricula, 12 months after sign-off or approval (against a milestone of 84). With the first group of HPS projects drawing to an end, progress against this outcome was higher than expected. Health partnerships are in a better position to implement policies and curricula once they have been able to develop the protocols, guidelines and course materials and obtain approval from the relevant authorities, which tends to happen early in the project life cycle. Almost all partnerships seek alignment of their projects with the national health priorities of the countries where they work. As such, many work closely with the ministries of health, governments at district and local level, and national education boards/teaching institutions to develop protocols, guidelines and courses, obtaining their approval before implementation. Larger health projects including multi-country partnerships and volunteering grants often work directly with ministries and education institutions across several countries. This government and institutional buy-in facilitates the roll-out of policies and curricula to healthcare institutions and also increases sustainability.

Example: MCP1: As part of the Emergency Triage, Assessment and Treatment + (ETAT+) project to improve the quality of emergency care for infants and children in Kenya, Rwanda and Uganda, 18 hospitals implemented ETAT+ guidelines in this review period. The guidelines were first adopted by the ministries of health and form their basic paediatric protocols in each of the 3 countries. ETAT+ guidelines were then adhered to by 18 hospitals across these countries, which include a range of clinical practice guides, safety protocols and procedures which form the WHO ETAT+ package.

Outcome 3. Participating institutions using and maintaining improved equipment, ICT or health information management systems

68 participating institutions used and maintained improved equipment, ICT or health information management systems, 12 months after delivery (against a milestone of 50). The higher than expected result is due to the timing of data collection in one project. It includes 16 labs in the Labskills Africa project (MCP2.10), out of 20 that were provided with microscopes in January 2014. In May 2015, these were still being using and maintained.

Outcome 4. UK volunteers self-reporting or demonstrating improved clinical and leadership skills

339 UK volunteers self-reported or demonstrated improved clinical and leadership skills, against a milestone of 655. This number was lower than expected as only 554 (37%) of volunteers were sent the survey by their health partnership during this review period, with only 179 (32%) completing it. However, of this sample, 96% self-reported or demonstrated improved clinical/leadership skills (see Section H for more details).

THET will be working with partners to increase the number of volunteers who complete the survey, which is now available on Health Education England's website.

Overall output score and description
The overall score is A, reflecting outputs that met expectation. This reflects the fact that milestones were amended last year to be more stretching.

Key lessons
The HPS has now been running for four years, with the original grant funding coming to an end and the extended programme beginning that will end in 2017. THET are taking forward the learning from the HPS to improve the management and performance of new grants, including increasing the level of support to grant applicants/holders and looking at new ways to overcome previous data collection challenges, such as value for money indicators and assessing changes in health worker performance. The upcoming external evaluation of the Programme will provide DFID with further information on what what works and what does not work in the current programme's approach, in terms of building health worker capacity in developing countries, and the reciprocal benefits of partnerships in the UK. It will also allow DFID to further test some of the assumptions of the programme, including assessing the degree to which the Programme is reaching the poor.

Has the logframe been updated since the last review?
Yes. After last year's annual review, many of the milestones were revised to be higher for the output indicators. The wording was also revised for output indicators 1.1, 3.3 and 4.4, as explained under Section C.

C: DETAILED OUTPUT SCORING (1 page per output)

Output Title	Improved and strengthened knowledge and capability in participating health institutions		
Output number per LF	1	**Output Score**	A
Risk:	Low	Impact weighting (%):	50
Risk revised since last AR?	N	Impact weighting % revised since last AR?	N

Indicator(s)	**Milestones**	**Progress to 30 April 2015**
1.1 Number of training course places or other educational opportunities provided to developing country health workers (directly by project or by trainers trained in project)	39,000	38,701 (20,735 female, 14,402 male, 3,564 no data)
1.2 Percentage of tested trainees showing improved skills or performance immediately after training or education.	87%	91% (11,943/13,221 female, 7,146/7,777 male, 1,662/1,795 no data)
1.3 Number of developing country institutions with improved medical equipment, ICT or health information management systems	130	133 (58 in this review period)

Key Points

1.1. Training course places or other educational opportunities provided

- Up to April 2015, 38,701 training course places or other educational opportunities were provided to developing country health workers, either directly through the partnership or by trainers trained as part of the partnership, almost meeting the milestone of 39,000. In this review period, 12,113 course places/educational opportunities were provided. Women accounted for over half of the places.
- Training and other educational opportunities offered through the HPS is tailored to different country contexts and the specific needs of the health workforce. Training ranges from practical sessions for multidisciplinary health teams in their workplace to more formalised teaching in the classroom, all based on recognised good practice and teaching resources (e.g. WHO/EU/UK recognised teaching material and standard procedures/ checklists; carefully adapted to the country context). A number of health partnerships set up continuous educational opportunities by providing mentoring, peer-to-peer support, and sharing of resources via e-learning platforms such as webinars and forums when access to technology is adequate.

1.2. Tested trainees showing improved skills or performance

- Up to April 2015, 91% of the 22,793 tested trainees showed improved skills or performance immediately after training or education, exceeding the milestone of 87%.
- There was very little difference in test results between genders (92% males, 90% females).
- Testing is appropriately tailored for the type of training. Methods include test/exam-based assessments and more practical testing, such as trainees using teaching equipment (e.g. mannequins) and trainers observing progress. THET supports grant holders to develop appropriate methods for assessment.
- Grant holders are required to develop detailed monitoring and evaluating plans, outlining the tools and methods they plan to use for data collection and analysis. THET's Evaluation and Learning team supports each grant holder to strengthen these plans, whicn includes ensuring that appropriate assessment methods are used to test the improved skills or performance of health workers trained.

Example: LPIP15: 55 Clinical officers, 7 anaesthesia Master of Medicine students and 3 consultant anaesthetists in Zambia were trained in SAFE obstetric anaesthesia. 30 of the clinical officers and all of the students and anaesthetists were tested with multiple choice questionnaires at the end of the course, with all showing improved knowledge.

1.3. Improved medical equipment, ICT or health information management systems

- Up to April 2015, 133 developing country institutions reported having improved medical equipment, ICT or health information management systems (58 in this review period).

Example: MCP3: Kiwoko Midwifery Training School, Kibusi Midwifery Training School and the Uganda Private Midwives Association were provided with five 'Mama-Natalie' and five 'Neo-Natalie' simulation trainers for use in maternal and neonatal emergency obstetric skills training for midwives and students.

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

- Wording of output indicator 1.1 was revised to better describe the data reported. THET also collected data to disaggregate numbers trained by direct and indirect training types.
- THET have encouraged partnerships to improve completeness of data on gender and other demographic characteristics of trainees, developing more explicit guidance and standard training registers for the new grants. Details on the gender of people attending training course places or having other educational opportunities has improved from 69% last year to 91% this year.
- THET have improved the proportion of trainees whose skills and performance is assessed after training, from 56% last year to 59% this year.
- The health impact of the HPS will be explored as part of the external evaluation, due to take place this year.
- Milestones were amended to be more stretching.
- THET is supporting existing grant holders to collect data on the effects of training on behaviour change in health workers and on the quality of health services.

Recommendations

- DFID and THET to review and agree milestones for 2016 and 2017, by Sept 2015.
- THET to continue to support partnerships to collect good quality data on improved skills/performance post training, including reviewing grant holders' evaluation strategies and advising on how proposed methods can be improved.

Output Title	Improved and strengthened policies, protocols and curricula in participating health and health education institutions or acrss health systems.		
Output number per LF	2	**Output Score**	A+
Risk:	Low	Impact weighting (%):	25
Risk revised since last AR?	N	Impact weighting % revised since last AR?	N

Indicator(s)	**Milestones**	**Progress to 30 April 2015**
2.1 Number of national and institutional health strategies and professional standards / protocols to which projects have contributed for development, review or update	380	410
2.2 Number of new or improved policies and professional standards approved and signed off by end of programme	285	286
2.3 Number of medical education curricula to which projects have explicitly contributed for development, review or update	88	96
2.4 Number of new and / or improved medical education curricula explicitly approved for teaching	55	46

Key Points

2.1 and 2.2. National and institutional health strategies and professional standards/protocols (2.1, 2.2)

- By April 2015, HPS partnerships contributed to the development, review or update of 410 national and institutional health strategies and professional standards/protocols (144 in this review period), exceeding the milestone of 380.
- Of these, 286 have been formally approved (88 in this review period), one more than expected.
- The four volunteering grants (VG5, VG8, VG10, VG17) contributed to nearly half (196) of the total protocols furthered by the programme, and 62% (176) of all protocols approved and signed off (2.2). This high proportion is facilitated by a high number of long-term volunteers (6 months or longer).

2.3 and 2.4. Medical education curricula

- By April 2015, partnerships contributed to the development, review or update of 96 medical education curricula (31 in this review period); exceeding the milestone of 88.
- Of these, 46 were formally approved (14 in this review period); less than the milestone of 55.
- Since the last review, THET improved reporting on indicator 2.3., asking participants to only report on the number of medical curricula that were formally approved (making it clear that this should not include curricula just achieving broad support). Using this clarified definition, nine curricula were identified as being wrongly counted as being explicitly approved in the last review. As this year's milestone was based on last year's reported results (reported as 41 instead of the correct count of 32), the 2015 milestone was set too high and therefore not reached. If the 2015 milestone had been set against the correct 2014 achievement, the milestone would have been achieved (milestone would have been set at 44, based on 50% of developed curricula being formally approved).
- The four volunteering grants have cumulatively contributed to 41% of medical education curricula developed, reviewed or updated (output 2.3); with 69% of these approved for teaching (output 2.4).

Example: MCP3: The project aims to raise the standards of midwifery education and practice by working with the national midwifery associations of Cambodia, Nepal and Uganda. The project contributed to the development of 13 protocols, including strategies for the midwifery association. The project also contributed to the development of 17 curricula, including masters and associate degrees; three of which have been approved by the Training School Medical Care in Cambodia, with the others under review.

Summary of responses to issues raised in previous annual reviews (where relevant)
Milestones were amended as recommended.

Recommendations

- DFID and THET to review and agree milestones for 2016 and 2017, by Sept 2015.

Output Title	Stronger and more institutional and country health partnerships that promote an enable mutual learning and skills and technology transfer		
Output number per LF	3	**Output Score**	A
Risk:	Low	Impact weighting (%):	15
Risk revised since last AR?	N	Impact weighting % revised since last AR?	N

Indicator(s)	**Milestones**	**Progress to 30 April 2015**
3.1 Number of new institutional health partnership Memoranda of Understanding or other formal written commitments	69	72
3.2 Number of institutional health partnerships strengthened	55	58
3.3 Number of UK health professional days spent volunteering overseas and volunteering to support the project from the UK	50,000 overseas;	48,592 overseas (29,441 female, 13,159 male, 5,992 no data)

Key Points

3.1. Number of new Memoranda of Understanding or other formal written commitments

- By April 2015, 72 new institutional health partnership memoranda of understanding (MOU) or other formal written commitments had been written (18 in this review period), against a milestone of 69.

Example: MCP3: Building on the Global Midwifery Twinning Project, the Royal College of Midwives is drafting a MOU with GIZ, UNFPA and WHO in Nepal, to formalise contributions to establishing midwifery education in Nepal. In addition to this, the Uganda Private Midwives Association has signed an MOU with Kibuli School of Nursing and Midwifery for student midwife placements in UPMA clinics, setting out how the two organisations are working together to give student midwives from Kibuli the opportunity for placements at UPMA clinics, since workplace-based training is a crucial element of midwife education.

3.2. Number of institutional health partnerships strengthened

- By April 2015, 58 institutional partnerships had been strengthened (12 in this review period), slightly above the milestone of 58.
- In order to measure this indicator, THET take information from grant holders' progress reports. Partners involved in the MCP26 grant, for example, ran a paediatric orthopaedic surgery course together in July 2014. For the new partnerships, grant holders will report on this indicator through a standardised partnership development plan.

3.3. Number of UK health professional days spent volunteering

- By April 2015, 48,592 UK professional days were spent volunteering to support HPS partnerships (17,553 in this review period), almost meeting the milestone of 50,000.
- It was expected that by this review period, all HPS projects under the original grant funding would be completed. However, 15 projects have been given extensions to finish their projects, in order to enable further collection of quality data for outcome indicator 1 and to make up for unanticipated delays. Consequently, some of the volunteer time that was expected to be counted during this review period will now be provided over the next few months.

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

- THET have begun to collect data on volunteer time invested in training remotely from the UK. This data will be reported in next year's annual review for the new grants.

Recommendations

- DFID and THET to review and agree milestones for 2016 and 2017, by Sept 2015.
- THET to collect data to enable disaggregation of volunteer time by UK volunteering time and overseas volunteering time, for reporting by Sept 2015.

Output Title	Effective and efficient grant funding and strategic management support to projects and the health partnership community by the management agent		
Output number per LF	4	**Output Score**	A
Risk:	Low	Impact weighting (%):	10
Risk revised since last AR?	N	Impact weighting % revised since last AR?	N

Indicator(s)	**Milestones**	**Progress to 30 June 2015**
4.1 The amount of grant funding disbursed within agreed timeframes	£15,795,674	£15,248,410
4.2 The percentage of timely and appropriate provision of technical assistance to grant holders and other eligible stakeholders in a 12 month period	93%	94%
4.3 Number of advocacy and communication activities undertaken by THET in support of an enabling NHS environment for overseas volunteering	160	187
4.4 Number of page views for website resource library	3,500	3,864

Key Points

- Unlike outputs 1-3, where it was only possible to obtain data up until the end of April 2015, Output 4 milestones were set to report up until the end of June 2015.

4.1. Timely grant funding dispersal

- The amount of grant funding disbursed within agreed timeframes to June 2015 was £15,248,410, against a target of £15,795,674. This slight shortfall is due to project extensions being granted for a number of existing partnerships, as explained above. Final payments (£231,922) for these grants are yet to be disbursed against the new timeframe for these grants. In addition to this, some projects have underspent against ageed budgets, THET has withheld or recovered these funds (£288,508).
- Following the two year, £10m extension to the HPS, this review period has seen the allocation of a further £5.6m across 61 grants. Almost half of these grants have been awarded to existing HPS partnerships to build on the success of their original funding.

4.2. Provision of technical assistance to grant holders

- 94% of HPS partnerships submitting progress reports during this review period reported timely and appropriate provision of THET's technical assistance to grant holders and other eligible stakeholders in a 12 month period, just above the milestone of 93%.
- This was calculated using results from 9 progress reports from ongoing projects, plus anonymous online survey results from 17 partnerships who finished their projects during this reporting period.[2]

Comments from health partnerships regarding THET's performance included:

- *'The accessibility of HPS support staff, and the attention given to the needs of the projects, grant-holders and volunteers is extremely impressive and very much appreciated.'*
- *'The THET team is very responsive and sympathetic to problems encountered and above all ready to provide viable solutions.'*
- *'I think THET did a very good job and provides very well co-ordinated support and funding. We were also given some very useful help with transferring funding and obtaining visas.'*

[2] From these results, (a) 22 (85%) rated THET's performance as satisfactory/excellent in all all areas where they expressed an opinion; (b) 2 (8%) rated THET's performance as satisfactory in 4/5 of areas that they were asked to rate and 1 (4%) rated their performance as satisfactory in 3 /4 areas where they expressed an opinion; and 1 (4%) rated their performance as largely unsatisfactory / poor. The final score was calculated as follows: (a) 85% + (b) 4/5 x 8% + (c) 3/4 x 4% = 94%.

Several health partnerships suggested improvements to reporting templates which THET have done. THET are also looking into a resource pack for long term volunteers, after feedback from partnerships.

4.3. Advocacy and communication activities

- 187 advocacy and communication activities were undertaken by THET in support of an enabling NHS environment for overseas volunteering, exceeding the milestone of 160 (55 in this reporting period).
- Activities have included presenting at the Exporting Healthcare conference on 'Training and education: up-skilling the global health workforce' in March 2015 and writing an article for Cancer Control entitled 'Building Training Partnerships in Cancer for LMI countries' in June 2015.

4.4. Page views for website resource library

- There were 3,864 page views to THET's resource library which exceeded the milestone of 3,500 (1,114 in this reporting period).
- Page view rates accelerated in the last part of the review period, believed to be due to the quantity and quality of THET's recent publications. THET will be maintaining their publication schedule in future, and consequently it is recommended that more challenging milestones are set for subsequent review periods.

Summary of responses to issues raised in previous annual reviews (where relevant)
Last year's recommendation recommended removing outcome indicator 4.4. However, after further discussion, it was agreed to instead amend the indicator, recognising that it measured a significant strand of THET's work. The indicator was revised to measure the level of engagement specifically with THET's online resources, rather than visits to THET's website more generally.

Recommendations

- DFID and THET to amend milestones for Output 4 indicators so that they report to the end of April 2016, in order to align with the milestone dates for the rest of the programme's outputs, by September 2015.
- DFID and THET to agree increased milestones for Output 4.3 and 4.4, reflecting the strong performance in this review period, by September 2015.
- DFID and THET to agree a method to consistently measure Output 4.2. over the remaining two years, by September 2015.
- THET to look at options for providing a basic resource and advice pack for long term volunteers, to be ready by October 2015.
- DFID and THET to agree method to consistently measure timely and appropriate provision of technical assistance to grant holders/stakeholders over the next two years, by Oct 2015.

D: VALUE FOR MONEY & FINANCIAL PERFORMANCE (1 page)

Key cost drivers and performance
Aside from the grants themselves, the largest costs continue to be staffing; travel; and communication and engagement. There have been no significant fluctuations in either salaries or the level of staffing required to deliver activities. An increased workload in 2014/15, due to allocating new grants and managing existing programmes, has been managed well within existing staffing levels. Consultant costs fell steeply in this review period (£15,801 between July 2014-June 2015, compared with £137,603 in July 2013-June 2014[3]), as the contract with consultants under the original HPS came to an end and was not carried forward into the extension. THET staff accounted for 11% of total costs this year (July 2014-May 2015), which reflects the complexity and range of activities undertaken. Grant management and monitoring & evaluation are significant areas of activity, with a high level of interaction with grant-holders and the wider health partnerships community. Communications, and particularly the creation and dissemination of resources, are labour-intensive activities. THET also invest time in non-grant areas of HPS, such as advocacy and engagement with the UK health sector to create an enabling environment for partnerships to thrive, and to work towards overcoming barriers to volunteering within the NHS.

[3]HPS programme years run from July-June.

Travel costs were significantly lower in this review period compared to the last (£19,641 between July 2014-May 2015, compared with £42,597 in 2013/14), due to fewer trips rather than significant changes in key cost drivers. Where possible, THET try to undertake overseas monitoring visits on a regional basis, in order to reduce the frequency and cost of travel. Due to increased activity, communication and engagement costs increased substantially in this review period, compared to last (£93,552 between July 2014-May 2015, compared with £51,737 in 2013/14).

Within the grants, the largest costs continue to be travel and training/capacity development, usually accounting for 50-60% of grant funding. Aside from the long-term volunteering grants, most health partnerships deliver activities through a series of short term visits and therefore factors affecting the price of travel and accommodation are key cost drivers. Training and capacity development costs include venue hire; refreshments; trainee travel and accommodation costs; and materials/resources. Grant holders are sometimes affected by exchange rate fluctuations but this has been managed without having an impact on programme delivery.

VfM performance compared to the original VfM proposition in the business case

The original project memorandum did not include measures of value for money. Last year's annual review recommended that further work was needed to agree an appropriate set of VfM indicators for HPS. Since then, DFID have requested that partnerships report on the cost per health worker trained and cost per training day per health worker. Where two or more health partnerships/training activities have taken similar approaches, with similar benefits, their unit costs will be compared. Where it is possible to find other training providers offering similar results, comparative costs will also be presented. Evaluating the VfM of work to strengthen institutions, strategies and professional standards is challenging, with no clear methodology to enable a robust assessment of DFID's contribution to system changes. DFID will work with THET this year to explore the feasibility of collecting this information through case studies.

THET have undertaken a number of pilot studies, to understand the cost per health worker trained for eight partnerships (see Table 1), with a view to standardise data collection going forward. Due to a number of factors (including the type and duration of training and number of trainees), the costs per health worker trained varied significantly between the eight partnerships (between £193 and £5,807 per health worker trained). Although comparing programme approaches is challenging, due to the diversity of projects, there are some partnerships where meaningful comparisons can be made. This includes the six workshops held for midwives under the MCP2.02 partnership, which is working across different countries (see Table 1). The most signficiant cost variable in these workshops was the number of midwives who attended the training, as the costs for each course were fairly similar. THET are assessing whether meaningful comparisons can be made between other partnerships. In addition to this, THET will be assessing the value of volunteering time leveraged, providing data on the cost savings that the health partnership approach achieves through the use of volunteers, compared to using paid staff/consultants. They will report on their findings by the end of September 2015.

Table 1. Unit cost of training
(Excludes project management costs unless stated).

Partner-ship	Learning outcome	Length	Number trained	Cost per worker trained	Cost per training day per health worker
LPIP32	Certificate in CAMH assessment and management	1 year	23	£1,915	N/A
LPIP32	Diploma in specialised CAMH care, including training as trainers	1 further year	13 of the 23 above	£3,825*	N/A
MCP26	Primary Trauma Care knowledge and skills	2-3 days	1,849	£193	£97 per day per worker
MCP26	Specialist orthopaedic knowledge and skills	4 days	126	£856	£214
MCP26	Improved orthopaedic surgery skills through experience and mentoring	1–6 months	36	£5,807	N/A
MCP1	Paediatric emergency triage and treatment skills	5 days	556	£833	£167
MCP2.2	Understanding of critical analysis of research and practice	4 days	17	£572* / £519	£143* / £130
		4 days	20	£486* / £441	£122* / £110
		4 days	18	£574* / £521	£144* / £130
		4 days	17	£691* / £627	£173* / £157
		4 days	12	£897* / £815	£224* / £204
		4 days	20	£615* / £559	£154* / £140
LPIP3	Management of surgical emergencies and training of trainers	6 days	15	£3,658* / £3,463	£610* / £577

* = includes project manaement costs. Project management costs are calculated as a proportion of the total project management costs for the period equal to the proportion of the non-project management costs that was used in the training.

NB. Training costs include direct training costs (e.g. venue, training equipment and supplies, refreshments), travel costs for trainees and trainers and MEL costs directly linked to training activities. This pilot tested different methods for calculating unit costs for different partnerships.

Economy

- THET and grant holders continue to obtain competitive quotes, including charity fares where possible, and book as far in advance as feasible, to ensure the most economical use of funds. Partnerships are encouraged to explore remote ways of working and THET uses Skype as a means of communication with grant applicants/holders to reduce travel costs.
- To keep costs low, the overseas partner institution is used as a venue where possible and travel and accommodation is booked centrally as much as possible to limit the need to reimburse trainees.

Efficiency

- THET tracks performance through regular communication with programmes and formal six monthly reports to ensure that funds are put to best use.
- A number of partnerships are implementing standardised training that is recognised as an efficient way to deliver training (see Section B for an example of this: partnership MCP1).
- Partnerships aim to align their work with wider government strategies. THET are beginning to collect more information on this which will be available for next year's review. As one example MPIP 2.48, is supporting the development of national chronic disease guidelines in Ethiopia.

Effectiveness

- The programme is performing well against the logframe, delivering against expected outputs.
- 91% of tested trainees showed improved skills or performance immediately after training/education.

Equity

- There is gender equity in those attending training/educational opportunities and the proportion who show improved skills or performance immediately after training/education.

- 40 out of 86 of the partnerships report that their project serves rural populations.

THET has commissioned VfM analysis of three health partnerships. The reports will contribute to ongoing assessment of VfM and provide important lessons for future project implementation.

The analysis has led to several actions. Many of these mirror changes that THET have made to their grant selection and management processes for the newly funded HPS grants and more data will be available prior to the next annual review. THET now require that partnerships report quantitative benefits data more clearly and comprehensively, with a focus on changes in health worker performance. They are also looking at ways to amend partnership financial reporting templates to facilitate cost analysis of specific activities, as outlined above.

Assessment of whether the programme continues to represent value for money
Based on the information available, the HPS continues to deliver good VfM. THET continues to work with partners to ensure efficient and effective project implementation. There is a strong focus on cost saving, and gender equity within training /education opportunities. Further work on VfM in the upcoming year will enable DFID to further understand the VfM that this partnership approach brings.

Quality of financial management
Of the £30million, 6 year project budget, expenditure stood at around £20.1 million at the end of May 2015, which represents approximately 67% of the total budget. At this stage of implementation, it implies that financially the programme is largely on-track, i.e. 4 years into the 6 year programme is 67%. The slight short-fall in spend for this reporting period (see Output 4 above) will be addressed by October 2015 with final rounds of grant funding underway.

During the review period, some challenges have occurred with forecasting due to prolonged contract review negotiations with DFID, and some new grants for UK statutory bodies being delayed until ministerial approval was obtained for them to engage in international development activities overseas. These issues aside, THET have proactively addressed and maintained accurate forecasting.

Future costs against the current approved budget on UK and international travel has reduced as a result of use of telephone and Skype for routine grant holder communications. However, communication and engagement costs have exceeded the budget given the increased production of resources, particularly around medical equipment.

All financial reporting and invoices over the review period have been submitted by THET in a timely manner and have been accurate. Expenditure reports and invoices are scrutinised and reconciled against the contract budget before payments are made.

DFID are in discussions with THET to further strengthen the format and frequency of narrative reporting.

Menzies LLP, Tavistock Square, London, independently audited THET's accounts for 2013. The audit report, submitted to DFID July 2014, clearly accounts for DFID funds and expenditure for each HPS grantee and the financial statements were found to be true and fair.

Furthermore, during a recent visit to THET's offices, the DFID HPS Project Officer undertook a 'light-touch' audit of THET's internal financial systems and assets (reviewed two grant payments, international and UK travel, internal THET meeting costs, and asset check). Financial systems, vouchers, records and assets were found to be accurate and in good order.

Date of last narrative financial report	24th April 2015
Date of last audited annual statement	Year end Dec 2013 Received July 2014

E: RISK (½ page)

Overall risk rating: Low risk to successful delivery of the project logframe outputs.

Overview of programme risk
There has been no change to the overall risk environment since the last review.

Review of programme level risks is a standing agenda item at THET's fortnightly Grants Management Group meeting. Alongside the programme level risk matrix, the Group maintains a RAG-prioritised register of all grants. 'Red' grants, and those failing to improve, trigger a case review and plan of action. If severe, cases are notified to the Board and reported upon at Board meetings until satisfactory risk mitigation has been achieved. This process has been implemented once during this review period, when there was an unfounded allegation of corruption relating to an overseas partner.

Other risk management measures which have continued throughout this review period include regular reporting and UK and in-country financial verification visits and audits. THET have improved the grant giving process which will further mitigate against risks for the new grants, incorporating lessons from the original phase of the HPS. This includes one-to-one conversations with applications to discuss proposals in more detail; more focussed monitoring and evaluation support at pre and post selection stage; partnership assessments for all shortlisted applications and organisational due diligence assessments for grants over £100k; and using internal reviewers in addition to external reviewers and technical assessors to comment on the clinical validity of each application.

THET have recently undertaken a duty of care review, looking at the measures they have in place to ensure that grant holders are aware of their responsibilities and adhere to robust policies and procedures in relation to volunteer and staff management. A self-assessment questionnaire was completed by all ongoing grant holders to capture any areas of concern or where additional support might be required, and THET are working with grant holders to address these.

Key programme risks and mitigation are:

- Lack of interest from health partnerships to apply for funding linked to the complexity of qualifying for grants. For partnerships with lower capacity, THET delivers pre-application webinars and provides clear guidance and tailored support to applicants.
- Lack of interest from UK volunteers or barriers to entry. This is effectively addressed through the grant making process and through THET's advocacy activities.
- Projects are not effective due to health partnership capacity. Enhanced grant making processes ensure more support is provided at project inception. Ongoing support is provided alongside, and in response to, routine monitoring of partnership progress and expenditure.
- Security issues for volunteers. THET supports grant holders to ensure that duty of care and security measures are in place.
- Projects are not able to finish before the end of the HPS. THET will work closely with grant holders in advance of end dates to ensure that all activities are delivered on time.
- Multi-partnership arrangements and complex governance structures create challenges in effective accounting for DFID funds. DFID are working with THET to ensure that all organisations receiving DFID funds have in place robust financial systems and processes, fraud and bribery prevention policies, and procurement policies.
- Assumptions of programme not being valid. This includes the assumption that health services are accessible and appropriate to target populations; UK volunteers are able to make use of their experiences in a UK health setting; and that health workers support change and have the capacity to adopt improved practices. The external evaluation that is currently being commissioned will examine these assumptions in more detail.

Outstanding actions from risk assessment
There are no outstanding actions. Financial risk and fraud are considered low as a result of THET's rigorous grant award and management processes, as described above. The HPS undertakes minimal procurement. DFID monitoring visits have verified the adequacy of THET's financial management processes and systems, record keeping, and adherence to internal controls and approval processes.

Payments are monthly in arrears against detailed expenditure reports. There has been no identifiable financial loss due to fraud or corruption.

F: COMMERCIAL CONSIDERATIONS (½ page)

Delivery against planned timeframe
In April 2014, an extension of the HPS was announced, providing an additional £10 million for another two years. Time frames and annual budgets have been amended to reflect this extension, and as a result of the associated contract negotiations that took longer than anticipated.

Performance of partnership
The partnership between DFID and THET, and THET and HPS grant holders is strong.

Regular meetings, both formal and informal, are held between THET and DFID staff. These interactions not only ensure that project management issues are addressed as they arise, but also help to develop thinking relating to the effectiveness of the partnership approach in workforce development.

THET continues to maintain good relationships with grant holders (discussed under Output 4). Minor alterations have been made to the contract for new grants awarded under the HPS extension, to further clarify responsibilities and expectations around some aspects of monitoring & evaluation, financial management and staff/volunteer duty of care. These are discussed with each UK lead partner at the grant inception meeting to ensure a shared understanding from the outset.

THET staff engage on a regular basis with opinion-formers in many different contexts. Membership of the NHS International Health Group, and co-chairmanship of the NHS International Volunteering Group, for instance, have led to the development of policies designed to strengthen partnership working and the removal of barriers to international volunteering within the NHS. At a global level, THET chair the Global Group for Health Partnership, a coalition of key stakeholders made up of THET, WHO, the International Hospital Federation, the European ESTHER Alliance and the American College of Healthcare Executives. THET also has observer status on the European ESTHER Alliance.

DFID country offices are informed about all new HPS grants operating in their respective countries.

Asset monitoring and control
THET purchased office equipment in 2012 and 2013 with HPS funding, which is recorded in THET's asset register, adjusted to reflect the portion of assets attributable to HPS. All assets are assigned serial numbers and labelled. They are depreciated over three years using the straight line depreciation method. Assets are located in THET's office which is accessed by code locked door with closed windows reinforced by iron bars. The office is within a secured building with 24 hour security. Assets deemed to be at the end of their useful life will be disposed of by IT Green to comply with the WWE Directive ensuring hard drives are wiped and shredded. A spot check of assets was undertaken by DFID in June 2015: all assets that DFID purchased were identified.

G: CONDITIONALITY (½ page)

Update on partnership principles (if relevant)
N/A.

H: MONITORING & EVALUATION (½ page)

Evidence and evaluation
The HPS is founded on the assumption that the partnership model used by the Scheme is an effective method to strengthen health systems. The information collected as part of the logframe has generated data to support this assumption but lacks the level of detail required to fully understand what each partnership is achieving. Wherever possible, data about health workers is disaggregated by gender and cadre; information on health services/strengthening is disaggregated by health theme and level of

healthcare; data about health institutions is disaggregated by population served; and information on patients is disaggregated by gender.

The fact that the partnerships are diverse in geography, health theme, activity, approach, scope and more, means that pulling meaningful conclusions from the aggregated data is challenging. For example, 'number of training course places or other educational opportunities' might include Malawian midwives mentored over a six month period; Sierra Leonean nurses who have had a day's training on hand hygiene; and Indian doctors on one month surgical placements. However, there is a great amount of information available in individual progress reports, as well as case studies by consultants, that detail the many achievements of individual health partnerships. These achievements have also been highlighted during DFID's country visits.

DFID is in the process of commissioning an external evaluation of the HPS which will examine the health partnership model that has been implemented in the HPS programme. The focus of the evaluation will be on the effectiveness of the programme as a whole, plus what works and what does not work in the current programme's approach. It will also test the assumptions on which the logframe is based, including whether the HPS is reaching DFID's target population, a question which is challenging to answer in any detail, using the current data that is collected.

In addition to this, THET has commissioned King's Centre for Global Health to look more rigorously at the assumption that the partnership model provides a strong foundation for health workforce strengthening activities, as part of a three year research project that began in January 2015.

Monitoring progress throughout the review period

Project monitoring and support meetings take place with all grant holders every quarter, either face to face or over the telephone, which follow up on quarterly reporting.

THET visit all grants over £250k at least once in their lifetime for monitoring and audit purposes. In practice, some multiple country partnerships will be visited more frequently. During this review period, there were:

- 3 financial monitoring visits and attendance at the annual conference of the Kenya Hospice and Palliative Care Association in Nairobi, Kenya (MCP 1, MCP29, MCP2.2 & MCP2.10).
- 2 financial monitoring visits and 2 project visits in Malawi (MCP26, VG17, LPIP58, D9).
- Project visits to projects in Zambia with DFID (MEG3, MPIP2.59, LPIP3, LPIP15).

As part of the annual review process, DFID and THET visited a number of HPS projects in Uganda (D26, MCP1, LPIP6, MPIP14/A33, LPIP32/A2.8, MCP26); also meeting a number of their UK partners. These visits confirmed what is reported in this annual review, highlighting the many achievements of the partnerships. Projects were strategic, engaging local and national government; health system and health impacts were evident; and the partnership approach was highly valued. A common lesson identified by grant holders was the importance of establishing robust monitoring and evaluation mechanisms from the outset, and clear sustainability and phase-out plans. THET are working with new grant holders to incorporate this valuable lesson.

THET has used a number of methods to collect feedback from stakeholders during this review period:

Overseas partners survey: 78 overseas partners were asked to complete a survey about their partnership. Of the 20 overseas partners who completed the survey:
-19 reported their partnership had a shared vision (1 did not know).
-19 reported that their partnership had developed and used clear communication channels (1 disagreed).
-15 reported that their UK partners listened to their ideas and needs, with 4 feeling this to some extent (1 disagreed).
-10 reported that the project planning and management was completely equitable, with 9 reporting it was sometimes equitable and 1 reporting it was not equitable.
-14 reported that the project implementation was equitable, 5 reported it was sometimes equitable and 1 reported it was not equitable.
THET continue to work with grant holders to encourage and support equity between partners. Based on feedback from the survey, they are also making their online project management resources more

accessible to developing country partners by creating lower-res versions for easy downloading when bandwidth is low.

Returned Volunteer survey: A survey was sent out to 554 UK volunteers to assess the impact of their volunteering experience on their performance at work in the UK. 179 (12% of all volunteers) completed the survey, of whom 53 reported that they had discussed their volunteering experience in an annual appraisal with a manager or equivalent, and 126 had self-assessed their volunteering experience. Of the 53 health workers appraised, 30 (57%) reported that both themselves and their appraiser recognised significantly improved performance in at least one competency area, and 48 (91%) reported slightly or significantly improved performance in at least one competency area. 27 (51%) felt that their appraisal did not recognise the full effect of their volunteering experience on their competencies. Of the 126 health workers who self-assessed the impact of volunteering on their performance, 94 (75%) reported significantly improved performance in at least one competency area, and 123 (98%) reported slightly or significantly improved performance in at least one competency area. The survey has now been published by Health Education England (HEE) as part of the *Toolkit for the collection of evidence of knowledge and skills gained through participation in an international health project*.

THET have written and commissioned several case studies during this review period, including:

- 'Tailored volunteer support' (published on THET website).
- 'Good practice in monitoring: Wessex-Ghana Stroke Partnership' (published on THET website).
- 3 Value for money case studies (see VFM section above; to be published on THET website).
- 5 case studies to illustrate the Principles of Partnership, including 'Assessing needs to create effective plans'; 'Recognising health system challenges'; and 'Developing a respectful partnership (to be published on a dedicated Principles of Partnership website).

Other studies THET have undertaken or commissioned during the review period include:

- An information resources review, to clarify the extent to which THET's current information resources psupport practitioners to run more effective health Partnerships, and identify what additional information resources may be needed (includes input from developing country partners). The review found that awareness of THET's resources can be improved particularly in developing countries. Those who are aware of the resources use them reasonably well and rate them highly, although the more mature health partnerships are beginning to look for more advanced material. The review identified particular topics and resource formats of interest to developing country partners, and made some strategic and operational recommendations, which we have been putting into practice.
- Technology for effective partnership collaboration (includes input from developing country partners; published on THET website).
- A guide to fundraising (in publication).
- A resource on proper medical equipment management (to be published).
- THET is editing a special series in the journal Globalization and Health: 'What role can health partnerships play in addressing the disparities that exist in the availability of trained health personnel globally?'

This review was carried out by Katy Scammell, Health Adviser, with support from Mary-Ann Taylor (HPS Senior Responsible Officer/Programme Management Adviser), Peter Clarke (Policy and Finance Officer), Iain Jones (Deputy Team Leader/Economic Adviser) and Damon Bristow (previous HPS Senior Responsible Officer/Team Leader). The Human Development Department's Programme Review Group reviewed the draft. Jane Edmondson (Head of Human Development Department) approved the final version.

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 ongoing 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