



Department
of Health &
Social Care

International Health Regulations Strengthening Project Annual Review

Global Health Security Programme

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Clearance Checklist

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Abbreviations and acronyms

AAR	After Action Review
Africa CDC	Africa Centre for Disease Control
AMR	Antimicrobial resistance
BMGF	Bill and Melinda Gates Foundation
DAI	Development Alternatives, Inc
DEFRA	Department for Environment Food and Rural Affairs
DFID	Department for International Development
DHSC	Department of Health and Social Care
DRR	Disaster Risk Reduction
EBS	Event Based Surveillance
EOC	Emergency Operations Centre
EPRR	Emergency Preparedness, Resilience and Response
FCO	Foreign and Commonwealth Office
FETP	Field Epidemiology Training Programme
GHS	Global Health Security
GOARN	Global Outbreak Alert and Response Network
HMG	Her Majesty's Government
HMT	Her Majesty's Treasury
IANPHI	International Association of National Public Health Institutes
IATI	International Aid Transparency Initiative
ICAI	Independent Commission for Aid Impact
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
AAR	After Action Review
Africa CDC	Africa Centre for Disease Control
ISA	Institutional Stakeholder Analysis

International Health Regulations Strengthening Project

JEE	Joint External Evaluation
LMIC	Low and middle-income countries
MOU	Memorandum of understanding
NA	Not applicable
NCDC	Nigeria Centre for Disease Control
NIS	National Infection Service
NPHI / NPHA	National Public Health Institution / Agency
ODA	Official Development Assistance (UK aid budget)
OECD	Organisation for Economic Co-operation and Development
OIE	World Organisation for Animal Health
PHE	Public Health England
QA	Quality Assurance
RCDC	Regional Centre for Disease Surveillance and Control (West Africa)
SEARO	South-East Asia Regional Office
SOP	Standard Operating Procedure
SWOT	Strengths, Weaknesses, Opportunities, Threats
TDDAP	Tackling Deadly Diseases in Africa Programme
TORs	Terms of Reference
USCDC	United States Centres for Disease Control and Prevention
VFM	Value for money
WHO	World Health Organisation
WHO AFRO	World Health Organisation Regional Office for Africa
WB	World Bank
ISA	Institutional Stakeholder Analysis
JEE	Joint External Evaluation
LMIC	Low and middle-income countries

Introduction

Outline of programme

In the last spending review the Global Health Security (GHS) team was given £477m of UK Official Development Assistance (ODA) funding to develop projects in and for Low and Middle-Income Countries (LMICs), with the aim of contributing to a 'world safe and secure from infectious disease threats and promotion of Global Health as an international security priority.' This accounts for 34% of total Department of Health and Social Care (DHSC) ODA funding. The programme is made up of five projects; Fleming Fund, Global Antimicrobial Resistance Innovation Fund (GAMRIF), UK Public Health Rapid Support Team, International Health Regulations Strengthening project and Vaccines Project. Through delivery of each of these projects the programme aims to support ODA eligible countries to:

- prevent and reduce the likelihood of public emergencies such as disease outbreaks and antimicrobial resistance (AMR);
- detect health threats early to save lives; and
- provide rapid and effective response to health threats.

Outline of project in relation to the programme

PHE's IHR strengthening project is a £16m Official Development Assistance (ODA)-funded project (2016/17-2020/21) designed to support a selection of vulnerable countries to better prevent, detect, assess and respond to public health incidents through the building up of public health technical capabilities to enhance compliance with the requirements of the International Health Regulations (2005) (IHR).

The funding for this project enables PHE's already internationally-renowned scientific and technical capability to be mobilised for increased international engagement, significantly scaling up UK capacity to respond to demand for support on IHR. Specifically, the project provides targeted support to five countries (Ethiopia, Nigeria, Sierra Leone, Pakistan and Myanmar) at a bilateral level. The project also works with WHO country and regional offices, Africa CDC and other multi-lateral institutions in order to reach countries that may otherwise be neglected in terms of donor support. This will strengthen regional resilience networks for prevention, detection and response to future outbreaks.

International Health Regulations Strengthening Project

The programme aims to support the establishment of strong national public health systems to lead and coordinate timely and effective prevention, detection, response and control of public health threats.

In all its activities, the IHR project aims to increase access to technical expertise, develop a dedicated capacity to support strengthened international, regional and country level capabilities, create standard operating procedures and protocols for disease outbreak and increase resilience and response capability through training, supervision and mentoring.

This will be achieved through technical partnerships, knowledge exchange, system development, and to achieve sustainability, through linking IHR requirements to strengthened health systems. The project aims to develop sustainable institutional linkages, long term partnerships and professional relationships at country and regional level. These will build the foundation of global health security networks to enhance national and global health security.

This review covers the design phase (November 2016 – December 2017) and the first three months of implementation (January – March 2018).

Outline summary of project's last year annual review

1.	Project Management	N/A
2.	Finance	N/A
3.	Theory of Change	N/A
4.	External Engagement	N/A
5.	Overall RAG rating for reporting period	N/A

This is the first annual review for the International Health Regulation Strengthening Project.

Key successes

- Six detailed, standardised and multi-disciplinary scoping missions successfully conducted between January and March 2017 in order to build relationships with key stakeholders, assess needs/gaps, and provide the evidence base for the project's outline business case. This was followed by a one-HMG approach to the options appraisal process involving DHSC, DFID and DEFRA, to select the intervention countries
- An evidence-based and collaboratively developed business case submitted to deadline and approved by Minister for Public Health and HM Treasury (May 2017). This was supported by an M&E Framework developed in partnership with academics from UCL.
- A two part Institutional Stakeholder Analysis conducted to identify key stakeholders, define project risks and determine potential partnerships to ensure project sustainability.
- Five detailed and consultative technical country assessments conducted in order to collaboratively develop project implementation plans. These plans have been shared and agreed with Phase One countries and with Africa CDC and WHO AFRO. An MOU signed between PHE and Nigeria CDC, and has been shared with Ethiopia Public Health Institute.

The support we have received from our partners including PHE, has been instrumental in no small measure to the successes and progress we have achieved over the past year. [Email from NCDC CEO to PHE CEO, 24.12.18]

- Trusting and transparent relationships developed with key stakeholders within PHE, across wider HMG, WHO (HQ and AFRO), Africa CDC and with in-country partners. This has included working across HMG to ensure alignment on global health security initiatives, such as the Tackling Deadly Diseases in Africa Programme and the Fleming Fund.
- Eight full time project team members successfully recruited including country leads for Nigeria, Sierra Leone and Ethiopia, and the establishment of well-functioning project management systems, including monitoring and evaluation.
- A number of early successes achieved with implementation phase including:

- Ethiopia Public Health Institute provided with toxicology training materials and access to a key clinical toxicology database.

...Fantastic progress so far. We have already set up the poison information centre and will start the test by next week. Your positive energy already gave us power... you deserve millions of thanks for arranging this opportunity [Email from St Peter's Hospital Ethiopia 15.03.18].

- Nigeria CDC supported in the creation of Emergency Response Concept of Operations.
- Nigeria CDC supported to establish a roadmap towards a National Action Plan for Health Security following the JEE in 2017
- Nigeria CDC supported in the development of its AMR action plan and surveillance strategy and guidelines
- Technical expertise provided to inform HMG involvement in Nigeria's Lassa fever outbreak
- Support provided to Sierra Leone's Ministry of Health and Sanitation to employ a local laboratory manager in order to train and sustain other local laboratory staff.

Project Management

Delivery confidence assessment

Risk Rating: Amber/Green (Medium/Low)

Risk revised since last annual review: N/A

1. Evidence of managing the delivery of project

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
	Amber	Amber	Amber	Amber	Amber	Amber	Amber/ Red	Amber

Overall delivery RAG rating over the reporting period: Amber

Key Points:

The IHR project has delivered consistently and effectively over the past 15 months, despite contending with internal process delays (recruitment, procurement), external factors (e.g. elections, humanitarian crises) and the complexities of setting up a new project.

The IHR project team uses the following delivery management tools:

- an active risk register, reviewing risks and mitigating actions monthly
- a weekly team ‘priority setting’ exercise to set the weekly agenda and highlight upcoming activities/risks. This is accompanied by a weekly team meeting to highlight any risks
- monthly reporting of key activity, risks and forward look to PHE’s Head of Global Programmes
- monthly monitoring meetings between technical teams and project manager to track progress against the project log-frame
- monthly reporting of key activity to the GHS programme board
- quarterly reporting of key activity to the IHR Project Board
- quarterly meetings of the IHR technical working group, to provide a forum for updates, discussion and opportunities for cross-cutting activities across the project.

2. Evidence of meeting milestones/deliverables

Key Points:

This review covers a 15 month period:

- 12 months of 'design phase', which included the development of the project theory of change and log-frame amongst other phase deliverables
- 3 months of implementation, against the project log-frame.

Overall, the project has made good progress against its milestones. The deliverables set out for the design phase were achieved, and during the first three months of implementation, a number of activities have been conducted against the log-frame.

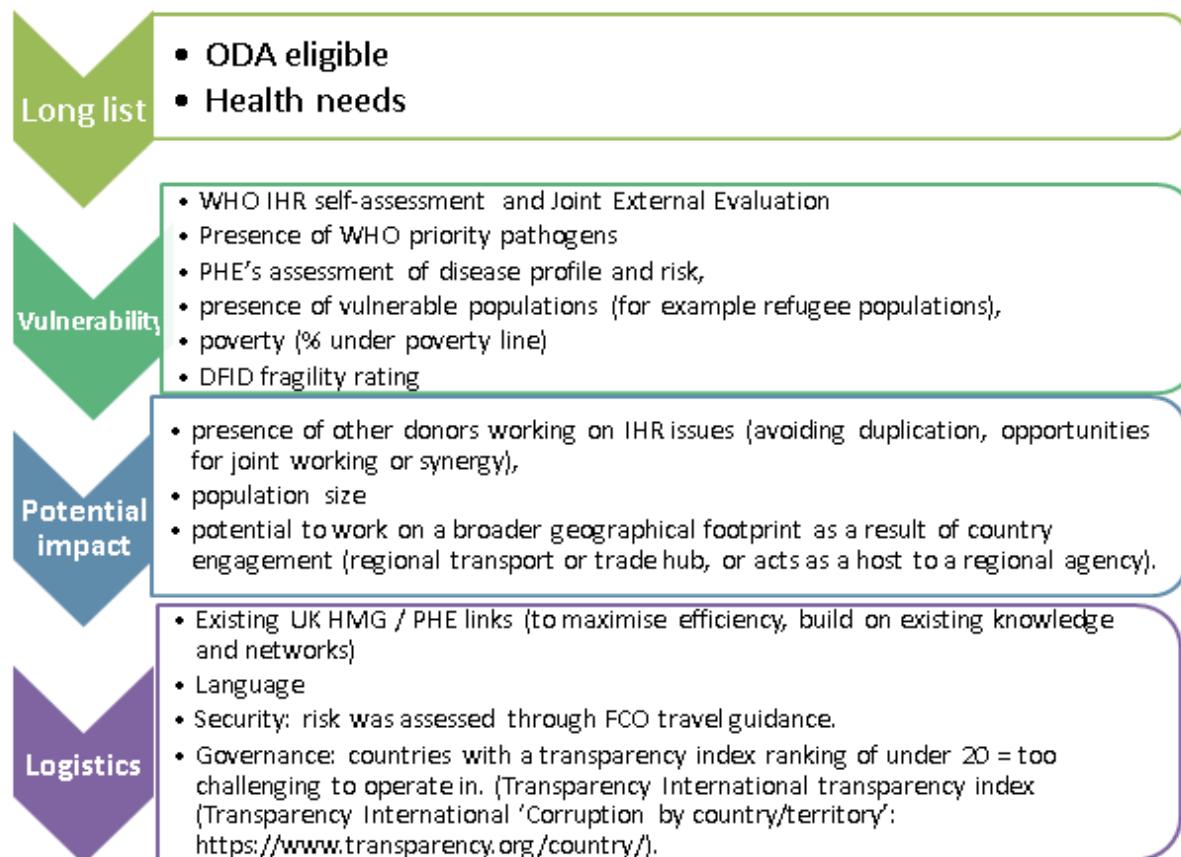
The project was slightly behind schedule early on during the design phase due to delays in receiving Programme Board approval of the business case. This had a knock-on effect on the recruitment of the project team, the delivery of early objectives and most significantly, on project spending (see section 2). However, once the project management team was in place (November/December 2016 – January 2017) the project was able to make rapid progress and submit the full business case within the pre-set deadline.

Design phase (November 2016 – December 2017):

A number of objectives for the Design Phase were identified in the first business case that went to the Department of Health in November 2016. These were to:

1. Identify focal countries for the IHR strengthening programme, and
2. Define the costs and benefits of different approaches to conducting IHR strengthening.

In the early stages of the design phase, the project team took a stepwise approach with to progressively assess and filter countries to be included in the project based on a series of qualifying criteria. The process is summarised in the diagram below:



Between December 2016 and February 2017, the IHR team focused on in-depth assessment of the suitability of the shortlisted countries for the proposed intervention, taking a systematic approach to endure an evidence-based, transparent and consistent final selection process.

This involved designing a country assessment approach and templates, seeking and developing political and technical relationships, and assembling multi-disciplinary groups to make the initial scoping visits to the countries. These five day scoping visits to each country involved meetings with the national public health institute/Ministry of Health, UK Government in-country presence (specifically with DFID health advisers), WHO representatives, relevant academic institutions, and with other international organisations e.g. US CDC, World Bank. The purpose of the scoping missions was to assess IHR compliance needs, existing programmes of support, and the ability of the PHE IHR project to make a difference. The process involved conducting a series of interviews and meetings to gain a deeper understanding of the following:

- national public health system (including links to animal health and agriculture – One Health);

- public health workforce and training capacity;
- political engagement;
- the status of the national public health institution;
- IHR capability – including engagement and outcomes from the JEE process;
- capability as a regional resource;
- potential for successful implementation – including sustainability and opportunities for partnerships;
- logistics, and
- opportunities/challenges and proposals for PHE engagement

Following the conclusion of scoping missions, an internal options appraisal was conducted wherein opportunities and the costs/benefits of working in each country were considered by PHE technical experts, and scored. This was followed by an external stakeholders' options appraisal where cross HMG partners could independently assess the options and advise on the project's direction. The value for money of different approaches was assessed and set out in the business case (see appendix 1. IHR Strengthening Project Options Appraisal).

3. Commission a political economy and institutional analysis of the country, regional and global disease surveillance and control mechanisms for the geographic areas where the priority countries are based.

An independent Institutional Stakeholder Analysis (ISA) was successfully procured using the DFID procurement framework in March 2017. Split into two parts, the purpose of the ISA was to better understand stakeholders in the AFRO region with influence in, or responsibility for meeting IHR responsibilities at a regional and supra-national level and to determine the potential barriers to change both nationally and regionally. This analysis was intended to demonstrate where PHE might best add value and contribute to measurable, beneficial impact for any UK-funded activity, and horizon scan for opportunities to maximise impact.

4. Work with WHO partners from the AFRO, EMRO and SEARO regional offices over the course of the design phase to explore how best to support these institutions in relation to IHR implementation.

Engagement with WHO partners has been central to the IHR project from the start. A kick off meeting was held in London with WHO HQ IHR M&E colleagues in December 2016,

with a follow up meeting between senior PHE and WHO HQ teams in April 2017. At an early stage it was decided to prioritise engagement with AFRO, as it is an important WHO region for UK government, with plans to extend positive engagement experience to EMRO and SEARO at a later stage in the IHR project's delivery. Consequently, in November 2017, PHE organised a joint DHSC-PHE-DFID meeting with WHO AFRO and HQ colleagues at the WHO AFRO head office in Brazzaville. The purpose of this meeting was to define a work programme for PHE to support the WHO Health Emergencies programme in the AFRO region, ensuring cohesion with the DFID funded Tackling Deadly Diseases in Africa programme activities.

5. Consider other assessments of in-country capacities relevant to the IHR including those of disaster and health emergency response, integrated disease surveillance and response (IDSR), national public health institution functioning, OIE standards for animal health, and related political economy and stakeholder analyses.

All scoping missions included meetings and discussions with One Health leads and relevant animal health ministries. The IHR team has engaged with APHA, DEFRA and Royal Veterinary College throughout the Design Phase. IDSR has been a core part of all IHR system strengthening considerations. World Organisation for Animal Health (OIE) Performance of Veterinary (PVS) assessments are considered through engagement in the WHO Joint External Evaluation (JEE) process, which is closely linked to the IHR project. The need to enhance access to veterinary epidemiology expertise to advice project delivery was identified and pursued.

6. Develop an implementation plan to be agreed with the relevant national governments, donors and technical agencies to ensure a coordinated approach to identified gaps and priorities.

During the design phase high-level, outline implementation plans were drafted and agreed with our in-country partners (National Public Health Institutes) following extensive discussion and consideration of the countries' existing national plans and priorities, the activities of other donors (e.g. US CDC) and the ability of PHE technical expertise to meet identified gaps.

Plans have been agreed with Nigeria and Ethiopia, are near finalised for Sierra Leone, and are in draft form for Myanmar and Pakistan (second phase countries).

7. Develop long-term strategies for sustaining the progress made and maintaining IHR capabilities, with implementation to be underway on a supportive foundation.

Developing strategies for sustainability is a core part of the IHR project log-frame and all country-specific work plans. Approaches to sustainability include building institutional capacity in the project's focal countries and regions (focusing on institutions not individuals), looking for opportunities for collaboration and partnership, and seeking future

funding sources. A core function of the Senior Health Advisor roles (in-country leads) is to establish opportunities for sustainability, such as alternate funding sources and collaborations. As the implementation phase gets underway, foresight work is planned to identify potential future risks and opportunities and ensure project sustainability.

8. Ensure a strong interim and end of programme evaluation framework for all components of the programme that ensures: empowered national public health institutes with defined roles in IHR implementation; a well-trained public health workforce with transferrable skills and prospects for long-term employment; and funding support secured for continued long-term implementation of IHR prior to the end of the programme.

A monitoring and evaluation framework for the project was developed alongside the business case, with input from academic partners at the UCL Centre for Global Health. This informed the project's theory of change (see appendix 2), and the development of a log-frame. The log-frame contains four overarching outcomes that aim to ensure:

- Strengthened system coordination and collaboration through national public health institutes in partner countries, and at Africa region and global levels
- Health protection professional workforce developed in skill-shortage areas (such as laboratory diagnosis and epidemiological surveillance) to have improved capability to detect, prevent and respond to public health threats in partner countries and Africa region.
- Public health technical systems enhanced and expanded in partner countries and regions
- Effective cross-government (UK) delivery of international public health system strengthening

The project team worked closely with the DHSC programme management team to ensure alignment with the wider GHS Programme Board theory of change.

First three months of Implementation Phase (Jan – March 2018) - Progress against log-frame:

Outcome 1. Strengthened system coordination and collaboration through national public health institutes in partner countries, and at Africa region and global levels

Outputs:

- Enhanced inter-sectoral collaborations for all-hazards health protection in partner countries.
- ‘One Health’ capacities improved through inter-sectoral coordination and collaboration at regional level and in target countries.
- Functional network of emergency operations centres and emergency response systems capable of addressing potential public health threats established, led by WHO.
- PHE technical input complementary to DFID Tackling Deadly Diseases in Africa Programme supported priorities and influence allocation of World Bank funds aligned to national strategies.
- Defined package of technical assistance for antimicrobial resistance shaping national strategy

The first three months of the implementation phase has seen good progress towards the outputs under outcome 1:

Through attendance and participation in post-JEE National Action Planning events in Nigeria, Ethiopia and Sierra Leone, PHE has provided technical expertise advice to enhance inter-sectoral collaboration for all-hazards health protection in our partner countries and improving One Health capacity through improving inter-sectoral coordination (outputs 1.1 and 1.2). For example, in January 2018, the IHR project worked with Nigeria CDC to fund and facilitate the first post JEE meeting of IHR stakeholders, to develop a road map towards full development of Nigeria’s capacity to prevent, detect and respond to public health threats. Workshop participants included the leadership and members of staff of the NCDC, the Federal Ministry of Health and its agencies, Federal Ministries of Agriculture, Environment, security agencies, partners and other stakeholders working across the broad areas. The workshop was evaluated positively by participants and Nigeria has now taken the first steps towards WHO-led national action planning for health security and is on target to complete the process within 18 months of the JEE (significantly shorter than the average timeline).

The IHR project supported and contributed to Nigeria’s Zoonotic diseases prioritisation exercise; an essential step to development an effective one health platform.

The IHR project team has also made progress towards output 1.3, by working with Nigeria and Ethiopia to define their Emergency Operation Centre needs, and plan a modular approach to building capacity and filling gaps. The Emergency Planning Resilience and Response (EPRR) team is working closely with WHO to align training and materials and to fit with EOCNET plans. In Nigeria, the IHR project team has already worked with NCDC’s Emergency Response team to develop an All Hazards Response Plan, a Concept of

Operations (CONOPS) and has re-written the Infectious Disease Outbreak Plan (IDORP) to include Dynamic Risk Assessment, Response Levels and flowcharts.

Ensuring alignment of technical activities with the Tackling Deadly Diseases in Africa Programme (TDDAP) priorities (output 1.4) has been an ongoing process from the design phase onwards. Between January and March, the detailed development of the PHE-WHO AFRO work plan has been conducted in close consultation with DFID's TDDAP team, to ensure synergy and added-value.

In January 2018, PHE funded and contributed expertise to NCDC's AMR Guidelines workshop, held in Lagos (output 1.5). The purpose of the workshop was to develop draft national guidelines for AMR surveillance and response in Nigeria. The IHR team provided guidance on anti-microbial stewardship and surveillance. As a consequence, NCDC has prioritised the promotion of antibiotic stewardship in health facilities. NCDC has also requested further input from the IHR team to develop guidelines for antibiotic stewardship in Nigeria health facilities. The IHR team's engagement has facilitated seamless engagement of other HMG projects with the NCDC, specifically the Fleming Fund

PHE's activities with Nigeria CDC have been very well received. In a message between Nigeria CDC's CEO and PHE's Chief Executive in December 2017, gratitude for PHE's efforts was noted. In particular NCDC remarked that:

'... the increasing confidence, cooperation and support from our partners including PHE, has been instrumental in no small measure to the successes and progress we have achieved over the past year. We were very pleased to welcome different PHE teams this year that strengthened our IHR, laboratory and emergency response capacities. My team at the NCDC also learnt a lot and had great feedback.'

[Email between Chikwe Ihekweazu and Duncan Selbie, 24.12.17]

Outcome 2: Health protection professional workforce developed in skill-shortage areas (such as laboratory diagnosis and epidemiological surveillance) to have improved capability to detect, prevent and respond to public health threats in partner countries and Africa region.

- Workforce needs assessments undertaken and toolkits available for workforce gap analysis.
- Workforce strategic plans developed & implemented and toolkits available for workforce strategy development.
- Public health leaders developed and mentored and capacity increased for leadership development

- Increased number of professionals field-deployable through GOARN, Africa CDC or other bilateral and national system
- 2.5 Increased number of public health professionals with shortage skills indicated by workforce needs assessments, with training capabilities increased in partner organisations

Between January and March 2018, the IHR team has started preparatory work on conducting a gap analysis of the Sierra Leone National Public Health Agency (NPHA) (output 2.1). Progress has been slower than expected due to disruption caused by the Sierra Leonean general election. However, a workshop is planned for June 2018, followed by a PHE-facilitated workforce needs assessment. This work will eventually lead to the development and implementation of strategic workforce plans and toolkits (output 2.2.).

The IHR team has sponsored a number of individuals for training in order to develop a cadre of public health leaders (output 2.3). This has included:

- Sponsorship of an NCDC staff member to attend GOARN training in Brazzaville (April 2018). (Other project countries applied but did not meet the eligibility criteria)
- Sponsorship of two EPHI / National Poisons Centre staff members to attend the Congress of European Association of Poisons Centres and Clinical Toxicologists (May 2018). Attendance at this congress is vital for developing networks for the Ethiopian Poison Centre and addressing some priority gaps in Ethiopia.
- Commissioned public health leadership development through sponsorship of three places on the Chatham House global health leaders fellowship programme, with clear criteria embedded to ensure retention of the trained leaders in the public health system if their countries.
- Selection and sponsorship of five fellows (£5k per fellow) from DFID recommended, high vulnerability, low resource countries, not already served by the IHR project (DRC, Benin, Yemen, Afghanistan and Bhutan to attend the Annual One Health Congress in June 2018. Criteria applied ensured that selected candidates would represent a wider geographical spread, gender balance and public sector focus.

Training of staff with skill shortages (Output 2.5) is the focus of the bulk of the IHR project's activities. Early steps have included: conducting training around emergency response in Nigeria, including participation in the development and delivery of a Yellow Fever simulation exercise in partnership with NCDC and West Africa Health Organisation (WAHO) in March 2018 (the first SIMEX in West Africa), the development of laboratory skills training modules in Sierra Leone, and introductions to toxicology provided to staff at the Ethiopia Public Health Institute.

Outcome 3: Public health technical systems enhanced and expanded in partner countries and regions

- Operationalisation of effective emergency preparedness, resilience and response systems through guideline utilisation in surveillance and laboratory settings.
- Strategy developed and operationalised for surveillance, laboratories and other health protection systems based on risk assessments of threats and capabilities
- System performance tested through exercises /simulations and/or events, with after-action reviews done and acted upon.
- Laboratory systems enhanced and quality assured, with capacity increased for laboratory QA, and laboratory networks strengthened
- Strengthened systems for detection and response to chemical-toxicological public health incidents

Initial work has begun on developing/strengthening guidelines and strategies for surveillance and laboratory diagnostics (outputs 3.1 and 3.2), and improving emergency response systems in Nigeria. To date this has included conducting a detailed needs assessment and plan for capacity building; identifying and specifying an outbreak case management tool to meet NCDC needs; supporting implementation of AMR surveillance; planning for surveillance review of event based surveillance; participation in laboratory diagnostics workshop for Lassa Fever; and planning for an e-surveillance workshop (to be held in May 2018).

Work has started on developing expert trainings for Nigeria and Sierra Leone on laboratory system enhancement, quality assurance and lab networks (output 3.4). In Sierra Leone, the IHR project has supported the employment of a national molecular laboratory network manager to support the Government of Sierra Leone to maintain the laboratory system developed after the Ebola outbreak (by the DFID-funded, PHE delivered, Resilient Zero project).

In Ethiopia, activities to strengthen systems for the detection and response to chemical-toxicological incidents began in February 2018, including scoping for the development of a poisons centre (output 3.5). PHE's efforts have been highly appreciated. Following a technical visit the Chief Executive of St Peter's Hospital, Addis Ababa, commented:

'... It's really a fantastic progress so far. We have already set up the poison information centre and will start the test by next week. Your positive energy already gave us power... you deserve millions of thanks for arranging this opportunity.'

[Email: 15.03.18]

Outcome 4. Effective cross-government (UK) delivery of international public health system strengthening

- Timely procurement through government systems
- Effective contract management
- Timely financial reporting, budget forecasting and reconciliation
- Effective robust monitoring and evaluation system
- Effective collaboration across UK government global health security programmes

The IHR project team has worked in partnership with DFID in the UK and in the project countries to ensure that the IHR activity is synergistically linked to health system strengthening activity led by DFID, in country and through the WHO. In addition, the IHR project has collaborated with the Fleming Fund, sharing resources and intelligence to enhance the impact of HMG activities and demonstrating value for money.

The project management team has successfully procured both expert advisory services (e.g. the ISA and expertise to conduct an IHR indicator development project) and a delivery service (a global health fellowship scheme, and provision of logistical support for Nigeria and Ethiopia) through government procurement systems (output 4.1).

The project management team has maintained timely reporting to DHSC governance systems, and has endeavoured to provide accurate budget forecasts (output 4.3). This is covered elsewhere in this review (section 1 and 2).

The project team has made excellent progress towards establishing an effective and robust M&E system (output 4.5). This has included developing an M&E framework, theory of change and logframe in consultation with an external academic partner (UCL), DFID and DHSC. In addition, a 0.5 FTE M&E lead has been recruited specifically to support the collection and management of IHR project data. The project manager runs monthly monitoring meetings with all technical teams in order to maintain oversight on progress against project plans, and the logframe.

In February 2018, the IHR project management team conducted an evaluation of its performance over the past 12 months by inviting feedback (via an anonymised online survey). The results of this survey have been considered and recommendations will be enacted to improve performance. This will be repeated annually as a core part of the team's internal M&E.

In addition, during the first three months of implementation processes were undertaken to engage an independent external evaluation provider to conduct a mid-point review

(January 2020). It is hoped that a mechanism can also be developed to enable a final evaluation 12 months after project completion.

In relation to output 4.5, collaboration across HMG GHS programmes has underpinned the IHR project. The joint PHE-DHSC-DFID meeting with WHO in Brazzaville in 2017 demonstrates the commitment of the IHR project team to ensuring a One HMG approach, ensuring minimal duplication of effort, and leveraging opportunities for sharing information and expertise. The IHR team has also shared information regularly with the Fleming Fund, especially around activities in Nigeria and Pakistan.

3. Evidence of managing risks

The IHR project team maintain a risk register for the project that is reviewed monthly. Significant risks (with a red RAG status) are escalated to the Project Board and added to the GHS Programme risk register.

An important role of the newly established Programme Management Group within PHE is to identify project management and delivery risks. The Group also acts as a means to reduce delivery risks by sharing learning between delivery teams who have different levels of experience of delivering ODA-funded programmes.

Finally, the project team seeks to reduce risk by obtaining expert advice on key decisions from the wider PHE Global Public Health team and DHSC.

Current risks and mitigating actions:

- As a result of increasing interest/investment in IHR by other donors, there is a risk of duplication, overlap or contradictory approaches, which may impact on the ability of PHE's IHR project to make an original contribution to the IHR strengthening field.

Mitigating action: Regular engagement with other agencies to ensure consistency and agree shared approaches where appropriate.

- As a result of cultural differences or lack of political engagement, there is a risk of slow timelines, patchy engagement and difficulty getting commitment to implementation phase activities from partner organisations. This may impact on implementation timelines and create issues with sustainability of projects. Lack of engagement may also cause delays in implementation and subsequent underspend.

Mitigating actions include working with DFID, IHR country leads and existing in-country partners, ensuring relationships with partner countries are strong and identify focal contact points where possible.

- As a result of external factors (e.g. elections) and internal factors (e.g. lengthy recruitment processes) there is a risk of delays to implementation activities which may impact on spending and timely achievement of project objectives

Mitigating actions include keeping DHSC well-informed about potential delays and underspend.

Initiation of a 'Foresight Planning' process to horizon scan for external factors with the potential to impact on the project and decide mitigating pathways.

In the case of an underspend, alternative complementary activities can be implemented / brought forward to mitigate this.

- As a result of working across a number of PHE directorates, there is a risk of inefficiency and lack of clarity on roles/responsibilities/governance processes which may impact on the transparency and efficiency of project delivery

Mitigating actions have included the creation of a document setting out ways of working, providing guidance on operational and strategic roles/responsibilities, circulated among PHE colleagues. Plans for a project dashboard are underway, and a monthly project newsletter to keep all PHE teams up to date.

- As a result of lack of awareness about PHE's role in global health work there is a risk of difficulties interacting with other HMG departments, including operationally, while sharing the HMG platform in country which may impact on PHE's reputation, and its ability to meet its programme objectives.

Mitigating actions include the development of a communications plan to clarify PHE's role in global health. This will cover communications within UK HMG and also with external partners.

4. Evidence of delivery partner management

The project has limited use of delivery partners. However, it has commissioned providers to deliver specific outputs. Most notably in the first year of the IHR project this included the two part Institutional Stakeholder Analysis (see above, section 1.2). Procurement of the ISA used appropriate approved processes (in alignment with DFID mechanisms). The successful bidder was supervised by a project oversight group assessing performance through different stages and ensuring timely delivery of a quality output.

The ISA report (parts 1 and 2) were both delivered on time, to a high standard and within budget.

5. Evidence of relationship management with stakeholders delivery partner(s) / supplier(s) or sub-contractor(s)

Stakeholder relationship management and risks

In-country stakeholders:

Stakeholder engagement is critical for the IHR project. The project's activities are intended to reflect the priorities of the countries worked with and to 'work with' the country, not 'do for'. This requires strong relationships with in-country partners such as National Public Health Institutes. Building relationships with these in-country partners has been achieved to date through regular visits and face-to-face meetings, frequent email and phone communications, and consultation around project plans.

The centrality of the in-country stakeholders to the success of the project brings risks. For example, political buy-in to IHR and PHE's work has the potential to be de-railed by external factors e.g. changes of leadership, political / economic unrest; humanitarian crises. However, the IHR team is mitigating against this by conducting horizon scanning activities to pre-empt external factors, working closely with other partners to gain intelligence, and spreading project activities across a number of countries. The project has also chosen to embed Senior Health Advisors into the first phase countries, thus helping to increase the visibility of the IHR project and ensure its continuing place on the political agenda.

There are also significant risks associated with cross-cultural working, especially around timescales and planning. In the implementation phase we have experienced a number of last-minute cancellations or changed plans from in-country partners. This has the potential to waste funds (cancelled flights/hotel bookings) and also create inefficiencies (lost expert time). The project and in-country leads are working with partners to emphasise the importance of advance planning. Until this is achieved, it is challenging for technical teams and the project manager to provide accurate forecasts.

Other International donor organisations:

It is also important for the IHR project to engage with other international donor organisations such as US CDC, IANPHI, China CDC and World Bank, in order to avoid duplication of activities and ensure alignment in order to maximise impact. The IHR project team has proactively extended communications to WHO country offices and regional

teams, US CDC and China CDC (among others) in each of the project's focal countries, leveraging the well-established networks accessible through DFID country teams. This has involved face-to-face meetings, sharing of plans, insights and strategies, and consultation on best-practice and lessons learned. This has been particularly successful in Ethiopia, where the US CDC team has offered desk space to the IHR in-country lead, to ensure continuing communication and collaboration and in Sierra Leone where the IANPHI country lead has facilitated access to government health leaders and shared intelligence.

There are several risks associated with working closely with other international donors, however. Firstly, partnership working can undermine the profile of PHE's international work. US and China CDCs have a broader reach and potentially bigger profile than PHE at present. A branding and communication strategy is essential to prevent IHR project activities being subsumed by partner projects.

A second risk is the potential instability caused by external factors outside of IHR project control. For example, changes to US funding streams for global health activities are anticipated, causing potential disruption to country activities. Consequently, awareness of potential opportunities to work together or complement one another is critical. It is also important to maintain relationships with a range of alternative stakeholders, to increase the resilience of PHE's networks.

Multi-lateral organisations e.g. WHO AFRO, Africa CDC

Working with multi-laterals such as WHO is a core aim of the IHR project, and our partners in WHO, Africa CDC and others e.g. WAHO, are key stakeholders. Through alignment and close collaboration with our multilateral partners the IHR project can reach beyond its five focal countries in order to add to global and regional efforts to create resilience against public health threats. The risks of working with multilateral stakeholders include slow and bureaucratic processes and variation in priorities and ambitions of different sectors of multilateral agencies. The IHR project mitigates these risks by building strong relationships with individuals within the organisations, leveraging existing UK HMG influence and collaborating with partners with shared ambitions. PHE is prioritising a joined-up approach with DFID, specifically, in order to maximise engagement and impact.

PHE technical teams:

The IHR project is delivered through PHE's technical teams across the breadth of the organisation. PHE has a wealth of public health expertise and experience to deploy, and this is a core strength of the project's methodology. A number of reporting mechanisms and communication methods have been established to ensure the relationship between the IHR project management team and the technical experts is strong and responsive and to ensure synergies are enhanced in the development of project interventions to minimise cost while optimising impact (included in section 1.1).

The risks associated with working with PHE's technical teams are primarily around balancing competing demands for high-cost, limited technical expertise and ensuring a consistent shared vision of the project ambitions. Feedback in February 2018 confirmed that communication and information dissemination needs to be improved and actions to address this are underway, including processes articulated in a 'ways of working' document. Meanwhile, recruitment of backfill staff to alleviate pressures on technical teams has also mitigated risks of project activities being delayed. Actions suggested in survey feedback are being progressed in order to improve transparency of information about project activities for all involved.

Suppliers:

In the first 15 months of the project only one contracted supplier was extensively used (as mentioned in section 1.4). DAI/HPI was procured to deliver the Institutional Stakeholder Analysis. Communication between DAI/HPI and the IHR project was excellent. Following their successful bid, the IHR project ISA oversight team held a number of face-to-face meetings, with regular email and phone contact to ensure appropriate oversight. Any changes from either side were swiftly communicated and dealt with. Despite the tight timescales, the supplier was supported to deliver a high-quality product within the agreed timescales.

6. Significant changes to the assumptions made in the business case i.e. changes to the initial approach and strategic risk

There have not been significant changes to the assumptions, project approach or strategic risks identified in the business case at the beginning of the programme. Strategic risks relating to underspend and political disruption have materialised (specifically, delays caused by the General Election in Sierra Leone), and the mitigating actions identified were deployed to minimise impact on the project, such as bringing forward other activities and allowing flexibility between workstreams. Other strategic risks remain on the project risk register (e.g. the risk of overlap, and external security risks) with ongoing mitigating actions (see section 1.3).

7. Value for Money

The cost of public health incidents can be devastating to the social and economic situation of countries. Major pandemics erode hard-won gains against poverty, in human development and economic growth. The overall impact of the Ebola crisis on Guinea,

Liberia, and Sierra Leone has been estimated at \$2.8 billion¹. Although many disease detection and control improvements have been implemented in the years since, important gaps in global capacity and coordination remain, specifically global capacity for an all hazards approach. The need to strengthen and monitor national systems is critical to achieving full compliance with IHR (2005)², and the avoidance of future devastation through public health incidents. This provides a strong rationale for the value for money presented by the IHR project.

A qualitative cost-benefit analysis was undertaken to compare the different mechanisms through which the project could be delivered. A number of factors supported the decision to deliver the project directly through PHE, drawing on resources from across the agency. The benefits of this approach are as follows:

- Cost-effective access to and involvement of the broad spectrum of PHE specialist expertise, rather than requiring step cost of additional specialist headcount.
- Access to some of PHE's experts will come at no cost to the project as PHE recognises the value and benefits of improving global health security to the UK through reducing the risk of future outbreaks.
- Global public health engagement, includes investing in our own capacity and experience that, ultimately, will contribute to the health security and safety of the UK population while enhancing the UK's credibility internationally, strengthening global influence.
- PHE's staff costs are fixed, established using the HMT model and guaranteed for the life of the project; overhead costs are typically 25% lower than would be the case for using 3rd party experts such as US CDC.
- Backfill for experts releases them to project without detracting from PHE core activities and facilitates skills development in PHE workforce, expanding the range and numbers of specialists able to be brought to bear on the IHR project, supporting organisational knowledge retention and sustainability.
- Additional opportunity for PHE to continue to offer technical support to other HMG global health project such as Fleming fund and TDDAP
- Access to Field Epidemiology Training Programme (FETP) and other specialist Public Health trainee resources at minimal cost (expenses only). Staff on these

¹ World Bank 2014-2015 West Africa Ebola Crisis: Impact Update <http://www.worldbank.org/en/topic/macroeconomics/publication/2014-2015-west-africa-ebola-crisis-impact-update> (accessed 23 May 2017)

² Ijaz K¹, Kasowski E, Arthur RR, Angulo FJ, Dowell SF International Health Regulations--what gets measured gets done Emerg Infect Dis. 2012 Jul;18(7):1054-7 https://www.ncbi.nlm.nih.gov/pubmed?cmd=Retrieve&db=PubMed&list_uids=22709593&dopt=Abstract

training programmes contribute valuable skilled manpower to the project at minimal direct cost due to the clear benefit to their training gained from project participation.

To date, these points have all been realised. For example, implementation phase activities have been running for three months, and have already involved expert input from over 20 staff members, without exerting a major impact on PHE core activities. As recruitment of backfill posts continues, access to public health expertise will expand further. In addition, the project management team has benefited from expertise from three senior public health registrars at minimal cost, and from ad hoc input from a range of public health expertise within the global public health directorate, at no cost to the project.

PHE has provided technical support to other HMG global health projects such as the DFID TDDAP programme providing, for example, expert public health advice on its theory of change and logframe. PHE experts have also been contributing to the Fleming Fund's scoping exercises, most recently in Pakistan and Nigeria.

PHE's own capacity and experience in delivering global health security activities has been built, and in the first few months of implementation the IHR project is already engaged in preparing to disseminate learning through events such as the Global Symposium on Health Systems Research in Liverpool, in October 2018.

The IHR project is the first global health project of its size to be managed by PHE. This brings with it operational challenges. Slow and inflexible recruitment processes within PHE have occasionally limited the project's ability to make full use of expertise from the wider public health system (e.g. from other government departments and academia) but these barriers are being addressed through close working with PHE's Global Operations Team.

The cost of staff expertise has been as expected. The costs of access to the HMG Platform have been harder to predict, due to confusing and changing forecasts provided by the FCO. However, this has not been a major impact on the value for money of the project.

The outcomes of the implementation activities are not yet known, but the project's monitoring and evaluation process intends to contribute to the evidence base around the value for money of strengthening health systems through the deployment of targeted expertise.

Summary of project's progress towards last year's issues and recommendations that were made.

N/A

List of recommendations for reporting year

- Ensure roles and responsibilities among key stakeholders are clearly defined at the outset of the project, and facilitate regular opportunities for communication and updates.
- Ensure M&E planning and delivery remains a central focus of the project, and is as non-onerous as possible.
- Continue to proactively engage with in-country partners to build strong relationships/effective communication in order to avoid cross-cultural misunderstandings.

Finance

Delivery confidence assessment

Risk rating: Red (High)

Risk revised since last annual review: N/A

8. Evidence of meeting ODA funding eligibility

Key points:

ODA eligibility is considered in the IHR project outline business case, to ensure that the funding provided to the project furthers the sustainable development and welfare of developing countries. Project funds are only spent on activities that will benefit ODA-eligible countries.

All project funds are directed towards technical expertise and system development to support the current work programmes. These include:

Nigeria:

- Enhancing emergency preparedness capacity; building stronger surveillance and laboratory systems;
- Supporting public health system coordination;
- Contributing to National Action Planning for Health Security;
- Supporting AMR planning and guidelines.

Ethiopia:

- Enhancing emergency preparedness capacity;
- Building chemical and environmental hazards systems;
- Contributing to National Action Planning for Health Security

Sierra Leone:

- Conducting a workforce needs assessment for the National Public Health Agency (NPHA) and supporting the coordination of the NPHA.

- Contributing to the sustainability of the laboratory network

WHO-AFRO/Africa CDC:

- Developing a work programme to support WHO AFRO plans to strengthen health emergencies capacity across the AFRO region
- Supporting WHO AFRO and Africa CDC to work effectively together, by developing an action plan to operationalise their partnership framework
- Providing technical support for regional health system strengthening activities

9. Evidence of financial year budget

Project annual budget 2016/17	£1m
Actual spend 2016/17	£0.3m
Project annual budget 2017/18	£1.5m (an additional 0.4m for design phase = 1.9m)
Actual spend 2017/18	£1.3m

Key Points:

The IHR Project had an underspend of £0.7m against its £1m budget in 2016/17. The 16/17 underspend was the result of the significantly delayed project start time (sign off was only received in November 2016, just 4 months to the end of the financial year) and lengthy recruitment processes. A further £0.4m was allocated to the project to continue post business case approval design activities into Q1/2 of 2017/18 to mitigate for the delay and loss of funds at the end of the financial year.

This initial delay had a knock on effect in the 2017/18 financial year. In 2017/18 £1.5m was allocated for implementation phase activities, against which the project was underspent by £0.2m. With the additional design phase funds included, the budget for 2017/18 was a total of £1.9m against which the project was underspent by £0.6m.

The underspend in 2017/18 was partly the result of slippages due to delays in recruitment, and slight shifts in project plans (e.g. no work conducted in Pakistan due to a successful extension of PHE’s ongoing DFID-funded Pakistan project). However, the bulk of the underspend was the result of last minute drastically revised forecasts for the cost of HMG platform places in Nigeria, Ethiopia and Sierra Leone. This issue has been raised with

HMG platform HQ and acknowledged. Some of the resultant underspend was used to bring forward some other planned and additional activities.

10. Evidence of meeting the target given by HMT on annual returns

Key Points:

The project team meets with PHE finance colleagues on a monthly basis to discuss actual project spend and revised forecasts. The IHR team then meets with DHSC finance on a quarterly basis. This supports the DHSC requirement to complete in-year monitoring returns to DFID/HMT.

In 2016/17 and 2017/18, the initial budget profiles, though based on the best information at the time, were necessarily highly indicative for a new programme. With respect to the 2016 and 2017 targets, the IHR project achieved 28% against its budget in 2016 and 59% (including accruals) against its budget in 2017. These lower spends against calendar year profiles for the first 18 months of the project are in large part due to the original profile being set (unavoidably) before detailed plans had been developed, and due to delays in the sign off the business case for the design phase impacting on the project's start time. Significant additional time was needed to conduct scoping missions and build relationships with partner NPHIs, to recruit to the core project team and to provide the time needed to subsequently establish the successful projects.

Building on its increasing experience of ODA funding, including a better awareness of the potential internal delays, the project team will be looking to meet the targets set in the remaining years of the programme. The team is seeking clarification on the possibility of modifying the spending profile to optimise efficient use of the funds

11. Evidence of progress and actions to meet IATI transparency standards

Self-assessed score against the IATI transparency standards.

0 - 19%	Very Poor	<input type="checkbox"/>
20 - 39%	Poor	<input type="checkbox"/>
40 - 59%	Fair	<input checked="" type="checkbox"/>
60 - 79%	Good	<input type="checkbox"/>

80 - 100%

Excellent



Provide an overview of actions the project has undertaken to meet ITAI transparency standards of 60% target.

Key Points:

ODA funding was new to DHSC in 2016 and as such the Department as a whole is beginning the process of ensuring it meets IATI transparency standards. As part of this work DHSC is aiming to meet the 'Good' standard (60%-79%) by March 2019.

To move toward this target for the IHR Project, the GHS Programme Management team has uploaded information about the IHR project onto a publishing tool called AidStream. This information links directly to the IATI registry.

To build on this further, the IHR team will fully engage with DHSC plans for deciding different options for achieving 60% score against IATI standards going forwards.

The IHR project will aim to increase this score further in subsequent years, with a focus on publishing business cases, MoUs and other supporting documents.

Summary of project's progress towards last year's issues and recommendations that were made.

N/A

List of Recommendations for reporting year

- Work closely with technical teams, in-country partners and finance to regularly check in on spending to avoid under-/over-spend in 2018/19.
- Ensure that there is clarity around HMG platform costs, working closely with HMG HQ and the PHE global operations team to understand the processes/expectations.
- Build additional contingency into financial forecasts to account for delays in recruitment and slippage of delivery.
- Work closely with DHSC to improve IATI transparency score.

Theory of Change

12. Evidence to show Project's theory of change assumptions remain accurate.

Assumptions of the theory of change:

- Budget available to meet proposal requirements
- Partnerships and multi-sector engagement can be attained
- Possible to identify suitable and available candidates for training and mentoring
- Strategic plans have adequate resources, political engagement and leadership for implementation
- Partnerships and multi-sector engagement can be sustained
- Continued political leadership and alignment of donor funds behind national IHR plans
- Funding and management capacity is sufficient
- Leadership from national public health professionals drives system and health development and securing of resources
- System coordination enables effective use of other inputs into health protection systems.
- Trained public health workforce can be recruited and retained
- Strategic inputs to health protection systems can strengthen global health security without comprehensive health system strengthening

General comment on assumptions:

The IHR project has recently commenced implementation phase in January 2018. A foresight planning session was conducted during the team Away Day in January 2018, providing opportunity to reflect the potential impact of external factors on project delivery. This approach enabled to project team through horizon scanning, to identify future opportunities and threats, and to assess risks and influencers to the project and plan for their impact. This process is a similar approach to “strategy testing” advocated by

international agencies for highly flexible aid programmes, but where “strategy testing” looks at the external factors affecting activities to date, “foresight planning” looks at how potential external factors could affect future activities. This was most appropriate as the implementation phase had not yet begun, but at the same time allowed us to test some of the assumptions of the theory of change.

The foresight planning session identified a number of external factors which could influence the project over the next two years, including:

- Domestic politics and issues e.g. Brexit, UK general elections
- UK public opinion on the value for money of UK aid and changes to the ODA budget
- Elections in partner countries
- US investment / disinvestment in global health security
- Conflict in partner countries or regions
- WHO leadership focus and funding

Some of these external factors have already had an impact on the programme. For example, the general election in Sierra Leone has meant delays in work plans.

- As a result of the workshop, and future planning for the project, the following recommendations were made:
- Create list of election dates and domestic budget/spending reviews to guide programme planning
- Seek involvement in FCO/DFID conversations in relation to political changes e.g. Africa strategy/WHO
- Ensure that the in-country leads are working in the FCO network
- Diversify relationships and resilience by making use of local (in-country) knowledge networks and soft intelligence e.g. party manifestos. This is anticipated to assist in both horizon scanning and informing IHR strengthening programme decision making.

At present, four months into implementation, the assumptions still stand and there are no recommendations to modify the theory of change.

Comments on assumptions:

- Budget available to meet proposal requirements
- Funding and management capacity is sufficient

These assumptions remain true and we do not anticipate the budget will change during project period. Funding and management capacity has been sufficient for this review period and underspend was reported for FY 17/18.

- Partnerships and multi-sector engagement can be attained
- Partnerships and multi-sector engagement can be sustained
- Strategic plans have adequate resources, political engagement and leadership for implementation
- Continued political leadership and alignment of donor funds behind national IHR plans
- Leadership from national public health professionals drives system and health development and securing of resources

The approach that the IHR Strengthening project takes includes a strong emphasis on the quality of relationships, partnerships, networks and institutional linkages in facilitating and enhancing the technical work that takes place. This includes with partner countries, regional organisations, other donors and within HMG to ensure that national public health systems are strengthened. At present, assumptions 4-7 are accurate, but it is recognised that maintaining political will, engagement and partnerships will be key in ensuring impacts are realised.

- Possible to identify suitable and available candidates for training and mentoring
- System coordination enables effective use of other inputs into health protection systems.
- Trained public health workforce can be recruited and retained
- Strategic inputs to health protection systems can strengthen global health security without comprehensive health system strengthening

These assumptions remain reasonable, though they are high level and refer to the transition from project outcomes to impact.

Summary of project's progress towards last year's issues and recommendations that were made.

N/A

List of Recommendations

- Use foresight planning methods to test the assumptions of the theory of change and plan for external events that can impact on project delivery
- Work closely with HMG partners (FCO, DFID, DHSC) and in-country leads to ensure that programme planning is cognisant of political changes in partner countries, the UK and other donor countries.

External Engagement

Delivery confidence assessment

Risk rating: Amber/Green (Medium/Low)

Risk revised since last annual review: N/A

13. Evidence of use and success of the communication strategy

Key Points:

For the majority of the review period, IHR project communications have been targeted at its partners within PHE, wider HMG, partner national public health institutes and international donor organisations.

A 'communiqué' was developed initially to introduce the project and its aims to potential partners and collaborators. This was tailored and sent out ahead of initial scoping visits to Nigeria, Kenya, Sierra Leone, Myanmar and Pakistan. Different versions were created for our key stakeholders (NPHIs) and other future partners (e.g. China CDC). Following business case approval, and prior to planning missions, a 1-sider update paper was developed to reinitiate contact and provide context to the next steps of the project. Throughout the review period the IHR team has contributed to routine communications in the form of briefing papers and updates targeted at PHE and DHSC senior leadership.

Communication with the wider global health security community was also achieved through participation in relevant meetings, workshops and conferences and a standard PowerPoint slide set was designed and adopted for this purpose.

As implementation begins, the IHR team is working with PHE's communications department to create a proactive and reactive communications strategy for engaging across our stakeholders: partner NPHIs, other international donors, wider HMG organisations, internal PHE departments, wider UK public health colleagues and academia, and the general public.

This plan will include the following components:

- Social media communications: e.g. tweeting about project activities and events/re-tweeting relevant publications from our partner organisations. Audience: partner NPHIs and general public in focal countries and the UK. Purpose: to raise

awareness of the content of the IHR project and to engage with our partners, in order to show shared interest and objectives.

- Blog postings: Audience: PHE internal colleagues, wider HMG, UK public health workforce. Purpose: To demonstrate PHE's global health expertise, generate interest and build the IHR project's reputation.
- Creation of 2-sider information factsheet for online publication/sharing. Audience: both international donors/potential partners (e.g. US CDC) and for partner NPHIs. Purpose: to explain the project's goals and activities in order to raise PHE's profile in global health and potentially increase opportunities for collaboration
- Publications: Audience: Academia/public health workforce. Purpose: to start building an evidence base about the IHR project's approach to building health system capacity; to raise PHE's profile in global health.
- Presentations/conference posters/briefing papers: Audience: Wider HMG; UK public health workforce. Purpose: to raise PHE's profile in global health and reduce misunderstanding of PHE's role in international development.
- Events: Road-shows; senior leadership meetings: Audience: PHE internal; wider HMG. Purpose: to raise PHE's profile in global health and reduce misunderstanding of PHE's role in international development and potentially increase opportunities for collaboration.
- Press releases: Audience: UK public. Purpose: raise awareness of PHE's role in global health/increase support for ODA spending.

The IHR project team will engage with DHSC to ensure its communication strategy is in line with the wider Global Health Security portfolio plans.

14. Evidence of external engagement

In addition to stakeholder engagement through the communication channels outlined in 4.1, the project has engaged stakeholders are follows:

Stakeholders

UK HMG:

The Project Board, including representation from DHSC, DFID and DEFRA has met monthly (recently reduced to quarterly) since the project design phase started. The Project Board provides regular opportunities for engagement with HMG stakeholders, sharing

updates, asking advice and horizon scanning. The project team regularly engages with other ODA programmes such as Fleming Fund and TDDAP through ad hoc face-to-face meetings and engagement with fora such as the DHSC programme board and the UK / WHO-AFRO strategic partnership forum. This is to ensure the team maintain an understanding of activity in the field, avoid duplication, share learning where appropriate and identify opportunities for collaboration.

Where there are clear overlapping objectives between the IHR programme and other HMG programmes e.g. regarding WHO AFRO and Africa CDC, the IHR team has ensured proactive engagement. The organisation of a joint PHE, DHSC and DFID mission to Brazzaville in November 2017 to meet with WHO HQ and AFRO is a good example of this engagement.

NPHIs and other country partners:

The IHR team has prioritised regular face-to-face engagement with its partner NPHIs and international donors. Aside from the initial six scoping missions, the subsequent planning visits to the five final countries, and regular project-specific meetings, this has frequently involved participation in a number of workshops and events in order to raise the project's profile, strengthen relationships and create opportunities for collaboration.

Selected events include:

18-20 July 2017, WHO AFRO coordination meeting, Dakar Senegal

- Purpose: Building relationships with NPHIs across Africa and international partners
- Relevance to IHR Programme: Inform priorities for engagement with WHO AFRO and Africa CDC
- Relevance to IHR Programme: Inform priorities for IHR workplan

Sept 2017, Chatham House Roundtable (London), PHE Sponsored

- Purpose: Build up relationship with Nigeria health leadership
- Relevance to IHR Programme: Position IHR programme as linked to HSS

October 2017, Sierra Leone NAPHS workshop

- Purpose: Contribute to SL post JEE NAPHS workshop
- Relevance to IHR Programme: Identify priorities to inform IHR workplan for SL

3 Oct 2017, Chatham House and ECOWAS RCDC host Roundtable Discussion (Abuja, Nigeria)

- Purpose: WAHO roundtable to explore material transfer and data transfer for regional collaboration in emergencies
- Relevance to IHR Programme: Inform understanding of regional networks and explore mechanisms for leveraging IHR programme input to impact other countries

23-27 Nov 2017, National Action Planning for Health Security, Ethiopia

- Purpose: Facilitate post JEE NAP
- Relevance to IHR Programme: Ensure synergy of IHR programme activities with national priorities

January 2018 – Roadmap to National Action Planning workshop post-JEE, Nigeria.

- Purpose: Supporting Nigeria CDC to consider next steps to improving JEE scores and IHR compliance.
- Relevance to IHR Programme: Ensure synergy of IHR programme activities with national priorities

March 2018: Africa CDC Meeting of African Health Leaders to Discuss Framework for the Establishment and Monitoring of National Public Health Institutes in Africa

- Purpose: To review and adopt a continental Africa framework for the establishment and strengthening of national public health institutes
- Relevance to IHR programme: The project aims to strengthen NPHIs. To ensure our approach is consistent with the AU priorities

Public Audience

Engagement with the public has been limited to date. However, PHE's press team has been encouraged to tweet about the IHR project on several occasions. Example include tweets about details of PHE's involvement in emergency response training: https://twitter.com/PHE_uk/status/974656967930195968 and mentions of the IHR project in the PHE Chief Executive's publicly published Friday Message: https://publichealthmatters.blog.gov.uk/2017/12/08/duncan-selbies-friday-message-8-december-2017/?utm_source=staff36&utm_medium=Email&utm_campaign=DSF

PHE's engagement has also been publicised by our partners in-country, e.g. by Nigeria CDC: <https://twitter.com/NCDCgov/status/952924382636204032>

Summary of project's progress towards last year's issues and recommendations that were made.

N/A

List of Recommendations

- Finalise and implement project communications strategy to improve proactive communications and extend reach, including building on relationships with stakeholders to collaborate where beneficial. This should be developed in alignment with PHE and DHSC communication teams.
- Maintain regular communication with internal PHE stakeholders and HMG partners. Create a 'dashboard' and a monthly newsletter to collate and share updates from each of the IHR project's focal countries, and cross-cutting activities.
- Continue face-to-face interaction with in-country partners through facilitating and contributing to key public health events.

Lessons Learned

The first 15 months of the IHR Strengthening project have been very successful, with a number of key milestones met and objectives achieved. This is all the more notable for the fact that these were delivered with a small project team and through a period of significant and rapidly evolving changes within PHE's global public health division. The IHR project, being the first global health project of its size, breadth and profile to be led by Public Health England, proved to be a challenge to which the organisation has risen. In recent months the project team has built on strong foundations to further consolidate project management processes, including monitoring and evaluation, and further enhance relationships with key stakeholders in order to deliver a well-designed and meaningful project. Challenges remain, however, and a number of key lessons have been learned in the process.

Lessons and Improvements for the future:

The importance of close working with HMG colleagues

The development of strong relationships with key stakeholders within HMG has been crucial for the success of the IHR project to date. This was especially evident during the creation of the outline business case. The IHR team engaged DHSC and DFID in an options appraisal session ahead of starting work on the business case. This ensured that the expectations of all parties were met in advance, eliminating time-wasting. The good relationships the IHR team had developed with DHSC and DFID were important for achieving the trust and transparency required for this process to be successful.

However, PHE's position as an HMG partner has sometimes not been well-understood by others across government. This has been demonstrated through some conversations with DFID in-country offices, and with FCO colleagues regarding HMG platform provision. We hope that this is improving as PHE and the IHR Programme become more established on the global health scene. It is expected that the development of a communications plan will address this.

Challenges of working across cultures

The IHR project is working with five different focal countries and with a number of regional institutions. Cultural differences are inevitable, occasionally bringing challenges. In particular, it has been difficult to establish and maintain fixed timelines with each of our partner countries. This is caused by differing approaches to planning, external factors (such as elections) and has also been linked to the presence of multiple donors, all placing different demands on NPHIs. This often results in last-minute changes of plans, occasionally meaning hastily booked or cancelled flights, at great cost to the project, (time

and delivery) and placing a strain on the IHR project management team's relationships with its technical delivery teams.

Country priorities can also shift suddenly, as a result of socio-economic and political change, or as a consequence of input from other donors. This has the potential to result in changed work plans. The IHR project team have learned to maintain close communication with its stakeholders, and also to ensure the project is relatively flexible. However, this has made it challenging to provide accurate financial forecasts.

By building trust and strong individual working relationships between technical teams at PHE and partner NPHIs, communication and expectations will become clearer. In addition, going forwards, PHE will make its expectations of working relationships transparent at the outset.

Delays

The IHR project is intended to 'work with' our partners, not 'do for'. As a consequence, all project planning has been a collaborative process. Though this is an important principle of the project, it can lead to lengthy delays. Consultation deadlines are frequently missed, and it occasionally has become apparent that documents have not been circulated to the correct recipients. The importance of building additional time into the project planning to mitigate for these delays is a critical lesson to learn, and is applicable to any project with a collaborative approach.

The IHR project has also experienced a number of severe delays in recruitment and procurement, due to complex and unclear internal PHE processes. This had a significant impact on the project management team's ability to progress the project in the first months, and later delayed the start of in-country activities. These delays also had a financial impact, contributing to the project's underspend.

As the IHR project is the biggest global project managed by PHE to date, the teething problems related to managing international operations (such as procurement, recruitment and securing platform places) are not unexpected. In recent months the IHR project management team has been working with the PHE Global Operations team to streamline a number of processes, with good effect. However, in future we will build more time into our recruitment and procurement planning processes and made more realistic forecasts and plans as a result.

Overall Project Delivery and Recommendations

Delivery confidence assessment

Project Management	Amber/Green
Finance	Amber
Theory of Change	Green
External Engagement	Amber/Green
Overall Delivery Confidence rating	Amber/Green

List of Recommendations

Project Management

- Ensure roles and responsibilities among key stakeholders are clearly defined at the outset of the project, and facilitate regular opportunities for communication and updates.
- Ensure M&E planning and delivery remains a central focus of the project, and is as non-onerous as possible.
- Continue to proactively engage with in-country partners to build strong relationships/effective communication in order to avoid cross-cultural misunderstandings.

Finance

- Work closely with technical teams, in-country partners and finance to regularly check in on spending to avoid under-/over-spend in 2018/19.
- Ensure that there is clarity around HMG platform costs, working closely with HMG HQ and the PHE global operations team to understand the processes/expectations.
- Build additional contingency into financial forecasts to account for delays in recruitment and slippage of delivery.

- Work closely with DHSC to improve IATI transparency score.

Theory of Change

- Use foresight planning methods to test the assumptions of the theory of change and plan for external events that can impact on project delivery
- Work closely with HMG partners (FCO, DFID, DHSC) and in-country leads to ensure that programme planning is cognisant of political changes in partner countries, the UK and other donor countries

External Engagement

- Finalise and implement project communications strategy to improve proactive communications and extend reach, including building on relationships with stakeholders to collaborate where beneficial. This should be developed in alignment with PHE and DHSC communication teams.
- Maintain regular communication with internal PHE stakeholders and HMG partners. Create a 'dashboard' and a monthly newsletter to collate and share updates from each of the IHR project's focal countries, and cross-cutting activities.
- Continue face-to-face interaction with in-country partners through facilitating and contributing to key public health events.

Appendix 1. Options Appraisal

IHR Strengthening Project Delivery options appraisal

Options	Strength	Weakness	VFM / costs
<p><i>Option 1: PHE to directly deliver technical input into the project, drawing on resources from across the agency</i></p>	<p>Ability to deploy most appropriate high level range of technical expertise together with public health leadership skills and experience</p> <p>utilising PHEs global experience and activity e.g. in Sierra Leone, and recognition as world leaders in areas such as emergency preparedness and response</p> <p>Synergies, collaboration and sharing intelligence, expertise and learning with other HMG projects such as TDDAP, Fleming Fund and UKPHRST</p> <p>Further build PHE and UK capacity for future global health engagement</p>	<p>Potential competing priorities</p> <p>Requires significant time</p> <p>Some expertise not available within PHE may still need to be commissioned</p>	<p>Cost-effective access to and involvement of the broad spectrum of PHE specialist expertise, rather than requiring step cost of additional specialist headcount.</p> <p>Access to some of PHE’s experts will come at no cost to the project as PHE recognises the value and benefits of improving global health security to the UK through reducing the risk of future outbreaks.</p> <p>Global public health engagement, includes investing in our own capacity and experience that, ultimately, will contribute to the health security and safety of the UK population while enhancing the UK’s credibility internationally, strengthening global influence.</p>

<p>Enhance HMG and organisational reputation</p> <p>Leverage additional resources through networks of NPHIs</p> <p>WHO looks to PHE to provide technical expertise to support their IHR activities; this will consolidate this approach and reinforce HMGs commitment to support WHO</p> <p>Ability to deploy most appropriate high level expertise.</p> <p>Develop PHE and UK capacity for future global health engagement</p> <p>Enhance organisational reputation</p> <p>Leverage additional resources through networks of NPHIs</p>		<p>PHE's staff costs are fixed, established using the HMT model and guaranteed for the life of the project; overhead costs are typically 25% lower than would be the case for using 3rd party experts such as US CDC.</p> <p>Backfill for experts releases them to project without detracting from PHE core activities and facilitates skills development in PHE workforce, expanding the range and numbers of specialists able to be brought to bear on the IHR project, supporting organisational knowledge retention and sustainability.</p> <p>Additional opportunity for PHE to continue to offer technical support to other HMG global health project such as Fleming fund and TDDAP</p> <p>Access to FETP and other specialist Public Health trainee</p>
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		<p>resources at minimal cost (expenses only)</p> <p>As an executive agency of the DHSC, PHE is able to access the One HMG Platform and the broader procurement services associated with the Crown Commercial Services practices and policies. Procurement costs are thus reduced to a minimum for necessary third party involvement, while ensuring full best value and competitive practice to the highest HMG standards</p> <p>Access to some of PHE's experts will come at no cost to the project as PHE recognises the value and benefits that return to the UK from global public health engagement, which ultimately contributes to the health security and safety of the UK population while enhancing the UK's credibility internationally,</p>
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			strengthening global influence.
<p><i>Option 2: Create a dedicated in-country project team to deliver as a discrete project</i></p>	<p>Clear understanding of project requirements in team</p> <p>Constant point of contact for project partners</p> <p>Stakeholder engagement and working in country</p> <p>Easier to manage</p> <p>Avoids the possibility of pressure on PHE UK responsibilities</p>	<p>This will not give access to the full range of PHE knowledge & expertise</p> <p>It would also limit the number of people engaged and therefore gaining experience of global health work – which builds UK capacity for future engagement.</p> <p>Benefits of potential links to other projects would not be realised.</p> <p>Reduced flexibility and adaptability. There will be less opportunity to adapt the programme to reflect learning from ongoing operational research and evaluation</p>	<p>May have lower travel costs if more project team members are embedded in partner countries; this may be offset by higher HMG FCO platform costs with greater longer-term stay</p> <p>Significant penalty costs may be accrued from any in programme adaptations to priorities and technical interventions</p> <p>Learning from the funded projects in Sierra Leone and Pakistan has highlighted the costs of this approach</p>
<p><i>Option 3: Fund WHO, US CDC (or other 3rd party supplier) to deliver the project</i></p>	<p>Signal of UK commitment to the WHO</p> <p>Known technical competency and legitimacy of WHO/US CDC</p> <p>Easier to manage</p>	<p>PHE is not a funding agency; this approach is already being implemented by DFID via TDDAP and other programmes.</p> <p>This model would not build up long-term UK capabilities for engaging in PH system strengthening</p>	<p>VFM would depend of mix of international, national and consultant staff able to be recruited by WHO for programme delivery. Costs would be high if engaging organisations such as US CDC (where overhead cost typically exceeds</p>

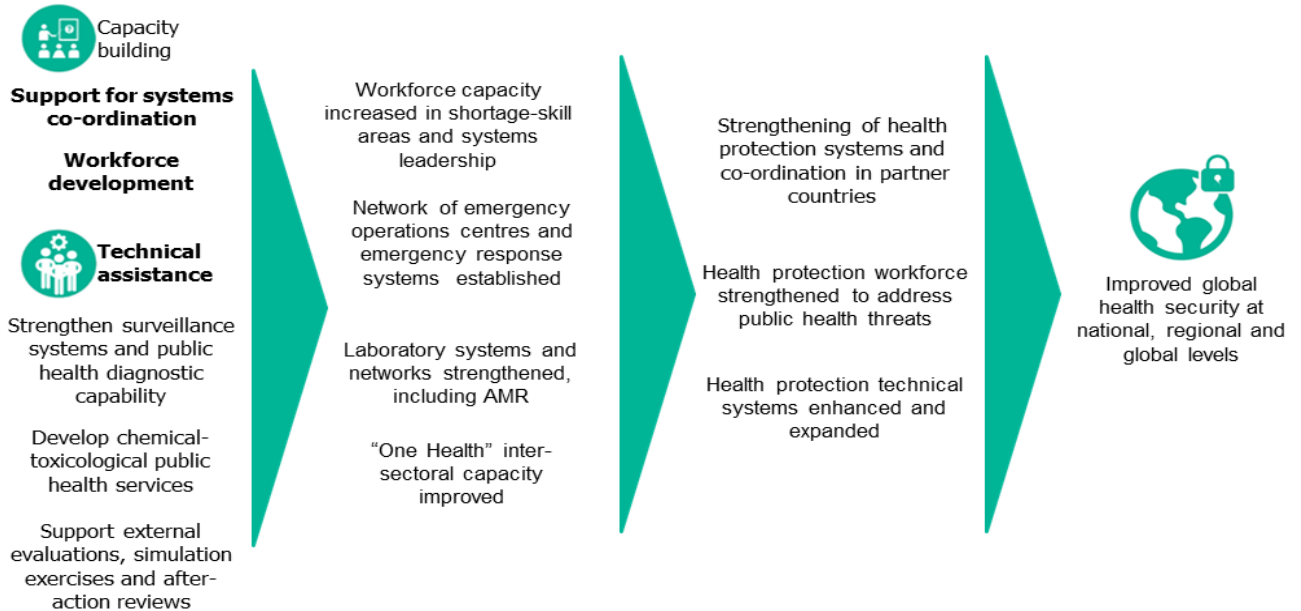
<p>No pressure on PHE UK responsibilities</p> <p>Flexibility - expertise recruited as needed, matching expertise and staffing to each project</p>	<p>Challenge of ensuring capacity and commitment to IHR project and UKHMG priorities.</p> <p>WHO's limited technical capacity</p> <p>Less likely to build relationships with NPHIs or monitor long term results</p> <p>Potential loss of control and focus from UK's aims for IHR strengthening in favour of the corporate/organisational aims and political influences of the 3rd party supplier</p> <p>Would not meet the UK IHR objective of using UK technical expertise to build WHO capacity.</p> <p>Project delivery might incur high costs or be significantly curtailed if suitable national officers could not be recruited.</p>	<p>70% of all staff costs) or WHO (to embed or fund a consultant is c.£250k per annum and PHE/DHSC might have limited control over output/work priorities once staff are within WHO)</p>
<p><i>Option 4: Do nothing (Counterfactual)</i></p> <p>Lowest cost – ODA expenditure could be diverted elsewhere</p>	<p>Does not improve global health security</p> <p>Limited UK strategic engagement</p>	<p>Investment in global health security can deliver substantial cost savings to UK HMG which are not realised in the “do nothing” option.</p>

	Missed opportunities for learning and improving skills of UK workforce Outbreak risk	
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Preferred option: The preferred option is option 1 - PHE to directly deliver technical input into the project, drawing on resources from across the agency

Appendix 2. Theory of Change

International Health Regulations System Strengthening Programme




ACTIVITIES AND OUTPUTS

-  Budget available to meet proposal requirements
-  Partnerships and multi-sector engagement can be attained
- Possible to identify suitable and available candidates for training and mentoring


ACTIVITIES AND OUTPUTS - INTERMEDIATE OUTCOMES

-  Strategic plans have adequate resources, political engagement and leadership for implementation
- Partnerships and multi-sector engagement can be sustained
- Continued political leadership and alignment of donor funds behind national IHR plans
- Funding and management capacity is sufficient

INTERMEDIATE OUTCOMES - LONG TERM OUTCOMES

-  Leadership from national public health professionals drives system and health development and securing of resources
- System coordination enables effective use of other inputs into health protection systems.
- Trained public health workforce can be recruited and retained

LONG TERM OUTCOMES - IMPACT

-  Strategic inputs to health protection systems can strengthen global health security without comprehensive health system strengthening



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