Department of Health & Social Care

International Health Regulations Strengthening Project Annual Review 2018-19

Global Health Security Programme

Published 20 July 2020

Clearance Checklist

	Name	Date
Project Lead	Dr Ebere Okereke	14 June 2019
External Assurance – Independent body sign off	Dr Renu Bindra, Consultant in Health Protection Public Health England (PHE)	14 June 2019
Project Board sign off	Dr Neil Squires, Director Global Public Health PHE	17 June 2019
Global Health Security (GHS) Programme Board sign off	Nick Adkin	20 May 2020

Abbreviations and acronyms

Abbreviation or acronym	Meaning
AAR	After Action Review
Africa CDC	Africa Centre for Disease Control
ASLM	African Society for Laboratory Medicine
AMR	Antimicrobial resistance
DFID	Department for International Development
DHSC	Department of Health and Social Care
DRR	Disaster Risk Reduction
EBS	Event Based Surveillance
ECOWAS	Economic Community of West African States
EOC	Emergency Operations Centre
EPHI	Ethiopia Public Health Institute
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
ISA	Institutional Stakeholder Analysis
JEE	Joint External Evaluation

LMIC	Low and middle-income countries
MOHS	Ministry of Health and Sports (Myanmar)
MOHS (SL)	Ministry of Health and Sanitation (Sierra Leone)
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
RCSDC	Regional Centre for Surveillance and Disease Control (ECOWAS)
WHO SEARO	World Health Organisation South-East Asia Regional Office
SNAP-GHS	Strengthening National Accountability and Preparedness for Global Health Security
SOP	Standard Operating Procedure
SWOT	Strengths, Weaknesses, Opportunities, Threats
TDDAP	Tackling Deadly Diseases in Africa Programme
TORs	Terms of Reference
USCDC	United States Centers for Disease Control and Prevention (*CDC*)
VFM	Value for money
WHO	World Health Organisation
WHO AFRO	World Health Organisation Regional Office for Africa
WB	World Bank
ZNPHI	Zambia National Public Health Institute

Introduction

Outline of programme

In the 2015 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 GHS programme is made up of 5 projects: the Fleming Fund, the UK Vaccine Network, the Global Antimicrobial Resistance Innovation Fund (GAMRIF), the International Health Regulations Strengthening project and the UK Public Health Rapid Support Team (UK-PHRST). Through delivery of these projects the programme supports 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

• provide rapid and effective response to health threats

Outline of project in relation to the programme

PHE's IHR Strengthening project is a £16m Department of Health and Social Care (DHSC), Official Development Assistance (ODA)-funded project (2016/17-2020/21). It is 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 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 5 countries (Ethiopia, Nigeria, Sierra Leone, Pakistan and Myanmar) at a bilateral level. The project also works with World Health Organization (WHO) country and regional offices, Africa Centre for Disease Control (CDC) and other multi-lateral institutions 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.

The programme aims to support the establishment of and strengthen existing national public health institutions 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 technical capabilities in our partner countries and agencies through facilitating access to experts in PHE and other UK organisations; develop a dedicated capacity to support strengthened international, regional and country level capabilities; create standard operating procedures and protocols for detection, prevention and response to public health threats; and improve resilience and response capability through training, supervision and mentoring.

Working alongside National Public Health Institutions (NPHIs) to improve health security with the development of stronger health systems contributes towards the Universal Health Coverage agenda, which overlaps and complements the attainment of IHR compliance.

This is achieved through technical partnerships, knowledge exchange, system development and - to achieve sustainability - through linking IHR requirements to strengthened public health systems. The project aims to develop sustainable institutional linkages, long term partnerships and professional relationships at country and regional level.

This review covers the first full year of implementation (from April 2018 to the end of March 2019).

Outline summary of project's last year annual review

1.	Project Management	Amber/Green (Medium Low)
2.	Finance	Amber (Medium)
3.	Theory of Change	Green (Low)
4.	External Engagement	Amber/Green (Medium Low)

Overall Delivery Confidence RAG rating from last annual review:

Amber/Green (Medium Low)

Summarised key recommendations from the previous review

The following recommendations were made by IHR Strengthening Project and accepted by the programme board at the last annual review:

Project management

Ref	Recommendation	Status
1	Ensure roles and responsibilities among key stakeholders are clearly defined at the outset of the project and facilitate regular opportunities for communication and updates.	Met
2	Ensure monitoring and evaluation (M&E) planning and delivery remains a central focus of the project, and is as non-onerous as possible.	Met
3	Continue to proactively engage with in-country partners to build strong relationships/effective communication to avoid across-cultural misunderstandings.	Met

Finance

Ref	Recommendation	Status
4	Work closely with technical teams, in-country partners and finance to regularly check in on spending to avoid under/over-spend in 2018/19.	Partly met –see section 5 for finance detail.
5	Ensure that there is clarity around Her Majesty's Government (HMG) platforms costs, working closely with HMG HQ and the PHE global operations team to understand the processes/expectations.	Met
6	Build additional contingency into financial forecasts to account for delays in recruitment and slippage of delivery.	Met

7	Work closely with DHSC to improve International Aid Transparency Initiative (IATI) transparency score.	In progress

Theory of Change

Ref	Recommendation	Status
8	Use foresight planning methods to test the assumptions of the theory of change and plan for external events that can impact on project delivery.	Met
9	Work closely with HMG partners (Foreign and Commonwealth Office [FCO], Department for International Development [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.	Met

External Engagement

Ref	Recommendation	Status
10	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.	Unmet
11	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.	Met - a SharePoint/Jira project management software pages created and the IHR project contributes to a divisional newsletter

12	Continue face-to-face interaction with in-country partners through facilitating and contributing to key public health events.	Met

Key successes

Key achievements include:

- Work plans finalised and agreed, and technical activities fully initiated in Ethiopia, Nigeria, Sierra Leone, and Myanmar. An official launch event for the IHR strengthening project was held in Abuja, Nigeria, involving PHE's Chief Executive and Director of Global Public Health, DHSC Head of Global Health Security Planning, the British High Commissioner and DFID. In addition, the process for the alignment of the DFID-funded PHE-led Pakistan Integrated Disease Surveillance and Response (IDSR) system project under the umbrella of the IHR project was agreed ahead of the April 1 start date.
- An external evaluation was commissioned by the IHR project to conduct a mid- and end-point evaluation of impact.
- The IHR strengthening team also worked with Capacity Development International to tailor and apply the 'EFFective in Embedding Change' tool, developed by the ESTHER Alliance (ESTHER EFFECt tool) to evaluate institutional partnerships for public health capacity building. The application of the ESTHER EFFECt for public health capacity building through institutional partnerships is unique to the IHR project.
- Relationships were established in Nigeria with other organisations involved in health security – WHO, GIZ (Regional Programme on Pandemic Preparedness), Resolve to Save Lives (RTSL) and the Japanese International Cooperation Agency (JICA).
- Trusting and transparent relationships were strengthened with NPHIs in partner countries and with regional organisations such as Africa CDC. In Nigeria and Ethiopia, the IHR project Senior Public Health Advisors (SPHAs) were invited to join working groups addressing outbreaks such as Monkey Pox and Acute Watery Diarrhoea; a Letter of Intent was signed between PHE and Africa CDC detailing plans to collaborate; Memorandums of Understanding were signed between PHE and the Ethiopian Public Health Institute (EPHI) (March 2019) and between PHE and World Health Organization Regional Office for Africa (WHO AFRO) (finalised May 2019).
- Continued cross-HMG engagement including close working with DFID's Tackling Deadly Diseases in Africa Programme. A second joint meeting was held between WHO AFRO, PHE and DFID in Brazzaville (January 2019). The IHR team has also continued to contribute to HMG knowledge sharing forums such as the Cross-Government Alignment Group. The IHR project has also contributed to cross-HMG initiatives such as Spending Review planning and the New Approach to Africa.
- Project team recruitment continued, including the appointment of Senior Public Health Advisers for Myanmar, Africa CDC, Sierra Leone and Zambia. A Senior Technical Microbiology Lead for Sierra Leone was also appointed to the team, alongside additional administrative support to align with the IHR project's expansion to Zambia and acceleration of activities.
- Excellent progress on the IHR Project-funded Strengthening National Accountability and Preparedness for Global Health Security (SNAP-GHS) initiative, including the

delivery of workshops in pilot countries (Nigeria, Ethiopia and Pakistan). The SNAP-GHS project also received endorsement from WHO HQ.
- Successfully bid for Africa Strategy funding for IHR strengthening activities to expand to Zambia. Two subsequent scoping visits were conducted to Zambia (August and November 2018) and initial steps were made towards building relationships with Zambia's National Public Health Institute (ZNPHI).

Notable technical achievements include:

Nigeria:

- Delivery of 2 major multi-state emergency response exercises, Keep Pushing 1 and 2, in Nigeria, both resulting in the implementation of recommendations within Nigeria CDC.
- Nigeria CDC was also supported in participating in WHO AFRO regional and WHO global multi-country exercises.
- Delivery of Incident Coordinating Centre/Incident Manager training and review of Standard Operating Procedures (SOPs) for Nigeria CDC to enhance ability to coordinate and respond to incidents at national level.
- Tailoring and implementation of a new outbreak response management tool in Nigeria (SitAware) – already used to log major incidents.
- Delivery of Biosafety training for Nigeria CDC's Lassa Fever network laboratories and audit of biosafety requirements with implementation of recommendations
- Development of the first External Quality Assurance (EQA) process for enteric diagnosis for Nigeria's national reference laboratory.
- Support to the validation, costing and development process of the National Action Plan for Health Security (NAPHS) for Nigeria.
- Evaluation of the event-based surveillance system in Nigeria and recommendations made to further improve its ability to prevent, detect and respond to outbreaks and public health events.
- Mentoring and training to improve technical skills in using data/information for public health response.
- Supported the review of the potential to include Monkeypox in routine surveillance in Nigeria following its re-emergence in-country.

"I really want to thank you for the support, effort, energy and devotion that resulted in today's highly successful [ASLM] manuscript writing workshops. The participants were similarly effusive with their thanks and I imagine that today's activities will place them firmly on a path towards future high-quality papers."

Iruka N Okeke, Professor and MRC/DfID African Research Leader

Editor-in-Chief, African Journal of Laboratory Medicineupdates from each of the IHR project's focal countries, and cross-cutting activities.

Sierra Leone:

- Completion of Workforce Gap Analysis and Planning in Sierra Leone, conducted with extensive input from Sierra Leone Ministry of Health and Sanitation (MOHS) – the process has already averted a significant gap in Scheme of Service relating to emergency planning and response.
- Initiation of detailed planning for Strengthening Laboratory Management Toward Accreditation (SLMTA) process in Sierra Leone. Nigeria CDC was also mentored and supported for its Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) programme audit.

Ethiopia:

- Support provided to the Ethiopia Public Health Institute towards the development of a Chemical Hazards Technical Working group – 3 new chemical hazards staff already recruited by Ethiopia Public Health Institute (EPHI) as a result of IHR project advice.

Myanmar:

- The establishment of a ToxBase system for managing chemical and toxicological events in Myanmar. IHR project plans have received endorsement by Union Minister in Myanmar.

Regional and multi-partner activities:

- Continued strengthening of South-South networks through IHR sponsorship of events such as the African Society of Laboratory Medicine (ASLM) Annual Conference and the first International Lassa Fever Conference in Nigeria. The IHR project funded attendees from Zambia, Sierra Leone, Nigeria and Ethiopia to attend, while attendees from Sierra Leone were funded to attend the International Lassa Fever Conference. Representatives from Sierra Leone, Nigeria also attended a well-received 'microbiology laboratory leadership' training in the UK.
- Initiation of an exercise to map health emergency capacity across Africa CDC member states.
- Delivery of enteric bacteria training in both Nigeria and Ethiopia, as well as advanced enteric training in the UK for Nigeria CDC National Reference Laboratory staff.

Project Management

*TO BE READ IN CONJUNCTION WITH THE ANNUAL REVIEW EXPLANATORY NOTE

Delivery confidence assessment for reporting year

RAG rating for this reporting year:	**Green**
Changed since last year (Y/N)	N

1. Evidence of managing the delivery of project

Quarter 1	Quarter 2	Quarter 3	Quarter 4
A/G	A/G	G	G

Overall delivery RAG rating over the reporting period: A/G

Key Points:

The IHR project has delivered consistently and effectively over the past 12 months, despite contending with internal process delays (recruitment, procurement) and external factors (elections in Nigeria and Sierra Leone, changes of government leadership in Ethiopia). The IHR project team continues to use the following delivery management tools:

- An active risk register, reviewing risks and mitigating actions monthly
- A decision log to record the outcomes of important discussions
- 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, and a weekly business management meeting which includes colleagues from Global Operations. During the business management meeting, issues relating to logistics, recruitment and finance are discussed and progressed.
- Six-weekly meetings of the IHR technical working group (TWG), to provide a forum for updates, discussion and opportunities for cross-cutting activities across the project
- Monthly/6-weekly country-level coordination meetings (aligned with TWG).
- Quarterly reporting of key activity, risks and forward look to PHE's Head of Global Programmes
- Quarterly reporting of key activity to the IHR Project Board – recently reduced to bi-annual reporting
- Quarterly engagement with PHE technical partners to review progress (and ad hoc meetings as needed)
- Monthly reporting of key activity to the GHS programme board

In the final quarter of 2018/19, with the expansion of the project team and scope, a second project manager was recruited to ensure continuing close oversight of project activities. The addition of a second project manager in February 2019 has further increased the efficiency of IHR project delivery.

A priority for 2019/20 will be a comprehensive review of the project management structure and governance, to implement improvements from lessons learned during this full year of project implementation.

2. Evidence that the project is meeting the agreed milestones and deliverables (delivering against the stated project objectives).

The following milestones / deliverables were made by International Health Regulations Strengthening Project for this reporting year.

Workstream 1: Ethiopia

Output Indicator	Milestones / deliverables	Status
1.1	Laboratory Strengthening **Year 2 Milestone**: Enteric pathogens workshop delivered	Completed
1.2	Laboratory Strengthening **Year 2 Milestone**: Programme across IHR partner countries for laboratory leadership and management initiated	Completed
1.3	Laboratory Strengthening **Year 2 Milestone**: Workforce development: EPHI delegates sponsored to attend African Society for Laboratory Medicine workshop	Completed
1.4	Surveillance system strengthening **Year 2 Milestone**: Plans and materials developed for surveillance preparedness for viral haemorrhagic fevers	In progress

1.5	Emergency Response **Year 2 Milestone**: Delivery of training on command structures: strategic, tactical, operational	In progress
1.5	Emergency Response **Year 2 Milestone**: Delivery of training on command structures: strategic, tactical, operational	In progress
1.6	Emergency Response **Year 2 Milestone**: Delivery of incident director/incident manager training – to include leadership in a crisis	Completed (started in March 2019, completed in May 2019)
1.7	Emergency Response **Year 2 Milestone**: Review of Emergency Operations Centres guidance	Completed
1.8	Chemical Incident Management **Year 2 Milestone**: Gap analysis and baseline of chemical incident response capacity to inform input to development of chemical incident response service	Completed
1.9	Chemical Incident Management **Year 2 Milestone**: Support EPHI to establish a Chemicals Technical Working Group comprising key stakeholders for implementation of the work plan	Completed
1.10	Chemical Incident Management **Year 2 Milestone**: Delivery of introductory chemical hazard training and stakeholder workshop	Completed
1.11	Chemical Incident Management **Year 2 Milestone**: Produce hazard and risk assessment template to assist EPHI to map chemicals of concern and sources in Ethiopia (e.g. fertilizers, industrial chemicals, mining, waste disposal, import)	Completed

1.12	Chemical Incident Management **Year 2 Milestone**: Hazard and risk assessment template to be used to assist EPHI to map and risk assess these chemicals / sources. Additional support through the provision of expertise, sharing protocols, rapid risk assessment etc.	Ongoing
1.13	Poisons Centre Capacity Building **Year 2 Milestone**: Initiate development of clinical toxicology training programme (clinical, nursing staff, clinical pharmacists and poisons information specialists)	Completed
1.14	Poisons Centre Capacity Building **Year 2 Milestone**: Deliver training on establishing a poisons centre	Completed
1.15	Global Health Diplomacy **Year 2 Milestone**: Signed MoU with EPHI	Completed

Workstream 2: Sierra Leone

Output Indicator	**Milestones / deliverables**	**Status**
2.1	Workforce Development **Year 2 Milestone**: Develop a workforce planning tool for completion by divisions in Sierra Leone National Public Health Agency (NPHA)	Completed
2.2	Workforce Development **Year 2 Milestone**: Successful establishment of gap analysis and resourcing strategy to fill gap	Completed

2.3	Workforce Development **Year 2 Milestone**: Completed organogram signed off by SL NPHA and linked to gap analysis. Plan handed back to Government of Sierra Leone.	Completed
2.4	Laboratory Strengthening **Year 2 Milestone**: Review of laboratory functions and capabilities completed	Completed
2.5	Laboratory Strengthening **Year 2 Milestone**: Support technical working groups (networks)	Completed
2.6	Laboratory Strengthening **Year 2 Milestone**: Develop standardised approach to quality assurance.	In progress
2.7	Laboratory Strengthening **Year 2 Milestone**: Delivery 3 of 7 modules of laboratory capacity building training	In progress
2.8	Laboratory Strengthening **Year 2 Milestone**: Support SL workforce to access regional training opportunities	Completed
2.9	Capacity building of NPHA **Year 2 Milestone**: Recruit Head of Operations for SL NPHA	Change of focus by new leadership in Government of Sierra Leone - milestone deferred

Workstream 3: Myanmar

NB: Activities in Myanmar were due to start fully in 2019-20, to correspond with the appointment of the Myanmar Senior Public Health Adviser (January 2019). The milestones listed below were tentative 'quick wins' identified for Q3 of 2018-19. A number of these

have been deferred to 2019-20 to allow the SPHA to build relationships and consolidate work plans.

Output Indicator	Milestones / deliverables	Status
3.1	Emergency Response **Year 2 Milestone**: Delivery of workshop on reviewing national emergency preparedness policies	Completed
3.2	Emergency Response **Year 2 Milestone**: One Health Exercise in Myanmar delivered	Completed (Q1 2019/20)
3.3	Poisons Centre Capacity building **Year 2 Milestone**: Gap analysis and baseline assessment of poison centre delivered and clinical toxicology training provided to inform development of poison centre work package and toxicology training support	Completed
3.4	Poisons centre capacity **Year 2 Milestone**: Sponsor access to ToxBase (poisons information database) for Myanmar.	Completed
3.5	Chemical Incident Management **Year 2 Milestone**: Perform stakeholder mapping to identify agencies/organisations involved in chemical incident response and delineate roles and responsibilities. Identify lead ministry for chemical incident response or if not in existence provide guidance on appointing a lead Ministry.	Partially completed. Stakeholder analysis completed – there is no lead ministry for chemical incident response. This has presented a barrier to this particular milestone. We are working to overcome this by advocating a

		cross-sectoral approach.
3.6	Chemical Incident Management **Year 2 Milestone**: Produce template and provide technical expertise to support identified lead Ministry to undertake a situational mapping and orientation exercise (to provide baseline situational awareness of existing stakeholders and mechanisms)	Not complete (linked to the above)
3.7	Chemical Incident Management **Year 2 Milestone**: Gap analysis report and identification of priority areas	Completed – will evolve over the coming months
3.8	Chemical Incident Management **Year 2 Milestone**: Produce hazard and risk assessment template to assist stakeholders to map chemicals of concern and sources in Myanmar (e.g. fertilizers, industrial chemicals, mining, waste disposal, import)	Not started – moved to FY19/20

Workstream 4: Nigeria

Output Indicator	Milestones / deliverables	Status
4.1	Emergency Response **Year 2 Milestone**: Delivery of training on planning processes (reasons for having plans, risk assessment, writing a plan, senior level engagement, partnership engagement, training and exercising, embed learning)	Completed
4.2	Emergency Response **Year 2 Milestone**: Develop a Concept of Operations (CONOPS)	Completed

4.3	Emergency Response **Year 2 Milestone**: Develop an all hazards emergency response plan	Completed
4.4	Emergency Response **Year 2 Milestone**: Delivery of risk and vulnerability assessment training	Completed
4.5	Emergency Response **Year 2 Milestone**: Delivery of training on command structures: strategic, tactical and operational	Completed
4.6	Emergency Response **Year 2 Milestone**: Delivery of training for incident director/incident managers – to include leadership in a crisis	Completed
4.7	Emergency Response **Year 2 Milestone**: Training delivered on Emergency Operations Centres (EOC) – to include incident management, EOC roles, EOC activation and procedures, situational awareness and surveillance systems	Completed
4.8	Emergency Response **Year 2 Milestone**: Training delivered on One Health concept and multi-agency co-ordination	Delayed due to external factors and staff availability
4.9	Emergency Response **Year 2 Milestone**: Multi-state EOC exercise designed	Completed
4.10	Emergency Response **Year 2 Milestone**: Multi-state EOC exercise delivered	Completed

4.11	Coordination **Year 2 Milestone**: Advocated for Nigeria Centre for Disease Control (NCDC) establishment bill	Completed
4.12	Coordination **Year 2 Milestone**: Relationships established with DFID and United States Centers for Disease Control and Prevention (USCDC) in Nigeria	Completed
4.13	Surveillance System Strengthening **Year 2 Milestone**: Review conducted of event-based surveillance, make recommendations and support development/ revisions to protocol and SOPs as appropriate	Completed
4.14	Surveillance System Strengthening **Year 2 Milestone**: Provide support for NCDC to strengthen oversight, governance and assurance of surveillance and response activities	In progress
4.15	Surveillance System Strengthening **Year 2 Milestone**: Support NCDC to more effectively and efficiently translate surveillance data into public health actions	In progress
4.16	AMR **Year 2 Milestone**: Provision of a one-week training course from the reference laboratory in the UK	Delayed due to NCDC priorities (outside PHE control)
4.17	AMR **Year 2 Milestone**: Support delivery of Antimicrobial Resistance (AMR) workshop	Completed
4.18	Laboratory Strengthening **Year 2 Milestone**: Deliver enteric bacteria workshop	Completed

4.19	Laboratory Strengthening **Year 2 Milestone**: Role out 'train the trainer' for enteric bacteria diagnostics	Completed
4.20	Laboratory Strengthening **Year 2 Milestone**: SOPs and guidelines developed for existing clinical infectious diseases and laboratory related documents	Ongoing
4.21	Laboratory Strengthening **Year 2 Milestone**: Data management and utility of existing Laboratory Information Management System tools strengthened through review of data management and input provided to development of improved systems.	In progress / deferred (outside PHE control – competing NCDC priorities)
4.22	Laboratory Strengthening **Year 2 Milestone**: Map out areas that require support, develop hierarchy of need and ease of resolution	Completed
4.23	Laboratory Strengthening **Year 2 Milestone**: NCDC lab staff visit for Lassa Fever workshop at Porton Down and subsequent training at Colindale/Royal Free Hospital in London	Completed
4.24	Laboratory Strengthening **Year 2 Milestone**: Viral Haemorrhagic Fever training course (consider options, start with some short term [2 week] trips to attend course and spend some time with staff in the UK)	Ongoing
4.25	Surveillance System Strengthening **Year 2 Milestone**: Support NCDC to design and deliver surveillance workshop	Completed

4.26	Surveillance **Year 2 Milestone**: Implement and train staff on a new outbreak response management tool called SitAware.	Completed.
4.27	Surveillance System Strengthening **Year 2 Milestone**: Conduct review of event-based surveillance, make recommendations and support development/ revisions to protocol and SOPs as appropriate	Completed
4.28	Surveillance System Strengthening **Year 2 Milestone**: Review purpose, output and impact of routine data management tasks and process and implement solutions to facilitate data management and achieve efficiency gains	In progress

Workstream 5: Project management/cross project

Output Indicator	Milestones / deliverables	Status
5.1	Procurement **Year 2 Milestone**: Commissioning of third-party monitoring agency	Completed – this was delayed due to internal PHE procurement issues, but the contract has now been issued and work has started
5.2	Procurement **Year 2 Milestone**: Progress report on Global Health Fellowships received from Chatham House	Completed
5.3	Procurement **Year 2 Milestone**: Concept note of Strengthening National Accountability and Preparedness for Global	Completed

	Health Security shared with all IANPHI members and support of WHO achieved.	
5.4	Procurement **Year 2 Milestone**: Regular progress reports received on SNAP-GHS	Completed – IHR project chairs regular steering committee meetings
5.5	Leadership/mentoring **Year 2 Milestone**: Selected fellows to attend One Health Congress in Canada	Completed
5.6	Project Management **Year 2 Milestone**: Provide timely forecast to DHSC on spend	Completed

Workstream 6: Africa Region

Output Indicator	Milestones / deliverables	Status
6.1	Leadership/mentoring **Year 2 Milestone**: Successful recruitment of fellows with IHR focus from relevant countries/organisations for Chatham House Global Health Fellowships	Completed – fellowship programme is ongoing
6.2	Emergency Response **Year 2 Milestone**: Delivery of workshop on behaviour change for partner countries in Africa	Deferred – now taking place in July 2019
6.3	Emergency Response **Year 2 Milestone**: Concept note for mapping of emergency response assets for Africa developed and agreed	Completed

6.4	Coordination **Year 2 Milestone**: WHO AFRO - PHE workplan agreed	Delayed –ongoing Ebola outbreak in Democratic Republic of Congo (DCR) has pulled on AFRO resources
6.5	Coordination **Year 2 Milestone**: Letter of Intent signed between PHE and Africa CDC	Completed

(i) Summarise whether the activities that were completed as planned and indicate if the achievement delivered were the expected results.

(ii) If an agreed milestone / deliverable has not been achieved, provide a brief explanation as to why, and provide details of current status or actions that are still required (e.g. what is the new deadline, what has been done to resolve the issue and are there any critical dependencies or issues that you should flag for the attention of programme board).

Key Points:

The first full year of implementation for the IHR strengthening project saw increased and highly successful delivery against milestones across all outcome areas and workstreams.

The milestones listed above demonstrate the breadth of the IHR project's achievements. As noted, most activities were completed as planned. The detail below indicates how the achievements delivered are contributing to the project outputs and outcome areas. Additional highlights not captured by the milestone list above are also included.

Outcome 1. Strengthened global health security system coordination and collaboration through national public health institutes in partner countries, across the Africa region and globally.

Outputs:

1.1 Enhanced inter-sectoral collaborations for all-hazards health protection in partner countries

1.2 ‘One Health’ capacities improved through inter-sectoral coordination and collaboration at regional level and in target countries

1.3 Functional network of emergency operations centres and emergency response systems capable of addressing potential public health threats established, led by WHO

1.4 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

1.5 Defined package of technical assistance for antimicrobial resistance shaping national strategy

Following the first months of implementation in 2017-18, 2018-19 saw the IHR project gain momentum. Progress towards outcome 1, relating to strengthened system coordination in partner NPHIs and regionally, has been underpinned by the incremental contributions of an array of technical activities from across the IHR project – highlighted in the activity list above and detailed below.

However, the specific role of the IHR Senior Public Health Advisers (SPHAs) and the IHR programme lead should be emphasised. SPHAs were appointed to all IHR partner countries and to the Africa region (based in Africa CDC) in 2018-19. A core function of the SPHA role is to support NPHIs and advocate for enhanced inter-sectoral collaboration (output 1.1) through, for example, contributing technical and strategic expertise to National Action Planning for Health Security (NAPHS) discussions. In Ethiopia, Nigeria, Myanmar and Sierra Leone the IHR project has played a significant role in NAPHS processes, using the platform to promote an inter-sectoral all-hazards and One Health approach, and ensuring that project work plans and technical activities align with national priorities and Joint External Evaluation (JEE) focal areas.

The results of the IHR project's influence are already discernible in some cases. In Ethiopia, for example, the SPHA and IHR chemical hazards experts advocated for strengthening of the chemical hazards workforce – a previously weak area. As a result, 3 new staff members were recruited to Ethiopia Public Health Institute (EPHI) in November 2018. PHE is the only international partner working with Ethiopia to fulfil its National Action Plan for Health Security commitments towards improved chemical hazards/poisons capacity. Similarly, IHR project advocacy in Myanmar resulted in chemical-toxicological hazards ranking high on NAPHS proposals.

The SPHAs have played a key part in helping the IHR project to demonstrate an all-hazards approach in action through, for example, facilitating joint-delivery of technical activities from across PHE. In Ethiopia, the IHR Emergency Response team has co-delivered activities with both the infectious disease colleagues (jointly supporting EPHI in a simulation exercise run by the National Disaster Management Commission) and with chemical hazards teams, providing incident management and EOC training.

IHR project efforts towards strengthening system coordination in ODA-eligible countries in 2017-18 also included providing support to the secretariat of the International Association of National Public Health Institute (IANPHI) to increase its potential to reach out to low and middle-income member NPHIs – specifically in relation to IHR capacity building.

The IHR project continues to advocate for a One Health approach in all its activities (output 1.2). Further progress is being made towards demonstrating One Health in action through the appointment of a veterinary epidemiologist to bring animal health expertise into further project design and implementation. The veterinary epidemiologist participated in the scoping visit to Zambia to ensure better linkages between animal and human health in the IHR project. A One Health approach is being taken in all partner countries and will inform further activities. Planning is also underway to participate in Nigeria's Joint External Evaluation- Performance of Veterinary Services Bridging workshop (a WHO initiative that the IHR project contributed to the development of) to enable the IHR project to further implement its offer to operationalise Nigeria's One Health plan.

The IHR project continues to work in close partnership with DFID's Tackling Deadly Diseases in Africa Programme (TDDAP), sharing information and expertise, and adopting a coordinated approach to engage with WHO AFRO (outputs 1.3 and 1.4). A second joint IHR-TDDAP meeting was held in Brazzaville in January 2019, during which PHE committed to collaborate with the TDDAP implementing partner where possible. However, progress with WHO AFRO has been slow due to the ongoing DRC Ebola outbreak, exacerbating existing resource shortages. Where possible, the IHR team has continued to support WHO through engagement with WHO country-level technical staff in IHR project partner countries, and with the development of functional emergency response networks (1.3) through participation in regional After Action Reviews, such as an East African Community cross-border simulation exercise in Tanzania (July 2018).

There has been continued progress towards supporting selected partner countries to develop capacity to respond to the challenge posed by AMR (output 1.5). In Nigeria, the IHR project's Senior Public Health Adviser continues to work closely with the Fleming Fund and to offer support around the further development and implementation of the country's AMR plan. The Senior Public Health Adviser and laboratory experts, working in partnership with the Robert Koch Institute, supported Nigeria CDC's successful bid for a Fleming Fund Country Grant. In Ethiopia, opportunities to support EPHI with AMR are being explored with capacity building to ensure readiness for future Fleming Fund opportunities.

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

Outputs:

2.1 Workforce needs assessments undertaken and toolkits available for workforce gap analysis

2.2 Workforce strategic plans developed and implemented, and toolkits available for workforce strategy development

2.3 Public health leaders developed and mentored, and capacity increased for leadership development

2.4 Increased number of professionals field-deployable through GOARN, Africa CDC or other bilateral and national systems

2.5 Increased number of public health professionals with shortage skills indicated by workforce needs assessments, with training capabilities increased in partner organisations

Following a workforce needs assessment, consultation and discussion with the Ministry of Health and Sanitation (MOHS) (output 2.1), strategic plans for the workforce for Sierra Leone's proposed national public health agency were completed in FY18/19 (output 2.2) and the recommendations agreed with the Deputy Chief Medical Officer and Director with responsibility for Public Health in March 2019. Early feedback has demonstrated that the recommendations from the IHR project successfully addressed a significant gap in the MOHS' Scheme of Service for the public health workforce. Toolkits developed for Sierra Leone will now be adapted for other settings.

Developing a strong public health workforce is an important part of all technical activities within the IHR project, The IHR project's microbiology and workforce development experts created and delivered a microbiology leadership training course for delegates from Sierra Leone, Nigeria and Ethiopia (output 2.3). An evaluation of the training found that all participants agreed or strongly agreed that the work done during the training would be useful and applicable to their daily job.

Effective leadership and succession planning are essential for investment in capacity building to be sustainable and retained in the public sector. Therefore, in 2018/19, the IHR project sponsored 3 mid-level health professionals (potential future leaders) working in aspects of the public health system linked to global health security to participate in the Chatham House African Health Leaders fellowship programme. An early evaluation of the fellowship scheme has shown positive results and feedback from participating fellows, but also areas for improvement. The IHR team has led the evaluation and modification of the fellowship programme to ensure it contributes to the development of effective future public health leaders. An action plan for improvements will be considered before funding for further cohorts is considered.

The project has also promoted South-South networks of public health leaders, facilitating and sponsoring attendance at major events such as the African Society of Laboratory Medicine (ASLM) Annual Conference, attended by 14 delegates from across the IHR project's African partners (Sierra Leone, Zambia, Nigeria and Ethiopia), and the first

worldwide Lassa Fever Conference, developed and hosted by Nigeria Centre for Disease Control, attended by over 200 delegates, including 4 from Sierra Leone sponsored by the project.

Training of staff in IHR relevant skill shortage subjects (Output 2.5) continues to be the focus of the IHR project's activities, and 2018/19 saw excellent progress towards this goal. In Nigeria, highlights included the delivery of training on biosafety and biosecurity, and laboratory diagnosis of enteric pathogens. A number of recommendations emerging from the biosafety/biosecurity training have been acknowledged by NCDC and prioritised for implementation. Enteric pathogens laboratory diagnosis training was also delivered in Ethiopia to 8 EPHI and 4 regional laboratory staff, leading to enhanced skills in diagnosis, characterisation and typing, and antibiotic sensitivity testing. Surveillance capacity building support was provided to the Ethiopian Public Health Emergency Management (PHEM), resulting in the production of a first draft of a new surveillance output, which will improve usability of surveillance information provided to EPHI decision makers. In Sierra Leone, an assessment of laboratory staff skill retention was conducted, and refresher training delivered in key areas, especially relating to Ebola Virus Disease (EVD) testing.

There has been an acceleration of training and mentoring on the public heath response to chemical hazards in Ethiopia. This included introductory training on chemical hazards detection and response, training on methodologies for vulnerability and risk assessment mapping (VRAM) and supporting the establishment of a national poison centre. The IHR team has provided extensive academic and practical support to Ethiopia's national poison centre in the lead up to its soft launch (Q2 2019-20), including roleplay on managing notifications, using ToxBase and developing Standard Operating Procedures. Activities leading to improvements in chemical hazards capacity has also been initiated in Myanmar, including the delivery of training on ToxBase and a gap analysis of poisons management capability.

As part of its commitment to building national and regional deployment capacity, (output 2.4) the IHR project has this year successfully initiated a project to map emergency response assets across the member states of the Africa Union, in collaboration with Africa CDC.

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

Outputs:

3.1 Operationalisation of effective emergency preparedness, resilience and response systems through guideline development and application in surveillance and laboratory settings

3.2 Strategy developed and operationalised for surveillance, laboratories and other health protection systems based on risk assessments of threats and capabilities

3.3 System performance tested through exercises /simulations and/or events, with after-action reviews done and acted upon

3.4 Laboratory systems enhanced and quality assured, with capacity increased for laboratory QA, and laboratory networks strengthened

3.5 Strengthened systems for detection and response to chemical-toxicological public health incidents

Work towards developing and strengthening guidelines and strategies for surveillance and laboratory diagnostics (outputs 3.1 and 3.2) and improving emergency response systems has progressed well across the IHR project. In Nigeria, the IHR project helped to facilitate a workshop on the future of surveillance with Nigeria CDC and conducted an assessment of event-based surveillance (EBS) in Nigeria. The workshop recommendations and assessment outcomes influenced the direction of national policy, by prioritising the use of EBS to complement standard indicator-based surveillance. An outbreak management software, SitAware - tailored specifically to suit NCDC needs, was also developed and implemented, with more than 45 staff members at NCDC trained in its use. Since July 2018, over 220 incidents have been logged on the system, including major nationwide outbreaks (e.g. Lassa fever, meningitis, measles and cholera). Data from SitAware is also being used for surveillance outputs including a new improved NCDC Weekly Epidemiological Report demonstrating the location and nature of live incidents and outbreaks. The software will be rolled out to other Nigerian States in the coming months to allow real-time information sharing between NCDC and States and facilitate improved coordination of outbreak response.

Work to improve national emergency response systems has taken place in Nigeria, Ethiopia and in Myanmar. Following the delivery of training on the fundamentals of emergency response in the first year of the project, 2 major simulation exercises were conducted in Nigeria to test the systems, including use of SitAware (output 3.3). A number of recommendations emerging from the first exercise have already been implemented by Nigeria CDC, including the development of a clear communications plan for both national and state level during an infectious disease outbreaks, and the development of formal pre-approved communication messages for the state public health emergency operations centres to use in specific response situations. A senior participant stated that ‘we learnt a lot of lessons [during the exercises] and identified opportunities for improvement' [email correspondence 29 March 2019]. The IHR team also supported EPHI in a simulation exercise in Ethiopia, and planning commenced for a One Health exercise and an after action review in Myanmar (scheduled for Q2 2019/20).

A number of expert trainings have been delivered in both Nigeria and Sierra Leone on laboratory system enhancement, quality assurance and lab networks (output 3.4). In Sierra Leone, a detailed training programme has been developed to take the Connaught Laboratory in Freetown through the Strengthening Laboratory Management Towards Accreditation (SLMTA) process. The IHR project's microbiology adviser successfully

advocated to strengthen laboratory network systems in Sierra Leone, working with the Laboratory Technical Working Group to improve specimen transfer mechanisms to improve laboratory surveillance for Ebola and other Viral Haemorrhagic fevers. In Nigeria, a number of core laboratory system functions were improved through the production and implementation of Standard Operating Procedures (SOPs) and training on External Quality Assurance.

Activities to strengthen systems for the detection of and response to chemical-toxicological incidents (output 3.5) have progressed well in Ethiopia, with a soft launch of the new national poisons centre planned for quarter 2 of 2019/20. In alignment with NAPHS priorities, efforts to build chemical/poisons capacity were also initiated in Myanmar. Opportunities to build chemical-toxicological capacity in Zambia were also scoped and will be developed in 2019/20.

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

Outputs:

4.1 Timely procurement through government systems

4.2 Effective contract management

4.3 Timely financial reporting, budget forecasting and reconciliation

4.4 Effective robust monitoring and evaluation system

4.5 Effective collaboration across UK government global health security programmes

4.6 Effective negotiation and influencing to further global diplomatic objectives

As technical delivery progresses, the project management team has refined and improved its management systems. In 2018-19, the IHR team successfully conducted several procurement processes (output 4.1), most notably the commissioning of a third-party evaluation provider through the DFID procurement framework. Other contracts have been maintained and managed (e.g. logistics suppliers and service providers) (output 4.2), including the relationship with Chatham House, delivering the Strengthening National Accountability for Preparedness for Global Health Security (SNAP-GHS) project. The SNAP-GHS Project develops and pilots an approach with NPHIs in Ethiopia, Nigeria and Pakistan, to improve the use of data for national and subnational decision-making and preparedness against public health threats. The first 4 phases of SNAP-GHS were delivered to schedule in 2018-19, and routine meetings between the IHR project team and the SNAP-GHS team were conducted.

The project management team has continued to maintain 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 5).

Excellent progress towards further strengthening an effective and robust M&E system has been made this year (output 4.4). This has included developing an online system (Jira) for updating against milestones and storing evidence, commissioning an external evaluator to conduct a mid-point project review (January 2020) and conducting regular reviews of the theory of change (see section 8). Routine reports are submitted to the project manager on a monthly basis by SPHAs and technical teams in order to facilitate oversight on progress against project plans and the logframe.

In December 2018, the IHR project management team conducted a second evaluation of its performance by inviting feedback (via an anonymised online team 360 survey). The results of this survey – 71% positive – have been considered and discussed at a team away day and recommendations will be enacted to improve performance. This will continue to be repeated regularly as a core part of the team's internal M&E.

In addition to routine monitoring and evaluation methods, the IHR team commissioned Capacity Development International to conduct training on using the EFFECt Tool, designed to evaluate the effectiveness and sustainability of interventions undertaken by international health partnerships. As institutional partnerships are at the heart of the IHR project methodology, this tool will be used with each NPHI to assess the perceived value of the relationships. This was the first application of the EFFECt tool for institutional partnerships for public health.

In relation to output 4.5, collaboration across HMG GHS programmes has continued to strengthen. Joint DHSC-DFID attendance at key meetings and events (IHR launch in Nigeria, second WHO AFRO meeting in Brazzaville) and routine information sharing meetings in partner countries enables effective cross-government working, ensuring minimal duplication of effort, and leveraging opportunities for sharing information and expertise. The IHR team has also continued to share information regularly with the Fleming Fund, joining forces on a scoping mission to Zambia, for example.

IHR Senior Public Health Advisers and the IHR programme lead have contributed significantly towards logframe outputs 4.5 and 4.6 through building relationships with HMG partners in IHR project countries, especially DFID country offices, and with external stakeholders. The official launch event of the IHR project in Nigeria provided an excellent opportunity to showcase the project's work, but also PHE's increasingly strong partnerships with the Ministry of Health, DFID, DHSC, WHO, US CDC and GIZ. In Ethiopia, the IHR project has helped to facilitate events and training run by US CDC. In Sierra Leone, the project has been working with representatives from the Public Health

Agency of Canada (PHAC) in relation to improving bio-banking facilities and staff training within the MOHS-SL.

3. Evidence of Risk Management

The following risks were identified and managed by the International Health Regulations Strengthening Project during this reporting year.

	Risk	Mitigation Actions	RAG rating	Current Status / Update
1	CAUSE(S): As a result of increased interest in IHR compliance from major donors e.g. World Bank, US CDC, BMGF RISK: There is a risk of duplication, overlap or contradictory approaches. IMPACT(S): Which may impact on the ability of PHE's IHR project to make an original contribution to the IHR strengthening field	Regular engagement with other agencies to ensure consistency and agree shared approaches where appropriate Communications strategy to improve visibility of PHE	Green	Lower risk as PHE becomes more established as global health actor. Official IHR communication strategy has been slightly delayed due to a desire to align with the PHE global health communications strategy – pending
2	CAUSE(S): As a result of lack of political engagement in the selected countries RISK: There is a risk of difficulty making progress with agreed plans IMPACT(S): Which may impact on implementation and issues with sustainability of projects Lack of engagement may also cause delays in implementation and subsequent underspending	Ensure existing commitment to IHR & JEE process Work with DFID and existing in-country partners Ensure relationships with partner countries are kept warm and identify focal	Green	This risk is lowering as the IHR project becomes more established and relationships with DFID and other partners strengthen

		contact points where possible		
3	CAUSE(S): As a result of delays in recruitment/country engagement on workplans/logistical issues/external factors (e.g. security in selected countries) and availability of PHE staff RISK: There is a risk of...delays to the start of the implementation phase workstreams IMPACT(S): Which may impact on spending and timely achievement of project objectives	Keep DHSC well-informed about potential delays and underspend Ensure recruitment paperwork is ready to go as soon as plans for activities are agreed Ensure alternative activities can be implemented to avoid underspend	Amber	There are still potential delays in delivering activities for a range of reasons, with impact on spending/outcomes However, lessons have been learned and more margins for delays are built into project planning - in addition, reporting relationships with DHSC are strong PHE & DHSC need to explore possibility of building up capacity for global health by creating some marginal additional capacity for core ‘grant in aid’ activity that can be flexibly used for global health activities
4	CAUSE(S): As a result of working across a number of PHE directorates RISK: There is a risk of inefficiency and lack of clarity on roles/responsibilities/ governance processes IMPACT(S): Which may impact on the transparency and efficiency of project delivery	The IHR project is planning a workshop for PHE's ODA funded projects, involving representatives from a number of PHE directorates in order to clarify and agree ways of working	Amber/ Green	This risk has been reduced through increasing clarity on ways of working Increasing project leadership capacity is also being considered to enhance governance capability
5	CAUSE(S): As a result of lack of awareness about PHE's role	A communications	Green	This has been delayed due to the need to align a

	in global health work RISK: There is a risk of difficulties interacting with other HMG departments, including operationally, while sharing the HMG platform in country IMPACT(S): Which may impact on PHE's reputation, and ability to meet its programme objectives	strategy is needed to clarify PHE's role in global health There should be one for within UK HMG and also for external partners		project communications approach with a PHE global health communications strategy The communications strategy in turn needs to align with the new 2019 - 2024 PHE global health strategy which is currently under development
6	CAUSE(S): As a result of Brexit and planning for a no deal RISK: There is a risk of resources the IHR project previously had available being pulled into Brexit planning There is also a risk of materials and equipment required for laboratory training being harder to procure than previously due to Brexit delays/trade negotiations IMPACT(S): Which may impact on timely and effective project delivery	We have requested that our lab staff consider lab equipment required in the near future, so that stocks can be ordered if necessary	Amber	
7	CAUSE(S): As a result of inflexible immigration policies RISK: There is a risk of delegates nominated to	This has materialised as an issue – especially in regard to Ethiopia – and has been	Red	This has been escalated to the One HMG group. Alternative locations for delivery of training (eg South Africa) are being explored

	participate in UK based activities being refused visas IMPACT(S): Which may impact on the delivery of the project, the UK's reputation internationally, spending (activities cancelled at last minute), gender imbalance and socio-economic inequalities	flagged to DHSC		

(i) Summarise any risks during the reporting year that have materialise as issues, provide a brief explanation as to why, and provide details of current status or actions that are still required.

Key Points:

The IHR project team continues to maintain a risk register for the project that is reviewed routinely. Risks are reviewed at the Project Board meeting. RAG rated red risks are escalated the GHS Programme risk register for discussion.

IHR project risks are also highlighted quarterly for discussion at the PHE Programme Management forum. As well as ensuring risks are communicated, the Programme Management forum also provides an opportunity to reduce delivery risks through sharing learning between delivery teams who have different levels of experience of delivering ODA-funded programmes.

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

Summary of overall project delivery issues and recommendations for improvement.

- Issue: Engagement with WHO AFRO regional team remains slow and limited due in part to their staffing challenges and the ongoing Ebola outbreak in DRC. Recommendation: If delays with WHO AFRO HQ continue, explore opportunities to engage with WHO Country Offices in IHR focal countries directly in order to deliver PHE WHO AFRO workplan. Assess approach to partnership with WHO AFRO in 2019/20 Q2
- Issue: Occasionally inconsistent methods of updating the project team about progress against technical activities. Recommendation: Issue new guidance as part of the Ways of Working document and circulate an M&E flow chart to explain the process and roles/responsibilities.

- Issue: The Technical Working Group is working well as a forum for operational updates and exchange of best practice, but there is a lack of opportunity to discuss strategic matters. Recommendation: Reconsider the strategic governance of the IHR project exploring options such as the creation of a cross-project strategic group to bring together relevant decision makers to inform strategic direction.
- Issue: Not always clear which IHR project risks have been raised to DHSC Programme Board level by the PMO. In addition, with new country engagement in Pakistan and Zambia and the complexity of the governance and reporting lines of the New Approach to Africa there can be parallel reporting lines and confusion about roles and responsibilities between DHSC and PHE. Recommendation: Linked to above, conduct an overarching review of governance arrangements from DHSC level to frontline, ensuring clarity about roles/responsibilities.
- Issue: Risks are not always current. Recommendation: Ensure risks are actively reviewed at a monthly basis during team meetings, and advocate to ensure RAG rating definitions are consistent between PHE Global Programme Management teams and DHSC Programme Board, to avoid confusion and duplication of effort.

Key recommendations:

- **Review the IHR project leadership and management structures in response to the expanding size and complexity to ensure continued efficiency and effectiveness**
- **Map roles and responsibilities (e.g. in relation to New Approach to Africa) and record and manage any risks identified to avoid parallel reporting or duplication between the IHR project and DHSC**
- **Strengthen mechanisms for continuous improvement based on lessons identified through monitoring and evaluation**

Finance

Delivery confidence assessment for reporting year

RAG rating:	Amber

Changed since last year (Y/N): N

4. How is the funding being used?

Annual summary:

Total annual budget for this reporting year: £3.5m
Total annual spend for reporting year: £3m

5. Evidence for effective budget management and forecasting

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Forecast	£735,000	£ 921,000	£ 1,093,000	£ 732,000
Actual spend	£392,000	£555,000	£753,000	1,375,000

Provide summary level explanation for deviations between forecast and actual spend

Key Points:

Spend in 2018/19 was less than originally forecast. The underspend in this FY is in part the result of efficiency savings, due to some technical activities costing less than originally anticipated, and a change in the IHR project's overhead rates from 50% to 30%, which improves the value for money of the project. These efficiency savings allowed us to achieve more, over and above existing deliverables this year. For subsequent years, these efficiency savings will continue and will be recognised during forecasting.

However, there were some delays and slippages in delivery at the start of the financial year due to staffing issues, procurement delays (e.g. there was a significant delay in

procuring an external M&E provider resulting in an underspend) and difficulties in securing staff time due external factors such as competing domestic priorities (e.g. following the Salisbury attack). Internal barriers to spending, such as problems with international recruitment and procurement, have been escalated and are being addressed through PHE's Global Operations team. Spending improved in the final quarters of the year, reflecting an uptick in activity due to recruitment and procurement issues being resolved.

6. Evidence of ability to administer ODA funding

Outline any process changes to finance reporting and monitoring?

Key Points:

A number of steps have been taken in FY18-19 to:

- Ensure even more rigorous financial reporting and monitoring mechanisms
- A new financial tracking tool has been developed to facilitate easier reconciliation of spending and transaction reports
- Following an incident of attempted cyber fraud/theft from the IHR project, more rigorous checks on invoices are now conducted by the IHR project team (involving cross-checking)
- Sponsorship forms have been developed and approved by the Senior Management Committee to improve the consistency of support provided to delegates attending IHR funded events

The project remains under pressure to pay 'facilitation fees' in some of our project countries as an incentive for locally employed staff to participate in training and other capacity development activities. While this has been resisted, it has led to reduced engagement of staff in some countries. Support from One HMG to advocate against these expectations through partner governments would be welcome.

In general terms, all project funds are directed towards technical expertise and system development in ODA-eligible countries in order to support the current work programmes.

7. Evidence of activities undertaken to meet IATI transparency standards

Self-assessed score against the IATI transparency standards

0 – 19%	Very Poor	☐
20 – 39%	Poor	☐
40 – 59%	Fair	☐
60 – 79%	Good	☒
80 – 100%	Excellent	☐

Summarise what steps the International Health Regulations Strengthening Project have taken to ensure transparency of activities

Key Points:

The IHR Strengthening team attended the Transparency Workshop run by DHSC in 2018. The workshop was very helpful for identifying the expectations of publishing transparency and provided practical advice on next steps.

Since the workshop, the IHR project and UK-PHRST have been working with PHE's internal publications team to better understand the controls on publishing project documents online. To move toward the DHSC set target of 'good' for the IHR Project, the GHS Programme Management team is intending to publish the project business case, MOUs and other relevant documentation to AidStream. This information links directly to the IATI registry.

The IHR team will continue to fully engage with DHSC plans for achieving higher scores against IATI standards going forwards.

A log of documents for publication has been created and an administrator has been tasked with driving forward publication for transparency. A number of documents have already been submitted and given approval for publication.

Summary of finance issues and recommendations for improvement

- Issue: The project was underspent in 2018-19 for a number of reasons. Recommendation: A) Technical teams will be encouraged to supply more detailed work plans to help improve forecasting and allow for the delivery of more, within the spending profile. B) An amendment to the IHR project business case to allow for greater flexibility in spending has been proposed to include capital investment and grant issuing. C) The PHE Global Operations team must continue to advocate for improvements to PHE internal systems to help increase the efficiency of doing business internationally (recruitment, procurement), thus avoiding delays to delivery, and resultant underspend.

- Issue: Risks of financial fraud when dealing with unfamiliar international suppliers. Recommendation: Follow new protocols designed to increase scrutiny during financial transactions (e.g. comparing invoices/checking bank details).
- Issue: Unclear internal PHE processes for publishing documentation relating to the IHR project. Recommendation: Work with the UK-PHRST to continue to adopt a joint approach to publishing documentation on a routine basis, while continuing to comply with PHE guidelines as necessary.
- Issue: With high workloads publishing for transparency may not always be a priority activity. Recommendation: Maintain an accurate log of documentation for transparency publication so that opportunities are not missed.
- Issue: Vulnerability to domestic events (e.g. Salisbury attack). Recommendation: record instances of disruption to the project as a result of domestic events and review risks/identify mitigating actions.
- Issue: Expanding collection of project assets e.g. laptops purchased for training purposes. Recommendation: to set up an asset register for the laptops and other assets.

Key recommendations:

- **Work closely with technical teams to maintain expenditure and adjust to ensure optimum efficiency**
- **Explore opportunities to use new financial mechanisms to increase the diversity of approaches the IHR project is able to use to achieve its goals, including capital investment and grant making**

Theory of Change

8. Evidence to show if the theory of change assumptions remains accurate?

Key Points:

Assumptions of the theory of change:

1) Budget available to meet proposal requirements

2) Funding and management capacity is sufficient

3) Partnerships and multi-sector engagement can be attained

4) Partnerships and multi-sector engagement can be sustained

5) Strategic plans have adequate resources, political engagement and leadership for implementation

6) Continued political leadership and alignment of donor funds behind national IHR plans

7) Leadership from national public health professionals drives system and health development and securing of resources

8) Possible to identify suitable and available candidates for training and mentoring

9) System coordination enables effective use of other inputs into health protection systems

10) Trained public health workforce can be recruited and retained

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

General comment on assumptions:

As the Theory of Change (ToC) was designed ahead of implementation, a number of exercises have been conducted by the IHR project team during the first full year of implementation, 2018-19, to ensure that the assumptions remain accurate and that the ToC is still relevant and meaningful.

Firstly, following initial discussions held during the first IHR project Away Day in 2017, the team led an in-depth Foresight Planning process involving interviews with key stakeholders, horizon scanning and analysis, with input from the Government Office for

Science. Foresight Planning is a process which encourages consideration of external factors which could affect future activities. The process highlighted topics that stakeholders felt might affect the impact of the IHR project. Two topics were chosen for detailed discussion at a workshop: 'the impact of fragile nutrition security/ food systems on achieving IHR compliance' and 'demonstrating the effect of the IHR strengthening project on country preparedness'. Following the workshop, priorities, barriers and opportunities for the project were outlined. The barriers identified were particularly pertinent for consideration against the assumptions in the ToC. Detailed comments against each assumption are included below.

The IHR project team also participated in a Theory of Change workshop designed for the wider PHE Global Public Health Programmes team. This allowed the project team to check its understanding of the principles of ToCs and ensure alignment with the development of an overarching Global Programmes ToC. The workshop also enabled preliminary discussions about monitoring and evaluation and alignment of ToCs with the DFID-funded Pakistan project ahead of its merge into the IHR project in April 2019.

In December 2018, the IHR project organised a team Away Day with a session on 'Rich Pictures'. Again, this encouraged discussion of internal and external factors influencing the project (short, mid and long term) and led to further reflection on our ToC assumptions – especially those relating to management capacity.

In the first year of implementation it has not been so feasible to test some of the broader assumptions in the ToC around the effect of system coordination and technical inputs on health system strengthening. As a result, the IHR project team commissioned a theory of change workshop in Q4 of 18/19 with a focus on the IHR project, involving all PHE stakeholders in order to help to map out the connections between project inputs, expected outputs and the ToC to help check the assumptions. Unfortunately, due to delays with procurement and contracting, the theory of change workshop did not take place until the start of Q1 19/20.

Detailed comment on assumptions:

1. Budget available to meet proposal requirements

2. Funding and management capacity is sufficient

Budget/funding: These assumptions remain true, and additional funds have been secured through the Africa Uplift and to enhance plans under the Pakistan work programme. Funding and management capacity has been sufficient for this review period and an underspend was reported for FY 18/19.

Management: Management capacity within the IHR team is sufficient – especially now a second project manager has also been recruited to help with project expansion. However, discussions during the Away Day ‘Rich Picture’ process highlighted the constraints placed on the project by unclear or lengthy internal PHE management processes. This is the result of PHE internal systems being designed predominantly for UK-facing engagement, rather than international. A number of improvements have been secured in FY18/19 (e.g. securing permission to recruit locally overseas through the FCO) thanks to escalation through the Global Operations department.

3. Partnerships and multi-sector engagement can be attained

4. Partnerships and multi-sector engagement can be sustained

5. Strategic plans have adequate resources, political engagement and leadership for implementation

6. Continued political leadership and alignment of donor funds behind national IHR plans

7. Leadership from national public health professionals drives system and health development and securing of resources

The IHR Strengthening project relies on strong partnerships, networks and institutional linkages to facilitate and enhance the technical work that takes place. At present, assumptions 3-7 remain accurate, but it is recognised that maintaining political will, engagement and partnerships will be key in ensuring impacts are realised. In FY18/19, our partnerships have been effectively strengthened and sustained. In 2019-20 the EFFECt tool (see above) will be used to measure the effectiveness and sustainability of the institutional partnerships developed through the project to date.

In terms of assumption 5, some risks around strategic planning within UK government were identified during the Foresight Planning process including:

- A perceived low level of political buy-in to global health and global health security,
- A perceived inability for PHE to influence on issues regarding global health at a senior UK government level,
- Perceived political uncertainty (BREXIT),
- Perceived lack of leadership and steer around the Sustainable Development Goals within HMG.

Recommendations were suggested, such as for PHE to achieve greater representation in strategic level HMG discussions (e.g. Africa Strategy) and have been enacted.

8. Possible to identify suitable and available candidates for training and mentoring

Whilst identifying suitable candidates for training/mentoring continues to be feasible, increasing constraints have emerged due to strict UK visa processes. This has meant that bringing delegates from partner countries to the UK for training events has become increasingly challenging – often impossible. Candidates from some countries, such as Ethiopia, have found it especially hard to secure visas, as have those with the lowest incomes (often women). This is impacting on the geographical and gender equity of our project approach

9. System coordination enables effective use of other inputs into health protection systems

10. Trained public health workforce can be recruited and retained

11. 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. To assess these assumptions now that implementation has taken place for a full year, a workshop with the project's external evaluator was commissioned in Q4 and took place in April 2019. A mid-point external evaluation of project impact will be delivered in February 2020.

Summary of any changes recommended to the theory of change

- No changes have been suggested for the ToC at this stage. However, the project team will carefully review and enact relevant recommendations emerging from externally facilitated IHR ToC workshop (April 2019). This may mean creating more detailed country-specific theories of change if relevant.

Key recommendation:

Review the Theory of Change in partnership with the third-party monitoring agent to ensure assumptions are still correct and to incorporate any new evidence of effectiveness

External Engagement

Delivery confidence assessment for reporting year

RAG rating:	Amber/Green

Changed since last year (Y/N): No

9. Evidence of use and success of the communication strategy

(i) Brief summary to the communications strategy or policy for each element of the project.

(ii) Overview if the planned communications activities (activities outlined or agreed in the relevant communication strategy or policy) in the current reporting period.

Key Points:

The IHR project team continues to work 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 public. A draft plan is now awaiting approval. However, progress has been delayed by the need to align with a wider PHE global health communications plan – which is still in development.

It is expected that the finalised plan will cover:

- Social media communications: e.g. tweeting about project activities and events/re-tweeting relevant publications from our partner organisations. Audience: partner NPHIs and public in focal countries and the UK. Purpose: to raise awareness of the content of the IHR project and to engage with our partners, 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.

- Regular updates to IHR project 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 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.

While the strategy is under development, the IHR team has already made good progress to ensure maximum coverage of relevant activities using PHE internal and external communications tools such as newsletters, social media, blog entries and the Chief Executive's widely read Friday Message. A 2-page information sheet about the IHR project designed for external partners was also developed and widely disseminated in 2018-19 to improve understanding of the breadth and aims of the project.

Twitter is widely used by the IHR project's partner NPHIs, and the project team has advocated for PHE's social media team to adopt a proactive approach to following, tagging and re-tweeting relevant materials from its partners. This is important both for the profile of the IHR strengthening project, and for demonstrating interest in PHE partners – vitally important for relationship building. The project's engagement on social media has also created an important communication channel between PHE technical experts and their counterparts in partner NPHIs, and for senior leaders to endorse the project. For example, following coverage from Nigeria CDC about PHE's CEO attending the launch of the IHR project in Nigeria, the IHR project received a tweeted endorsement of the PHE-NCDC partnership from the Director General of Africa CDC.

'Congratulations on this milestone [launch of IHR project in Nigeria] which is fully aligned with our heads of state vision when they issued the call to accelerate the implementation of IHR for Africa's health security. Africa CDC applauds this partnership!' John Nkengasong, Twitter, Oct 4 2018

Following his visit to the IHR project launch in Nigeria, Duncan Selbie's Friday Message praised progress with NCDC, stating that 'there is already significant mutual learning' (October 5 2018, Friday Message).

The IHR team regularly engages with internal communications opportunities, contributing regularly to the Global Health Newsletter, participating in a country-wide Global Health Roadshow, and taking part in a session at the PHE annual conference. These activities aim to publicise the project and highlight opportunities for involvement for public health experts from across PHE, to further diversify the technical resources available for project activities.

The project has also been exploring opportunities for engaging in academic and external facing publications, such as the WHO Weekly Epidemiology Report Special Edition (in press). Moreover, the project has recently been featured in a paper in the Lancet (Erondu et al. Building the case for embedding global health security into universal health coverage: a proposal for a unified health system that includes public health. Lancet 2018; 392: 1482–86). In October 2018, the IHR team successfully submitted an abstract to run a session on the linkages between universal health coverage and global health security at the acclaimed Fifth Global Symposium on Health Systems Research. The panel involved the representatives from Nigeria CDC, UCL Centre for Global Health, DFID and the IHR programme lead. The event was well-attended and received good social media coverage.

10. Evidence of external engagement (other)

(i) Overview of additional engagement with relevant partners (include, where appropriate, reference to engagements with in or out-country organisations, research and industry stakeholders, public audiences that have not been identified in part 9).

Key Points:

Engagement with project partners both in the UK and overseas was strong in 2018-19. A Memorandum of Understanding and a Letter of Intent were signed with EPHI and Africa CDC respectively, and the PHE workplan in Myanmar was endorsed by the Union Minister. The Director General of Africa CDC described PHE as an 'exemplary' partner. In Sierra Leone, PHE's Senior Microbiology Adviser bolstered PHE's relationship with the MOHS-SL, receiving invitations to sit on the Laboratory Technical Working Group and influencing change. Relationships have been slower to develop with WHO AFRO, due to the ongoing Ebola outbreak in DRC, pulling on capacity at AFRO HQ. The joint DFID-PHE meeting with WHO AFRO in January 2019 led to re-affirmations of commitment to work with PHE, and a renewed strategy to initiate joint work. A Memorandum of Understanding was finally signed with WHO AFRO in May 2019.

In 2018-19, the IHR project has continued efforts towards strengthening engagement beyond its core partners to reach the wider global health community (strengthening regional networks) and the public. This has been achieved in several ways, especially through funding, organising or hosting a number of successful external events.

A key aim of the project's external engagement has been centred on leveraging public health capacity building through already established networks. For example, the IHR project has been advocating for closer alliances between schools of public health (UK, European and African) and NPHIs, to improve public health capacity. In June 2018, the IHR project funded and organised a session at the Association of Schools of Public Health in the European Region (ASPHER) Dean's Retreat. This event brought together ASPHER, Association of Schools of Public Health in Africa (ASPHA), Faculty of Public Health (FPH), International Association of National Public Health Institutes (IANPHI), and WHO. The session helped to raise understanding between these networks of different models and approaches to public health capacity development, identifying potential areas for future collaboration and enabled exploration of options for strengthening collaboration in support of building a strong and capable public health workforce internationally. This work will be taken forward in 2019/20

Building on this engagement, representatives from the IHR project also attended the 2018 Annual ASPHA conference in South Africa, with its focus on public health competencies. In November 2018 at the IANPHI Annual Meeting in London, the IHR project advocated for IANPHI members to recognise their role in supporting public health training and competency development as part of their core functions. This challenge is yielding dividends, with increasing collaboration between IANPHI Europe member NPHIs and WHO.

The IHR project has engaged extensively with the IANPHI Secretariat and members to develop approaches towards strengthening the use of IHR-related indicators in member NPHIs (especially in ODA-eligible countries). The IHR-funded SNAP-GHS project will be handed over to IANPHI following completion of the pilot phase (August 2019). IANPHI will take over as the leading platform to coordinate capacity-building for NPHIs and facilitate a peer-to-peer support network of NPHIs. In preparation for this, the IHR team provided time-limited funds in 2018-19 to expand the capacity of the IANPHI Secretariat in order to begin the process of socialising the SNAP-GHS project among its members.

The IHR project continues to work closely with the Fleming Fund. We work collaboratively to help optimise Fleming Fund engagement in countries where the project already has a presence. Acting as a 'critical friend,' the IHR project attended the Fleming Fund partners event in Tanzania in November 2018 and through that process identified opportunities in the coming year to explore sharing approaches for evaluation of the fellowship programmes.

The IHR project is exploring new approaches and partners to ensure sustainability of our capacity-building activities through engagement with other regional public health bodies. Discussions have started with the West Africa Health Organisation (WAHO), the health body of the Economic Community of West Africa States (ECOWAS), to identify areas for potential collaboration.

In addition to working with IANPHI, the IHR project continues to build partnerships with US CDC, with whom we have close relationships and often co-deliver activities in partner countries, for example with GIZ and JICA in Nigeria on surveillance and laboratory strengthening activities. RESOLVE, a new initiative focusing on global health security and non-communicable diseases, sees PHE as a primary partner in Nigeria where training and system strengthening activities have been jointly developed and delivered.

Summary of engagement issues and recommendations to improve the effectiveness of stakeholder and delivery partner engagement.

- Issue: The finalisation of the IHR project communications plan has been held up due to delays with the wider PHE global health communications plan. Recommendation: A) Initiate routine meetings with Global Strategy team to ensure IHR project needs are reflected in the wider communications plan. B) Initiate weekly news round-up of press coverage to improve internal communications.

- Recommendation: Conduct a ‘mid-point’ stakeholder mapping process to review existing and potential partnerships – especially considering the expansion of the IHR project into Zambia, initiation of programme activities in Myanmar, the merging of the previously DFID-funded Pakistan project team into the IHR project, and increasing IHR project representation at events such as the IANPHI Annual Meeting and the Second WHO-coordinated biennial Africa Health Forum.

- Issue: Public awareness of the IHR project remains low. Recommendation: Increase external/public awareness of IHR project activities and achievements through the publication of an annual external-facing report/brochure, regular updates to the project information sheet, and a video ‘explainer’ of the IHR project.

Key recommendations:

1) Develop a communication strategy to inform and support a robust and reactive approach to external engagement. Development of a renewed PHE global health strategy to replace the 2014-2019 will provide the framework to steer such engagement

2) Develop and implement active horizon scanning to identify and engage with potential partners

3) Share lessons learned through publications in scientific journals and relevant conferences

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Key recommendations:

12) **Develop a communication strategy to inform and support a robust and reactive approach to external engagement. Development of a renewed PHE global health strategy to replace the 2014-2019 will provide the framework to steer such engagement**

13) **Develop and implement active horizon scanning to identify and engage with potential partners**

Share lessons learned through publications in scientific journals and relevant conferences

Lessons Identified

Key Points:

The first full year of implementation for the IHR Strengthening project has been successful. The achievement of most project milestones has been underpinned by strong partnerships between the IHR project and its partner organisations, and the project has received increasing recognition as an important contributor to the wider HMG global health security portfolio. As technical activities accelerate, the project team has continued to grow, especially with the recruitment of a full complement of Senior Public Health Advisers assigned to partner countries. In line with this expansion, project management processes have been further refined and consolidated, including more detailed monitoring and evaluation systems, robust operational guidance, and greater scrutiny of financial and risk management processes. Several improvements to PHE's operational systems have been secured following issues highlighted in the first year of the project through close working with the Global Operations team.

However, challenges remain. The IHR team is still working to thoroughly address delivery/operational lessons identified at the start of implementation in early 2018. The IHR project remains the biggest global project managed by PHE to date, and the teething problems related to managing international operations (such as procurement and recruitment) are not unexpected nor quickly resolved. While improvements are being secured, mitigating actions, such as building extra time into all recruitment and procurement processes, have now been enacted as a result of learning from FY17-18.

Additional lessons identified in 2018-19 include:

- **The importance of horizon scanning, planning and adaptability**

While planning for 2018-19, the project team worked with the technical teams and country leads to map out milestones. A number of external events with the potential to derail project delivery were considered as part of this process. For example, a risk assessment of the impact of the Nigerian election was conducted, which enabled teams to plan activities around election restrictions.

It was impossible to predict the ongoing impact of events such as the Salisbury Attack (March 2018) on the project. A significant number of Emergency Response Department staff, previously deployed for the IHR project, were required to resume full-time domestic responsibilities. This had a significant impact on progress against planned activities, especially in Ethiopia. This contributed to an underspend in the first 2 quarters of the year.

Two important lessons were learned because of these events. Firstly, due to the flexibility built into project plans, it was possible to deliver delayed activities later in the year, reducing the overall impact on the project. Going forwards, it will be important to maintain flexibility to protect against similar unexpected external factors in future.

Secondly, project capacity was rapidly diminished when an important cadre of experts was re-deployed away from global health to domestic responsibilities. To avoid this in future and to reduce the impact of external factors on the project in future years, the number of technical staff dedicated to global health and to the IHR project should be increased. Progress towards this goal has already been started and recruitment is underway.

- **Importance of early planning and open engagement with PHE internal systems**

The IHR project is intended to ‘work with’ our partners, not ‘do for’. As a consequence, all project planning has been a collaborative process – as in 2017-18 – and the priorities of the partner NPHIs strongly influence the direction of the project. Though this is an important principle of the project, it can lead to delays due to lengthy consultation and occasional changes in focus (in line with shifting national priorities or the activities of other donors). This has contributed to the underspend in 2017-18. The importance of building additional time into the project planning to mitigate for these delays is critical and is applicable to any project with a collaborative approach.

Overall Project Delivery and Recommendations

Overall assessment RAG rating

Activity areas	RAG rating	Has RAG rating change since last annual review?
Project Management	**Amber / green**	**No**
Finance	**Amber**	**No**
Theory of Change	**Green**	**No**
External Engagement	**Amber/ green**	**No**

Overall Delivery Confidence rating: Amber/green

List of recommendations:

<u>Project Management</u>

1) **Review the IHR project leadership and management structures in response to the expanding size and complexity to ensure continued efficiency and effectiveness**

2) **Map roles and responsibilities (e.g. in relation to New Approach to Africa) and record and manage any risks identified to void parallel reporting or duplication between the IHR project and DHSC**

3) **Strengthen mechanisms for continuous improvement based on lessons identified through monitoring and evaluation**

<u>Finance</u>

1) **Work closely with technical teams to maintain expenditure and adjust to ensure optimum efficiency**

2) **Explore opportunities to use new financial mechanisms to increase the diversity of approaches the IHR project is able to use to achieve its goals, including capital investment and grant making**

Theory of Change

1) **Review the Theory of Change in partnership with the third-party monitoring agent to ensure assumptions are still correct and to incorporate any new evidence of effectiveness**

External Engagement

1) **Develop a communication strategy to inform and support a robust and reactive approach to external engagement. Development of a renewed PHE global health strategy to replace the 2014-2019 will provide the framework to steer such engagement**

2) **Develop and implement active horizon scanning to identify and engage with potential partners**

3) **Share lessons learned through publications in scientific journals and relevant conferences**

At-a-glance country activity summary

The following summaries provide an at-a-glance overview of activity in each of the IHR strengthening project's primary areas of work in 2018-19, separated by country/regional organisation. An overview of the project's cross project activities and governance is also included.

The high-level activity depicted is categorised according to the logframe outcome/output it relates to, with colour coding to indicate the relevant technical area.

Outcome 1: Strengthened global health security system coordination and collaboration

Outputs:

- 1.1 Enhanced inter-sectoral collaborations for all-hazards health protection in partner countries
- 1.2 'One Health' capacities improved through inter-sectoral coordination and collaboration at regional level and in target countries
- 1.3 Functional network of emergency operations centres and emergency response systems capable of addressing potential public health threats established, led by WHO
- 1.4 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
- 1.5 Defined package of technical assistance for antimicrobial resistance shaping national strategy

Outcome 2: Health protection professional workforce developed in skill-shortage areas

Outputs:

- 2.1 Workforce needs assessments undertaken and toolkits available for workforce gap analysis
- 2.2 Workforce strategic plans developed and implemented and toolkits available for workforce strategy development

- 2.3 Public health leaders developed and mentored, and capacity increased for leadership development
- 2.4 Increased number of professional's field-deployable through GOARN, Africa CDC or other bilateral and national systems
- 2.5 Increased number of public health professionals with shortage skills indicated by workforce needs assessments, with training capabilities increased in partner organisations

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

Outputs:

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

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

Outputs:

- 4.1 Timely procurement through government systems
- 4.2 Effective contract management

- 4.3 Timely financial reporting, budget forecasting and reconciliation
- 4.4 Effective robust monitoring and evaluation system
- 4.5 Effective collaboration across UK government global health security programmes
- 4.6 Effective negotiation and influencing to further global diplomatic objectives

Ethiopia

Following scoping missions and discussions with the Ethiopian Public Health Institute in 2017-18, technical activity began in Ethiopia at the start of FY18-19.

The initial focus of work was on chemical hazards and toxicology, and Emergency Operating Centres.

Following the deployment of the Senior Public Health Advisor for Ethiopia in Q1, activity began to accelerate, though external factors such as a major Acute Watery Diarrhoea outbreak posed challenges.

Internal delays to recruitment caused delays to laboratory/surveillance system scoping and subsequent activity.

By the end of FY18-19, good progress across all outcome areas had been made.

Nigeria:

The Senior Public Health Advisor for Nigeria took up her post in FY17-18.

By the start of FY18-19, technical activities were already well underway, both on emergency response and strengthening laboratory and surveillance capacity.

An official launch event was held in Nigeria in October 2018, including PHE's Chief Executive, Nigeria's Federal Minister for Health, the British High Commissioner, DFID and DHSC representatives. Notable technical achievements during the year include 2 major simulation exercises designed to test Nigeria's emergency response systems, several bespoke laboratory skills training events, and the implementation of a bespoke outbreak management system (SITAWARE) in NCDC.

In 2018-19 capacity building events in Nigeria, such as the African Society for Laboratory Medicine Conference, were also opened up to other IHR project NPHIs in the region to encourage the creation of south-south partnerships and resilient networks.

Sierra Leone

A number of internal and external delays hampered progress in Sierra Leone at the start of 2018-19. These included changes in IHR team staffing and subsequent recruitment challenges. Although interim staffing was arranged, 2 full-time positions allocated to Sierra Leone (a senior microbiologist and a Senior Public Health Advisor) were vacant until August 2018 and February 2019 respectively. External delays included continued fall-out from the Sierra Leone general elections (March 2018), including changes in leadership at the Ministry of Health and Sanitation. Despite this, excellent progress on workforce

development needs assessments and planning was made with the MOHS in the second half of the year, culminating in the handover of jointly agreed plans and recommendations to the Sierra Leone government at the end of the year.

Good progress was also made on laboratory management, including PHE-led advocacy for the re-instigation of the Laboratories Technical Working Group and a redesign of EVD sample transport mechanisms. An assessment of laboratory capacity was also conducted and plans for Laboratory Accreditation were initiated.

Myanmar

Following initial scoping missions in 2017-18, PHE's proposals for engagement in Myanmar were endorsed by the Myanmar Union Minister in September 2018.

Detailed planning for activity on toxicology and chemical hazards, emergency response and laboratories/surveillance took place from Q2 onwards.

Training on public health EOCs and toxicology began in Q3.

A full-time Senior Public Health Advisor for Myanmar was appointed and began work in Q4.

By the end of the year technical capacity building in Myanmar was accelerating, including multi-disciplinary After-Action Review planning.

WHO AFRO

Following an encouraging start with WHO AFRO in November 2017, a number of external factors (e.g. DRC Ebola outbreak) have significantly delayed progressing the PHE-WHO AFRO workplan.

The IHR project has continued to link with DFID TDDAP to ensure a consistent approach.

A second joint PHE-DFID-DHSC meeting in Brazzaville took place in January 2019.

An MOU with WHO AFRO was signed at the end of Q4.

Engagement with WHO Country Offices remains good across the project, including PHE participation in NPHI and WHO National Action Planning for Health Security processes.

Africa CDC

Initial engagement with Africa CDC began in FY17-18 but accelerated with the deployment of the SPHA to Ethiopia.

The Ethiopia SPHA participated in Africa CDC working groups (e.g. training and development, rapid response) and strengthened the relationship between PHE and Africa CDC.

A Letter of Intent with Africa CDC was signed in October 2018. A project to map emergency response capacity among Africa CDC member states was initiated between Africa CDC and the IHR project in November 2018.

A dedicated SPHA for Africa CDC was deployed to Addis in Q4.

Preparations for a workshop on emergency response and behaviour change for Africa CDC member NPHIs were underway in Q4. PHE remains closely linked in to other HMG activity and discussions with Africa CDC and continues to support the Africa CDC-WHO AFRO relationship.

Cross-project

Several IHR project activities cut across all workstreams.

These include leadership and workforce development, IHR indicator development (SNAP-GHS) and monitoring and evaluation.

As well as all country-specific technical activities containing leadership development components, the IHR project funded 3 fellows to participate in the Chatham House African Public Health Leaders Fellowship in 2018-19, and 5 mid-career IHR specialists from low-income countries were supported to attend a One Health Congress in June.

The IHR project continued to engage with the African and European Schools of Public Health (ASPHA and ASPHER) to advocate for closer alliances between schools of public health (UK, European and African) and NPHIs, to improve public health skills and leadership capacity.

The IHR project also worked closely with IANPHI, especially to develop approaches towards strengthening the use of IHR-related indicators in member NPHIs (especially in ODA-eligible countries). Monitoring and evaluation processes were further developed in FY18-19, including the development of an internal web-based database for monitoring progress and the commissioning of an external evaluation.

Governance

Project governance functioned well in FY18-19.

Routine and ad hoc engagement with DHSC and DFID (HQ and country offices) ensured strong cross-HMG collaboration and information sharing.

The project team engages regularly with PHE's global operations team to ensure good alignment with internal policies (business management, procurement, recruitment, finance).

The IHR 'Ways of Working' document is updated frequently to ensure new processes are captured and understood by all working on the project.

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