Department of Health & Social Care

UK Health Security Agency

Annual Review 2020 - 2021 International Health Regulations Strengthening Project

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Abbreviations and Acronym List

AAR	After Action Review
Africa CDC	Africa Centre for Disease Control
AMR	Antimicrobial Resistance
AU	Africa Union
AVoHC	African Volunteer Health Corps
CSR	Comprehensive Spending Review
CTV	Communication Transparency and Visibility
FCDO	Foreign Commonwealth and Development Officer
DHSC	Department of Health and Social Care
DRR	Disaster Risk Reduction
DHIS2	District Health Information Software 2
EOC	Emergency Operations Centre
EPHI	Ethiopia Public Health Institute
EPRR	Emergency Preparedness Resilience and Response
FETP	Field Epidemiology Training Programme
GHD|EMPHNET	Global Health Development Eastern Mediterranean Public Health Network
GHS	Global Health Security
GHN	Global Health Network
GOARN	Global Outbreak Alert and Response Network
HMG	Her Majesty’s Government

Abbreviations and Acronym List

IANPHI	International Association of National Public Health Institutes
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
JICA	Japanese International Cooperation Agency
JEE	Joint External Evaluation
KP	Khyber Pakhtunkhwa
LMIC	Low and Middle-income countries
LQMS	Laboratory Quality Management System
MEL	Monitoring, Evaluation and Learning
MOHS	Ministry of Health and Sports (Myanmar)
MoU	Memorandum of understanding
NCDC	Nigeria Centre for Disease Control
NIH	National Institute of Health (Pakistan)
NIS	National Infection Service
NPCC	National Poison Control Centre
NPHI/NPHA	National Public Health Institute/ Agency
OH	One Health
ODA	Official Development Assistance
PHE	Public Health England

Abbreviations and Acronym List

PHEIC	Public Health Emergency of International Concern
PTU	Poison Treatment Unites
QA	Quality Assurance
QMS	Quality Management System
SLIPTA	Stepwise Laboratory Improvement Process Towards Accreditation
SLT	Senior Leadership Team
SNAP-GHS	Strengthening National Accountability and Preparedness for Global Health Security
SOP	Standard Operating Procedure
SWOT	Strengths, Weaknesses, Opportunities, Threats
TA	Technical Assistance
ToC	Theory of Change
TWG	Technical Working Group
ToR	Terms of Reference
UKHSA	UK Health Security Agency
VfM	Value for Money
WAHO	West African Health Organization
WHO	World Health Organisation
WHO AFRO	World Health Organization Regional Office for Africa
WHO EMR	WHO Regional Office for the Eastern Mediterranean

ZNPHI	Zambia National Public Health Institute

1. Summary and overview

Project Title: International Health Regulations Strengthening Project

Project Value: £24,000,000 (up until 31 March 2022)

Review period: 1 April 2020 – 31 March 2021

Project's Start Date: 1 April 2016

Project's End Date: 31 March 2022

Summary of Project Performance:

Year	2020/21
Project Score	A
Risk rating	Amber - Green

Outline of project

The International Health Regulations Strengthening Project (referred to as the 'IHR Project') is funded by Official Development Assistance (ODA) through the Department of Health and Social Care (DHSC), as part of its Global Health Security (GHS) Programme portfolio.

The purpose and scope of the International Health Regulations (IHR 2005) are "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with international travel and trade." The Public Health England (PHE) (which became the UK Health Security Agency (UKHSA) on 1 October 2021) led project provides technical assistance to selected low- and middle-income countries in order to improve their compliance with the International Health Regulations (IHR 2005). In 2020/21 the IHR Strengthening Project worked in 6 countries (Ethiopia, Myanmar, Nigeria, Pakistan, Sierra Leone and Zambia), and through regional multilateral agencies (for example, the Africa Centres for Disease Control and Prevention (Africa CDC) and the Global Health Development Eastern Mediterranean Public Health Network (GHD|EMPHNET)), linking with the World Health Organization (WHO) and its regional offices (Eastern Mediterranean Regional Office and African Regional Office).

The IHR project thus continues to work to reduce the impact of public health emergencies and improve national, regional, and ultimately global health security; contributing to the

building of strong national public health systems, better equipped to prevent, prepare for, detect, and respond to a wide range of public health threats.

The IHR Project has a triple mandate to:

1. Build technical capabilities of public health institutions and public health bodies
2. Strengthen leadership to improve multisector coordination
3. Develop sustainable resilient public health systems

Summary of progress

The COVID-19 pandemic had a significant impact on planned work during 2020/21. However, despite the many challenges, the IHR Project has been able to quickly pivot towards emerging and evolving partner needs through supporting COVID response deliverables, whilst maintaining a focus on achieving system-wide outcomes. The project has also worked hard to support the UK government's COVID-19 response efforts both in the UK and abroad.

Key achievements this year include rapidly adapting agreed workplans and activities to meet emerging COVID-19 partner priorities. For example, the project has supported COVID-19

After Action Reviews in Myanmar, delivered virtual training on emergency preparedness to Africa CDC and point of entry training in Pakistan.

The pandemic has enabled the IHR Project to showcase the strength of its relationships with partner organisations and countries The project has provided expert public health advice to Embassies and High Commissions in our partner countries on their response to the pandemic, provided key situational intelligence and support to key UK government led working groups. For example, situational intelligence has informed decision-making on travel restrictions and reduced HMG administrative burden on data gathering to feed into this process. Having IHR Project public health advisers embedded in-country and easily accessible in this way, is a more efficient and effective use of UK government resources for response.

The project supported the collaboration between PHE as the UK IHR Focal Point and national agencies in Pakistan, Nigeria and Zambia for contact tracing of COVID-19 cases imported into the UK. The project's engagement has been valued as a positive development by High Commissioners and Ambassadors in Pakistan and Nigeria.

For instance, when hosting a launch reception for enhancing national antimicrobial resistance (AMR) capacity, the British High Commissioner for Nigeria, Catriona Laing said:

> This work will build on and complement the long-standing UK Nigerian health partnership led by Department for International Development, and the work led by PHE on strengthening the International Health Regulations (2005) core capacities.

The pandemic has also allowed the IHR Project to demonstrate the effectiveness of its delivery model. Locally based technical staff have been able to continue face-to-face delivery and engagement, despite international travel restrictions limiting subject matter expert travel from the UK. Also, the project has pioneered cross-government approaches to remote delivery and has taken a blended approach of face-to-face and remote technical capacity building activities to work more effectively.

Since February 2021, project activities in Myanmar have been put on hold because of the Military coup and following the advice from the British Foreign Secretary. The project continued to monitor the situation, regularly liaising with FCDO Yangon, and in the meantime staff were reallocated to support other theatres of engagement (i.e. other IHR project focal countries and regions).

During 2020/21 the project expanded regional activities, with the project team successfully co-delivering a 'Multisector coordination during COVID' workshop in the Eastern Mediterranean region, with colleagues from GHD|EMPHNET, the WHO Eastern Mediterranean Regional Office (WHO EMRO) and senior public health leaders from Libya, Iraq, Sudan, and Pakistan. The event was the first partnership event between PHE and these organisations.

With Africa CDC, the project has continued to foster strong relationships and contributed to providing expert input into the Kofi Annan Global Leadership Programme. Moreover, the IHR project has contributed to supporting the Africa continent's COVID-19 response activities through the development of the Africa Volunteer Health Corps Network and the initial set up of the Africa CDC Regional Collaborating Centres.

As detailed in Section 3 of this annual review, there has been strong progress in all 3 groupings of outputs in the project logframe that were in place at the start of the reporting period. Factors outside the project's control have meant the range of partner countries the project is actively engaged with at the end of the period has reduced; nevertheless it has continued to demonstrate its value in supporting partner organisations and countries to build public health capacity and capability and strengthen their compliance with the IHR. It has maintained its direction of travel and successfully delivered on objectives whilst adapting to the emerging challenges of the COVID-19 pandemic. It has therefore been awarded an overall A score for this reporting period.

Progress against recommendations

Recommendation from last year	Progress	Current status
Strengthen mechanisms for continuous improvement based on lessons identified through monitoring and evaluation	Monitoring, Evaluation and Learning (MEL) processes have markedly improved from last year. The project has enhanced several processes, to better capture and demonstrate the immediate impact of training (for example revamped pre- and post- assessment forms and the completion process). Work is underway to develop a framework for assessing the longer-term impact of project interventions on workplace practices and performance. Lessons learned are routinely shared as part of six-weekly Technical Working Group (TWG) and theatre of engagement specific meetings.	Achieved
Increased Agile working within the project team	As a result of the COVID-19 pandemic, significant adaptions were made to the country specific workplans and activities pivoted to meet emerging COVID-19 priorities of our partners. An adaptive management working group was established to further the design and embedding of Agile practices into delivery. Outcomes from this group include streamlining MEL activities; making improvements to workplan information management and associated costs; and the complete redesign of guidance for project operations and processes.	Achieved

Recommendation from last year	Progress	Current status
Finalise and operationalise communication strategy to inform and support a robust and reactive approach to external engagement	The project developed and implemented a Communications, Transparency and Visibility (CTV) plan in September 2020. The plan outlines the systematic approach to ensuring project activities, investments, outputs and outcomes are accessible and visible to all stakeholders and contribute to the body of evidence for effective IHR capability building and global health security. As part of this plan, the project will launch a digital knowledge hub on the Global Health Network (GHN) platform in April 2021. The platform will showcase the project's accomplishments and increase visibility of its GHS expertise to external stakeholders.	Achieved
Develop and implement active horizon scanning to identify and engage with potential partners	Progress: The project continues to horizon scan, through coordination with partners such as Foreign and Commonwealth Development Office (FCDO) country missions, and WHO regional offices to ensure alignment and synergies across UK Government and with international partners. There is also ongoing proactive engagement with communications contacts at partner National Public Health Institutes (NPHIs).	Ongoing

Recommendation from last year	Progress	Current status
Strengthen lessons learned process through publications in scientific journals and relevant conferences	In the reporting period, the project published 11 peer-reviewed papers and 20 internal to PHE, publications and newsletters. The project has published in distinguished international public health journals such as the BMJ Global Health and the Journal of Infectious Disease. The project developed a number of lessons learned products, that were dynamic in scope, encompassing academic papers, case studies, and releases on relevant conference outcomes to external audiences via the Global Health Network online platform and other project communication channels	Achieved
Improving forecasting tools and increased delegation of responsibility to in-country teams	In the reporting period, the project conducted a review of its forecasting and budgeting procedures. Based on lessons learned from the previous year, the project improved a series of processes to calculate and maintain costs relating to workplans and tools used to collect this information. In 20/21 the project began work to delegate responsibility for managing country work activity budgets to in-country teams, but where oversight remains with the project's senior leadership team. The responsibility for costing work activities and maintaining costs has now been transferred to in-country teams. However further training and transfer of responsibility will take place in late 2021/22.	Met partially

Recommendation from last year	Progress	Current status
Develop and implement i) the revised logframe to better collect M&E data ii) data collection processes to collect data in a more effective way with all partners	Progress: The project logframe and indicators have been revised and updated to better measure outcomes and report impact. Indicators have been developed for each theatre of engagement nested logframe (these sit under the main project logframe) which will underpin the MEL framework and support improved data collection. The revised logframe and indicators will be operationalised in 2021/22. MEL data collection processes have also been streamlined in order to improve the efficiency and ease at which data is collected from all partners connected to the project.	Achieved
Develop and implement i) adaptive approach to stakeholder engagement to mitigate the impacts of COVID-19 pandemic on external relationships and engagement ii) strategies to create mutual understanding about IHR standards and how the working relationship between partners ensures that these standards are strengthened and iii) the Esther EFFECt tool to understand better the ways in which relationships can be improved	i) Theatre of engagement work plans and deliverables with partner NPHIs, have been adapted and reprioritised as a result of responding to the COVID-19 pandemic. ii) The project has continued to be guided by the principles of collaboration and partnership; 'working with' rather than 'doing for', which has fostered effective working relationships with NPHI partners. The project has adaptive programming, consultation, and partnership building in its core; adjusting the inputs to reflect the changing priorities of partners. This approach helped the transfer of knowledge across partners, ensuring a mutual understanding of IHR standards. iii) The Ethiopia Public Health Institute (EPHI) Esther EFFECt (Effective in Embedding Change) assessment was delivered in March 2021. Recommendations included monitoring	Achieved

Recommendation from last year	Progress	Current status
	the longer-term impact of workshops and improving dissemination of project activities across partners.	
Further efforts must be made to ensure the project is able to effectively use Jira and Confluence to support decision making and progress reporting.	Regular Jira training sessions have been held throughout the year and weekly drop-in sessions have continued. Jira champions (nominated Jira engagement leads) receive regular informal MEL training and provide support to country and delivery teams. Progress against Jira workplans are reported into key project management meetings to support adaptive project management. An indicator dashboard has also been designed to monitor progress and updates from this will soon be routinely shared with the IHR Project Board.	Achieved
Ensure the recommendations of the Itad Midpoint report are reviewed and actioned where relevant.	Progress: The project's senior leadership team developed an action plan to address and implement the recommendations from Itad's midpoint evaluation. Workstreams have been initiated, to address each of the recommendations. This includes developing financial processes, to transfer budget management responsibilities to country teams and embedding AGILE practices within the project's ways of working.	Achieved

Recommendation from last year	Progress	Current status
Strengthen understanding of the role of the country lead and how it has impacted on the IHR Project	A qualitative study was undertaken, to better understand and review the role of the country leads in the implementation of project deliverables. The findings of the study have been used to inform operations and country practices at the theatre of engagement level and will feed into the next Comprehensive Spending Review (CSR) bid.	Achieved
Ensure activities on COVID-19 response are captured effectively to demonstrate project adaptability and flexibility.	A specific COVID-19 label has been introduced to Jira to capture relevant deliverables related to supporting the COVID-19 response and to ensure the contribution of the project is tracked.	Achieved
Link Senior Leadership Team and project management milestones with revised logframe in order to better monitor project delivery	Progress: The revised project logical framework has been developed to capture project management and Senior Leadership Team milestones.	Achieved

Major lessons and recommendations for the year ahead

The recommendations presented below have been identified by the project team for the year ahead.

Recommendations

1. **Make further use of Esther EFFECt tool and explore other tools to measure partnership impact/benefits – Q4 21/22**

The project should continue to build on its triple mandate approach, delivering impactful and measurable interventions through the successful peer-to-peer relationship model. With respect to relationships, the project should build on the use of the Esther EFFECt tool to date and explore other avenues to measure the benefits and impacts of partnerships and identify areas for continued improvement.

2. **Devolve aspects of financial management to country teams - Q4 21/22**
   Building on the devolution of some financial management aspects to country teams, in the long term the project should aim to devolve further project management functions locally, in a phased manner as country teams grow and develop. In addition, the project team should consider overprogramming options in future years to mitigate risk of underspends emerging.

3. **Further build on remote delivery and explore other methods for remote support – Q4 21/22**
   In light of changing global travel restrictions and the longer-term impacts of the COVID-19 pandemic, the project should capitalise on its success of remote delivery, developing novel and innovative methods of remote support and relationship management whilst strengthening local sustainable capacity.

4. **Undertake a review of project's monitoring, evaluation and learning processes and system, with a view to enhance – Q4 21/22**
   The project should review and where necessary strengthen its monitoring, evaluation and learning (MEL) processes and systems, including refreshing key strategic evaluation frameworks such as the project logframe and the Theory of Change in light of changing global context resulting from COVID-19.

5. **Embed AGILE and other practical solutions to improve IHR project ways of working – Q4 21/22**
   The project should continue to embed more Agile management techniques and streamline project processes, to facilitate more flexible and efficient in-year planning and reduce the significant project management burden in the initial stages of project planning.

6. **Develop tools and methods to assess longer term impact of project activities – Q4 21/22**
   The project should begin to develop tools and methods to assess the degree to which in-country participants in training activities apply learning and skills in their daily jobs and to measure the longer-term impact of the project interventions.

7. **Develop a communication strategy – Q4 21/22**
   The project should further develop its communication strategy following launch of the CTV plan and capitalise on the opportunities afforded by the project's GHN presence to increase the reach of the project, create a community of learning and share the project's successes with a wider audience

8. **Review and scope expansion of regional footprint through existing partners – Q4 21/22**
   The project should review and scope potential expansion of its regional footprint through partners such as Africa CDC and its Regional Collaborating Centres (RCCs), the West Africa Health Organisation (WAHO) and potential partners in the Eastern Mediterranean and Indo- Pacific regions.

9. **Embed more local technical staff and resources into partner institutions to build resilience – Q3 21/22**
   Embedding more locally employed technical staff within the IHR project's partner institutions will have a two-fold benefit. Local teams can continue to support future face-to-face delivery without relying on UK staff having to travel and increase partner capacity to implement IHR.

2. Theory of Change

Summary of changes

The IHR Project Theory of Change (ToC) has been reviewed and adapted (see Annex 1) following recommendations from a midterm evaluation that Itad conducted in 2019/20.

The output and outcomes section of the ToC have now been categorised according to the project triple mandate and therefore grouped into 3 distinct categories:

1. strengthen technical capability

2. develop sustainable public health systems and

3. strengthen leadership

The output section of the ToC has been divided into a Venn Diagram to better reflect the cross-cutting deliverables of the project. The adaptations better demonstrate which areas of the IHR Project triple mandate contribute towards specific outcomes and in turn project impacts.

Project's progress

COVID-19 has presented challenges to the timely delivery of the workplan, with specific workplan activities delayed and others repurposed to a remote delivery implementation strategy (see case study in Zambia example below). The limited capacity of partner agencies to implement IHR activities agreed before COVID-19 has also slowed down progress.

The project has had to flex to meet new and emerging partner priorities, through repurposing and revising workplans to better support COVID-19 response and preparedness. Given the nature of the project, the overall strategy to support the improvement of IHR compliance in partner countries remained the same even with repurposing of workplans.

As a result of the challenges posed, some of the intended intermediate outcomes may not be fully realised until the next funding cycle. The project is still on track to contribute towards the long-term impact as the re-prioritised activities in light of COVID-19 still result in similar outcomes, e.g. strengthening laboratory capacity for detecting pathogens, even if COVID-19 is used a vehicle for achieving these outcomes. However, the pandemic has raised the profile and importance of the project's work with partner agencies and across UK

government partners in country, which should in future lead to a more conducive environment for realising project outcomes.

Case Study

Adapting to the new normal: remote delivery training in Zambia

The IHR Project Zambia in-country team worked in collaboration with the Zambia National Public Health Institute (ZNPHI) to identify training and capacity building activities that could be adapted for remote delivery, given the disruption caused by COVID-19 to international travel.

The project delivered a two-day training on spatial analysis using the Q Geographic Information Systems (QGIS) software package in collaboration with ZNPHI and the Japanese International Cooperation Agency (JICA). Training in the use of an open-source, license-free software like QGIS, expands access to tools for spatial analysis and creates opportunities to further institutionalise spatial analysis for surveillance.

Key learnings from the project team running the training included; testing audio visual equipment at the training venue in advance and using separate laptops for video calls between trainers and participants break out groups.

The training was successfully delivered and evaluated in collaboration with ZNPHI and JICA. Positive feedback from participants and the ZNPHI and JICA counterparts has given confidence in the ability to deliver high-quality, effective training via remote delivery.

Changes to the logframe

The primary changes to the logframe run concurrent to those made to the ToC, i.e. to reflect the triple mandate with the 3 primary outcomes of delivery: strengthen capability, develop sustainable public health systems, and strengthen leadership.

Each of the 3 mandates is now captured through an outcome, with outputs relating to the core domains of activity of the project (public health laboratories, surveillance, chemicals, emergency response, workforce development, One Health) being captured separately. This will improve alignment between project frameworks, output verification and tracking project performance going forward.

Further work is in train to refresh the logframe for the next financial year, including the indicators.

3. Detailed output scoring

During this reporting year, and in consultation with DHSC, significant work has been undertaken on monitoring and evaluation to improve the read across from outputs to outcomes to Impact.

As a consequence, given the large number and diverse range of activities undertaken by the project, it has been agreed that for this year's report, a summary of milestones completed and in progress will be presented for each output. This will be followed by a narrative on the progress against outputs. Subsequent annual reviews and evaluations will report against the new monitoring and evaluation framework for the project.

As such the 15 project outputs are grouped under the 3 outcomes of the original log-frame. The output score assigned, reflects the overall score for the group of outputs.

Outputs: system coordination and collaboration

Output number	**1.1.1-1.1.5**	**Output score**	**A**
Impact weighting (%)	**33%**	**Weighting revised since last AR?**	**N/A**

Summary of Outputs	Milestones completed	Milestones in progress
1.1.1 **Strengthened system coordination and collaboration through national public health institutes in partner countries, and in Africa region**	20	4
1.1.2 **Strengthened formal linkages between public health, animal health and security authorities, and those sectors responsible for chemical safety, industries, transportation and safe disposal**	16	1
1.1.3 **Strategy where PHE has supported development and operationalisation for surveillance, laboratories and other health protection systems based on risk assessments of threats and capabilities**	20	1
1.1.4 **MoUs, plans and/or processes are developed and implemented to facilitate One HMG alignment and engagement of regional bodies in IHR implementation**	2	1
1.1.5 **Plans are developed and disseminated for AMR: detection and reporting; surveillance; healthcare associated prevention and control programs; and antimicrobial stewardship**	2	1

Supporting narrative

Summary: A significant number of milestones set for outputs have been completed in 2020/21 to strengthen system coordination and collaboration, with efforts ranging from One Health workshops in collaboration with WHO AFRO and Nigeria CDC, supporting the development of an emergency preparedness and response lessons learned strategy in Ethiopia, to COVID-19 After Action Reviews (AAR). In Asia, output milestones have been completed on system strengthening and response in Myanmar and multi-sector coordination Pakistan.

There were 68 milestones relating to Outputs 1.1.1-1.1.5 being worked towards during the financial year. Approximately 9 in 10 of them have been completed within the year and

have met planned expectations. The majority of unmet milestones were as a result of COVID-19 and resulting shifts in partner priorities. These milestones will either be discontinued or rolled over into the next cycle.

Considering this strong progress against milestones an overall A score has been awarded for this output grouping.

Output 1.1.1

Strengthened system coordination and collaboration through national public health institutes in partner countries, and at Africa regional level

The project has produced Standard Operating Procedures (SOPs), plans and guidelines to assist public health institutions and stakeholders with operating in a formalised and coordinated manner. This year the project has co-developed a multi-sectoral emergency preparedness and response plan in Pakistan, antimicrobial resistance guidelines with Africa CDC, a chemical hazards' surveillance strategy in Ethiopia, and supported Nigeria CDC to review and revise their national public health emergency response plan.

Within the reporting period, the IHR Project has also made substantial contributions towards the global health security and International Health Regulations knowledge base through the generation of publications. A total of 11 peer-reviewed publications were produced for a variety of distinguished public health academic publishers, including The BMJ Global, the International Journal of Environmental Research and Public Health, and the Journal of Emerging Infectious Diseases. Moreover, the IHR Project successfully published 20 internal products within the reporting period, including thirteen articles on PHE net and seven news bulletins.

Collaboration and coordination has also strengthened through the GHN knowledge hub. The knowledge hub acts as a specialised sharing platform hosted on the GHN, a website dedicated to capacity development, process improvement and transfer of research, particularly focused on low- and middle-income country settings. The hub was developed to raise visibility and strengthen stakeholder collaboration of the IHR Project work through the sharing of evidence and knowledge with researchers and professionals in the global health security community. The online platform provides an outlet for publishing the rich information produced by the IHR Project including peer-reviewed publications, reports, and case studies covering specific activities, achievements and lessons learned.

Through the GHN knowledge hub, communication articles, and academic publications the IHR Project has successfully generated material on the principle that sharing, and publishing communication material helps to push the discipline forwards. strengthening of IHR knowledge by forging interdisciplinary links to global health security partners as well as validating effective measures and sharing lessons learned

Output 1.1.2

Strengthened formal linkages between public health, animal health and security authorities, and those sectors responsible for chemical safety, industries, transportation and safe disposal

The project has made significant progress to strengthen formal linkages between public health, animal health and security authorities and those responsible for chemical industry transportation and approaches to planning and coordination. This year the project has supported the development of the Africa CDC One Health guidance document, the Sierra Leone National One Health Action Plan and delivered One Health training exercises in Zambia and Myanmar. In collaboration with the Nigerian Centre for Disease Control (NCDC) and the One Health Tripartite (which is formed of WHO, Food and Agriculture organisations of the United Nations and World Organisation for Animal Health) the project led a One Health table-top exercise to test functionality of the National One Health Strategic Plan, which led to its successful implementation and operationalisation.

Output 1.1.3

Strategy where PHE has supported development and operationalisation for surveillance, laboratories and other health protection systems based on risk assessments of threats and capabilities

The IHR project has made considerable progress with this output, for example, on the topic of Emergency Preparedness Resilience and Response (EPRR). This includes supporting the Khyber Pakhtunkhwa province in Pakistan with the development of the Multisector Outbreak Plan and facilitating After-Action Reviews on COVID-19 with Africa CDC, Ministry of Health and Sport (MoHS) in Myanmar and with the Zambia National Public Health Institute.

Output 1.1.4

MoUs, plans and/or processes are developed and implemented to facilitate One HMG alignment and engagement of regional bodies in IHR implementation

A Memorandum of Understanding (MoU) with Global Health Development Eastern Mediterranean Public Health Network (GHD EMPHNET) was drawn up in June 2020. It sets out the scope of the project objectives, activities and engagement, each party's roles and responsibilities and the progress towards IHR compliance that is anticipated. The revision and extension of existing MoU's will take place in the next project cycle, once COVID-19 response pressures lessen and business as usual activities resume. In future logframes, MoUs will be considered as part of the required process for our engagement with partners and therefore won't be reported against as an output.

Output 1.1.5

Plans are developed and disseminated for AMR: detection and reporting; surveillance; healthcare associated prevention and control programs; and antimicrobial stewardship

The IHR Project in-country has worked in close collaboration with other UK aid funded projects including DHSC GHS Programme's Fleming Fund project, which works to build LMIC capacity and capability for AMR surveillance, and improves cross-HMG coordination. This includes supporting the launch of the Africa CDC Antimicrobial Guardianship page, working with Africa CDC to develop antimicrobial treatment guidelines and supporting the International Society for Infectious Diseases to pilot using their innovative digital disease surveillance system (ProMED).

Changes to the output

The IHR Project revised its Theory of Change and logframe during the 2020/21 financial year. As a result, changes have been made to each of the outputs listed in this section in line with Section 2.1 of this Annual Review. These changes have been made with a view to facilitating reporting against outcomes and monitoring progress and will be implemented in time for the subsequent annual review.

Under Outcome 3 of the new logframe, outputs have been added to track progress on building resilient and sustainable public health networks. In particular there are outputs relating to the promotion of cross-HMG collaboration and the provision of support given to multilateral partner such as WHO EMRO.

The COVID-19 pandemic has demonstrated the importance of the project being flexible and adaptive. The project successfully pivoted much of the work to strengthen system coordination and collaboration to fit within the current COVID-19 context, thereby assisting with the COVID-19 response in each partner country and ensuring partner engagement.

Outputs: workforce capacity

Output number	**2.1.1-2.1.5**	**Output score**	**A**
Impact weighting (%)	**33%**	**Weighting revised since last AR?**	**N/A**

Supporting narrative

The IHR Project has strengthened capacity to detect and respond to outbreaks and other public health hazards and events through achievements such as the development of a digital tool to support the African Volunteer Health Corps (AVoHC) recruitment and deployment. The Project has also played a key role in the design, facilitation and evaluation of the Kofi Annan Fellowship for Public Health Leadership, which will bolster the leadership capabilities of the public health workforce across the African continent.

Summary of outputs	Milestones completed	Milestones in progress
2.1.1 **Workforce needs assessments undertaken and toolkits available for workforce gap analysis**	5	1
2.1.2 **Workforce strategic plan(s) developed & implemented and toolkits available for workforce strategy development**	8	0
2.1.3 **Public health leaders formally trained and mentored to strengthen leadership capacity**	11	2
2.1.4 **Number of professional's field deployable through GOARN, Africa CDC or other bilateral and national systems**	3	1
2.1.5 **All selected public health technical staff and/or frontline workers to receive targeted training and/or mentoring**	28	1

Case study: Developing an online directory of emergency responders and rapid response teams for Africa CDC and AU Member States

Background

Africa CDC is committed to providing capacity building support to Member States; training the emergency workforce; and supporting the development of surge capacity at national, regional and continental levels.

The IHR Project has supported this work through the development of an interactive online directory of rapid response personnel and teams, to assess and improve capacity for emergency response.

Practice development

The IHR Project recruited a website developer and helped establish a project team to deliver on the agreed objectives in coordination with Africa CDC.

The IHR project supported user needs assessment and created specifications for the online platform as well as stakeholder feedback analytics and ongoing user research as part of the beta phase. Upon finalisation of the finished product the IHR project team delivered training and handover to ensure ongoing maintenance of this resource.

Results

The platform is called African Volunteer Health Corp (AVoHC) Net and was formally launched in September 2020. It is hosted on AU servers and accessible through a web browser. The platform supports fully customisable user profiles; advertising and expressions of interest for deployment opportunities; team management; a digital space for collaboration between Member States. During the reporting period, Member States have been receiving training on the rollout of the platform in order to fully operationalise it.

AVoHC Net has been commended by Dr John Nkengasong, Director of Africa CDC, who has said, “With AVoHC Net, Africa CDC will be in a better position to provide targeted workforce development support for public health emergencies as an integral part of the health systems strengthening agenda for Africa”

There were 60 milestones relating to Outputs 2.1.1-2.1.5 being worked towards during the financial year. Over 9 of the 10 active milestones have been achieved in year. Many of the unmet milestones were as a result of COVID-19 and unachieved due to travel disruption or a change in partner priorities following the pandemic. Some milestones will be rolled over into the new funding cycle and others cancelled. At the same time an additional number of unanticipated activities supporting the COVID-19 response were also delivered in the period.

Considering this strong progress against milestones an overall A score has been awarded for this output grouping.

Output 2.1.1

Workforce needs assessments undertaken and toolkits available for workforce gap analysis

The IHR Project's chemicals team undertook a scoping report and gap analysis of chemicals and poisons needs in Nigeria, which identified that advocation and support for a chemical multi-sectoral coordination, a training needs assessment and delivery of a foundational training course could improve the ability to detect and respond to chemical events. The project also worked internally to implement a sustainability, equity and inclusion plan and explored the needs of the project's own workforce to enshrine principles such as gender equity.

Output 2.2.2

Workforce strategic plan(s) developed & implemented and toolkits available for workforce strategy development

The IHR Project has supported Nigeria CDC on developing and implementing their plans for supporting employees in light of the COVID-19 pandemic, including contributing to guidelines and policies, a support and assistance programme, and COVID-19 related HR strategies.

Output 2.2.3

Public health leaders formally trained and mentored to strengthen leadership capacity

The IHR Project has taken considerable steps to formally mentor and train partner professionals and strengthen leadership capabilities. Notable achievements include support provided to the development of a network of women leaders in global health, and advancing leadership teams in partner public health institutions through the London School of Hygiene and Tropical Medicine Executive Leadership Programme for Global Health. The project worked with LSHTM to shape the programme design to support the IHR project outcomes, including empowering and equipping leaders to implement IHR core capacities. In 20/21 5 global senior health leaders, from Pakistan, Nigeria and Africa CDC, participated in the programme. The evaluation feedback was positive and showed the leaders felt the benefits of the programme despite the remote delivery. The benefits they outlined included having more influence over decision-making, seeing their own team members develop and progress because of their new leadership skillset.

To note, a couple of leadership building deliverables that started in 2020/21 will be finalised in the next project cycle, such as the delivery of the Kofi Annan Fellowship for Public Health Leadership Programme in coordination with Africa CDC.

Output 2.2.4

Number of professional's field deployable through GOARN, Africa CDC or other bilateral and national systems

For public health systems to respond effectively to health threats, they must have a resourced, resilient and deployable workforce In 2020/21 the project supported the African Volunteer Health Corps deployable networks, including through the development of a digital tool to manage the recruitment, dispatch, and training of volunteer medical and public health professionals to support emergency responses. At a bilateral level, the project has increased the capacities of the Nigeria CDC National Reference Laboratory to give staff the technical skills for field deployments.

Output 2.2.5

All selected public health technical staff and/or frontline workers to receive targeted training and/or mentoring

Two hundred and thirty public health staff were trained in Q1 and Q2 across Africa and Asia. This included the delivery of Integrated Disease Surveillance and Response (IDSR) training to points of entry staff in Pakistan, the delivery of outbreak data analysis training to staff from the Zambia National Public Health Institute, and Quality Management System (QMS) training in Sierra Leone.

In Q3 and Q4, 877 public health staff received targeted training. In Zambia public health professionals were trained on QGIS open source software. IDSR training was delivered to front line public health professionals in 4 provinces of Pakistan and workshops were delivered to build the capacity of Nigeria CDC laboratory staff on lab hazard and control measures.

Changes to the output

In the next project cycle all activities related to workforce planning, leadership and management capabilities will be listed under outcome 2 of the revised project logframe. There is clear separation between leadership, workforce development and organisational development activities within the new structure, which should allow for better monitoring of the different range of activities.

Recommendations

Workforce development activities will take a blended approach of face-to-face and remote technical delivery to work effectively during the COVID-19 pandemic. These methods have proven to be cost effective, more accessible, whilst offering the same quality standards. They will be supported by local technical staff based in the partner countries, which the project continues to build up. The project will also develop tools and methods to assess the degree to which participants apply learning and skills in their daily jobs and to measure the longer-term impact of the project interventions.

Output: enhancing public health systems

Output number	**2.2.1-2.2.5**	**Output score**	**A**
Impact weighting (%)	**33%**	**Weighting revised since last AR?**	**N/A**

Summary of outputs	Milestones completed	Milestones in Progress
2.2.1 **A functioning public health surveillance system capable of identifying potential events of concern for public health and health security**	16	4
2.2.2 **Preparedness: Emergency response operations plans are in place with adequate support of resources and capacities**	16	3
2.2.3 **Emergency response operations: Functional network of emergency operations centres and emergency response systems capable of addressing potential public health threats established, led by WH**	10	1

Summary of outputs	Milestones completed	Milestones in Progress
2.2.4 **Laboratory systems enhanced and quality assured, with capacity increased for laboratory quality assurance (QA), and laboratory networks strengthened**	25	0
2.2.5 **Strengthened systems for detection and response to chemical-toxicological public health incidents**	8	2

Supporting narrative

The IHR Project has supported the expansion and enhancement of public health technical systems in partner countries and regions. The project has been successful in setting up surveillance systems in Nigeria, strengthening the poisons service in Myanmar and working across HMG to set up genomics sequencing in Zambia. This work was made possible by the effort put in during previous years in scoping and understanding partner needs.

Case study**: Building National Poisons System Capacities in Myanmar, a collaboration with PHE's IHR Project team and the Myanmar National Poison Control Centre (NPCC)**

Background

The IHR Project's work on chemical events aims to develop and strengthen systems for the detection, assessment and response to chemical health threats. Myanmar scored a "1" for both chemical events indicators in its WHO Joint External Evaluation (JEE), demonstrating attributes of a capacity are not in place, for the prevention, detection and response to chemical events. The IHR project team identified the strengthening of the national poisons system including providing access to poisoning resources, developing standard operating procedures, and the provision of training to the as a technical capacity building priority for the National Poison Control Centre (NPCC).

Practice development

TOXBASE is the primary clinical toxicology database of the UK National Poisons Information Service and a first-line resource for poisoning information. The IHR project enhanced learning and knowledge management on poisons through TOXBASE access for NPCC and Poison Treatment Units (PTU) at the New Yangon General Hospital (NYGH), Mandalay and Magway General Hospitals.

The IHR project delivered TOXBASE courses at the National Poison Control Centre and established the call recording poisons database. The IHR Project also facilitated the delivery of a chemicals/toxicology laboratory gap and needs analysis, and delivery of analytical method development workshop to NPCC colleagues.

Results

The IHR Project's partnership with NPCC on strengthening national poisons and chemicals management capability and capacity has resulted in 41 healthcare staff, based at Mandalay and Magway General Hospitals, undertaking essential TOXBASE e-learning. Strengthening partner capacities to risk assess, detect, and respond to chemical events. As a result, Myanmar now has staff trained and capable to detect, assess and respond to chemical and poisons incidents. In addition, the project's engagement activities have promoted enhanced co-creation and collaboration with national stakeholders on poisons and chemicals management, including WHO Myanmar office, and the Occupational and Environmental Health Division from the University of Public Health.

There were 85 milestones relating to Outputs 2.2.1-2.2.5 being worked towards during the financial year. Over 9 of the 10 active milestones have been achieved in year, as well as a number of unanticipated activities to supporting the COVID-19 response, like the Zambia COVID-19 multisector response and contingency plan and contributing to the Ethiopia, Nigeria and Myanmar COVID-19 inter-action reviews. Therefore, outputs have moderately exceeded expectation. Outputs that were not achieved were again largely as a result of COVID-19 and a shift in partner priorities. The IHR project will review those unmet milestones ahead of the next funding cycle and assess whether should be carried over and continued.

Considering this strong progress against milestones an overall A score has been awarded for this output grouping.

Output 2.2.1

A functioning public health surveillance system capable of identifying potential events of concern for public health and health security

Work on the enhancement of surveillance systems includes: embedding IDSR surveillance infrastructure around District Health Information Software 2 (DHIS2) as well as scaling up

the weekly data flow from Pilot Districts' Health Facilities. Moreover, in Ethiopia training has been provided to the Ethiopia Public Health Institute on the development of algorithm for stepwise testing of samples from patients with unexplained febrile illnesses and at the Zambia National Public Health Institute, to set up a SARS-COV-2 genomic surveillance system.

Output 2.2.2

Preparedness: Emergency response operations plans are in place with adequate support of resources and capacities

The development of emergency response operation plans, and strategies based on internationally recognised standards, supports organisational preparedness to the prevention, detection and control of public health threats. The project co-developed the first draft of the Case Based Surveillance CBS form and associated protocols with the National Institute of Health Pakistan and Provincial Public Health Institute of Sindh in Pakistan. Work was also conducted in Nigeria to strengthen the national Event-Based Surveillance and epidemic intelligence by optimising the SITAware platform.

Output 2.2.3

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

The IHR project supports emergency response operations through the development and regular updating of national multisectoral, all-hazard emergency preparedness and response plans and through strengthening incident response Emergency Operation Centre (EOC) systems. In particular this year the project has supported the operationalisation of a Multisector Outbreak Plan in Khyber Pakhtunkhwa province of Pakistan, exercised national and state level response to a public health emergency exercise plan in Nigeria, and supported the Ethiopia Public Health Institute in developing an effective emergency response learning system. In response to the COVID-19 pandemic the project collaborated with Africa CDC on developing a series of webinars to support AU member states public health emergency operation centres.

Output 2.2.4

Laboratory systems enhanced and quality assured, with capacity increased for laboratory Quality Assurance, and laboratory networks strengthened

The project, in coordination with in-country delivery teams and PHE National Infection Service specialists, worked to enhance laboratory capacity and Quality Management System (QMS) in the targeted theatres of engagement. The project delivered training on quality and governance in Zambia that supported the national reference laboratory to progress towards an accredited quality management system. In Ethiopia, the project delivered training to improve the national public health institutes overall biosafety and biosecurity practices and capacity. The project also worked with Africa CDC to facilitate QMS modules as part of QMS training for quality officers from across AU states.

Output 2.2.5

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

Public health chemical and toxicology deliverables undertaken by the project in the reporting period are multi-faceted and have included chemical risk assessments, TOXBASE training and the development of chemical event training material and event surveillance plans.

Notable achievements this year include supporting EPHI with the co-development of a paper on chemical hazards and risk identification methodology and delivering a workshop in Ethiopia for institutional stakeholders to discuss contents of the chemical hazards and public health training manual. In Nigeria, the project contributed towards a gap analysis to identify chemicals and poisons needs. In Myanmar the project delivered TOXBASE training and mentoring and in Zambia conducted a literature review of poisonings epidemiology.

Changes to the output

In the 2021/22 project cycle, outputs related to emergency preparedness resilience and response, surveillance system strengthening, laboratory system enhancement, and strengthening chemical toxicological public health incident response will be categorised under Outcome One, of the revised logframe. The outputs in the revised logframe will separate out technical capability building across different specialist areas in order to better monitor and evaluate progress within those specific areas.

Recommendations

The IHR project will make the best use of remote working tools and techniques identified and developed during COVID-19. It will continue to integrate lessons learned and identify new and complimenting methods of remote support and relationship management with a view to strengthening local capacity.

4. Project performance not captured by outputs

Although the IHR Project logframe does not include outputs specifically related to COVID-19, the entire 2020-21 workplan pivoted to support partner priorities that emerged during the pandemic. Many deliverables completed demonstrate cross-cutting benefit to improving global health security through compliance with IHR as well as supporting the sub-national, national and regional response.

Examples of results that were not necessarily captured in the logframe outputs but supported the COVID-19 response include:

1. The project's in-country senior public heath advisors (also referred to as country leads) provided technical advice and support to government partners and respective public health institutes in senior level meetings and fora. For example, in Zambia the country lead acted as chair of the cooperating partners group for COVID-19 response.

2. Country leads provided public health advice to UK Embassies and High Commissions on their response to the pandemic, and situational intelligence to inform more efficient and effective use of UK government resources. High Commissioners and Ambassadors recognised this important contribution of the IHR Strengthening Project which they wish to retain and extend.

The IHR Project team was also nominated by its stakeholders for the Civil Service Awards in the ‘One Civil Service’ award category in recognition of the project’s collaborative work. The project has also supported multiagency coordination with the UK IHR Focal Point and national agencies in Pakistan, Nigeria, Ethiopia and Zambia for COVID-19 contract tracing.

Case Study: The Nigerian experience: **Nigeria Preparedness for and ongoing response to the COVID-19 Pandemic**

The Nigeria Centre for Disease Control (NCDC) set itself the goal of establishing Public Health Emergency Operations Centres (PHEOCs) to serve as epidemic intelligence hubs across the country.

The IHR Project worked in collaboration with the GHS Programme's UK Public Health Rapid Support Team (delivered as a partnership between PHE and the London School of Hygiene and Tropical Medicine) to develop initial diagnostic capacity for COVID-19 in the country, and to participate in National EOC meetings and general COVID-19 response activities. Moreover, the project's Senior Health Adviser for Nigeria acted as a member of the planning team, conducting a mid-action review.

As a result, there is a revised Incident Action Plan at a national level. The capacity of Nigerian laboratories has been strengthened and they are now able to conduct conventional real-time Polymerase chain reaction diagnosis for COVID-19. This has now been scaled up to 28 laboratories (and counting) across the country inclusive of private laboratories. This increase in capacity has been in part facilitated through the IHR Project's support, which was commended by NCDC's Director General, Dr. Chikwe Ihekweazu. NCDC has been identified as the first sub-Saharan African public health agency to commence validated testing for COVID-19.

5. Risk

Overall risk rating: **Amber-Green**

The overall risk rating for the 2020-2021 project cycle reflects the potential and realised impacts of risks to the project delivery. A number of substantive risks have occurred during the reporting period including risks stemming from COVID-19 (e.g. resulting shift in partner priorities and delivering remotely) and political instability in some partner countries. The IHR Project has taken strong measures to mitigate and reduce the likelihood of risk in the reporting period, including adapting the delivery model towards remote delivery, further strengthening information management with cross-government partners in the targeted theatres of engagement and expanding the locally based teams. Risks such as political destabilisation in the Myanmar, continue to pose challenges. The project will continue to apply an adaptive risk management process, whereby the project adjusts to the changing environment and follows a plan to identify, monitor, respond and adapt to risk.

Overview of project risk

Risk description: For COVID-19 risks have largely been linked with travel restrictions, shifting partner priorities based on the evolving needs of the pandemic, working remotely, and challenges in building partner networks.

COVID-19 was declared a Public Health Emergency of International Concern (PHEIC) by the World Health Organisation (WHO) in February 2020. The impact of the COVID-19 pandemic has resulted in an unprecedented public health crisis.

Public policy measures to reduce the spread of the virus have resulted in significant operational restrictions including travel restrictions, reduced person to person contact within the targeted theatres of engagement and shifting organisational priorities towards emergency response.

The COVID-19 PHEIC created a risk to the timeliness of project delivery of the agreed workplans, quality of technical delivery activities, and partner absorptive capacity to work in partnership with the IHR strengthening project.

Mitigation strategy: In the next project cycle the IHR Project workplans, financial forecasts and budgeting will routinely be reviewed and adjusted based on challenges posed by the COVID-19 pandemic. The project will continue to monitor the impact of the COVID-19 pandemic in coordination with cross-government partners such as Foreign Commonwealth and Development Office (FCDO) and DHSC. The project will maintain capabilities to deliver technical assistance deliverables using digital platforms. Moreover,

the IHR Project will continue to expand in-country teams, to ensure an effective presence in-country, for engagement and coordination capabilities.

Residual risk rating: Amber-Green

Risk description: Evolving geopolitical context in partner countries - Myanmar

Since February 2021, project activities in Myanmar have been put on hold because of the Military coup and following the advice from the British Foreign Secretary. FCDO Yangon has drawdown it's staff, with all locally employed staff expected to work from home.

Mitigation strategy: The Project will continue to embed adaptive processes to remain flexible and optimise effectiveness. The project will continue to ensure close engagement with government departments, both in the UK and abroad, conduct regular situational and political economy analysis, and follow FCDO advice. All staff connected to the Myanmar work programme have been reallocated to support other IHR project focal countries and regions).

Residual risk rating: **Amber-Green**

Risk description: Evolving geopolitical context in partner countries – Sierra Leone

Since April 2021, project activities in Sierra Leone have been put on hold due to the COVID-19 pandemic and the COVID-19 response in Sierra Leone being led by the military. The Country Lead in Sierra Leone has been withdrawn as this also aligns with the end of the project's remit in Sierra Leone which was to provide and build laboratory strengthening following on from the Ebola-virus disease epidemic and support the development of a National Public Health Institute for Sierra Leone.

Mitigation strategy: With lab strengthening activities completed as per the initial remit of the project, and COVID-19 preventing any further progress in the development of a National Public Health Institute for Sierra Leone, the Project will draw down from activity in Sierra Leone with an appropriate and full handover to other UK HMG projects such as the Fleming Fund to ensure gains made are further built upon. The project will continue to ensure close engagement with government departments, both in the UK and abroad, and with the International Association of National Public Health Institutes and through Africa CDC to determine whether the landscape in Sierra Leone becomes appropriate for further engagement on the development of an NPHI. All staff connected to the Sierra Leone work programme have been reallocated to support other IHR project focal countries and regions).

Residual risk rating: Amber

Risk description: Uncertainty related to changing UK public health, foreign aid and diplomacy structures

As a result of the FCDO and Department for International Development (DFID) merger and agreed proposals for implementing the new aid and diplomacy agenda, under Official Development Assistance (ODA) funding, there is uncertainty around governance and reporting structures and engagement, which could impact the delivery and strategic direction of the IHR Project.

Mitigation strategy: The project will continue to focus on engagement with key stakeholders on the latest reform and design of the new FCDO structures. Having strong early engagement and holding routine meetings with other government departments, has allowed the project to keep abreast of changes. The project will continue to review and re-establish key relationships where changes are taking place.

Risk description: Organisational transition from Public Health England to UK Health Security Agency

Public Health England will transition into the UK Health Security Agency (UKHSA), expected to come into full operation by October 1st, 2021. The UKHSA will replace PHE as the country's permanent standing capacity to prepare for, prevent, and respond to threats in public health.

The transition and remit changes from PHE to UKHSA, poses a disruptive risk to the operations of the IHR strengthening project, which can potentially impact project systems operations, and quality.

Mitigation Strategy:

The project will proactively engage with the UKHSA transition teams and attend briefings on the organisation changes. Staff will attend the necessary training to adapt to changed operating models on new structures, processes and governance. Any issues that pose a risk to the delivery of the project will be swiftly escalated to DHSC.

Residual risk rating: Amber-Green

6. Project management

Delivery against planned timeframe

At the start of the year and in light of the COVID-19 pandemic, country workplans were revisited and pivoted to meet emerging partner country priorities. Workplans were re-costed and there was a greater emphasis on remote delivery for the first half of the year.

Face-to-face delivery was initially pushed back to Q3 & Q4 of 2020/21 in the hope that travel restrictions would be lifted by then. Some One Health outputs were delivered in-country, however the remaining face-to-face delivery have had to be postponed until the 2021/22 project funding cycle. The COVID-19 pandemic has highlighted the value of the current delivery model, of building the capacity of locally employed technical teams to support future face-to-face delivery without relying on UK staff having to travel. Recruitment to further expand the capacity of locally based teams in each theatre of engagement is underway.

Performance of partnerships

Findings from the midpoint Itad external evaluation, concerning the project's external engagement, found that the project remains highly relevant to, and aligned with, country and regional partner goals. The evaluation considered the IHR Project coordination with other health security partners to be strong and has led to more coherent health security programming. At the national and sub-national level, the project was considered by Itad, to have made substantive progress in building effective bilateral partnerships in coordination with the respective public health institutions. At the global and regional level, the IHR Project has continued to work closely with international agencies and partners including relevant UN agencies, Africa CDC, the West African Health Organisation (WAHO), and Eastern Mediterranean Public Health Network (GHD|EMPHNET).

Progress in Africa regional work has continued amidst the COVID-19 pandemic, with the adaptation of key deliverables in the project to support the pandemic response and Africa regional priorities on preparedness. The IHR Project's Senior Public Health Advisor working with Africa CDC has fostered a strong relationship with the organisation and has contributed to a number of workstreams, including providing expert input into the Kofi Annan Global Leadership Programme, setting up AVoHCNet, and the initial set up and scoping of the Africa CDC Regional Collaborating Centres.

IHR Project multilateral coordination at the Asia regional level has also notably accelerated within the reporting period, including through engagement and joint delivery of a workshop

with the GHD|EMPHNET. The event was held in early 2021 and is the first project partnership event between the IHR Strengthening Project, GHD|EMPHNET, and WHO EMRO. The joint workshop focused on multisector coordination during COVID-19 from theory to practice. The workstream aimed to support participant understanding of how multisector coordination has been operationalised and is positively contributing to the COVID-19 pandemic response in case study countries from WHO's Eastern Mediterranean Region. The IHR project and GHD|EMPHNET aim to pursue multisector coordination as a joint project for 2021/2022 and develop a proposal for future activities, building upon recommendations and lessons identified from the workshop.

Partnerships and collaborative work continue to be impacted by travel restrictions, COVID-19 and changing partner priorities. Having a presence in partner countries that can maintain engagement has proven to be vital in continuing are work and where this hasn't been able to happen, work has suffered as a result. We continue to strengthen our remote delivery offer through learning and sharing across government, however, there remains no complete substitute for face to face engagement in maintaining partnerships.

Case Study: Esther EFFECt tool

Background

The IHR Project has utilised the Esther EFFECt tool to assess, and then improve, the quality of its institutional partnerships. This monitoring and evaluation tool is to help assess current practice and how changed can be embedded in a partnership model. The tool helps to capture key recommendations and actions for the partners to take forward to add value and sustain long-term benefits of working in a high-quality partnership, in a way that is comparable over time.

Practice Development

An Esther EFFECt assessment was completed in the Ethiopia theatre of engagement. The assessment process included the completion of a participant questionnaire followed by a facilitated workshop. The M&E team analysed the questionnaire data before facilitating the workshop remotely, to discuss the findings and agree recommendations. The tool was applied with a view of evaluating the effectiveness of the partnership intervention, quality of partnership and the lasting benefits of the partnership approach.

Results

The workshop and questionnaire were successfully delivered remotely, with recommendations agreed amongst participating Ethiopian Public Health Institute (EPHI) stakeholders. Key recommendations to come out of the workshop included:

1. Development of a model for improving absorptive capacity, including formal regular review of activity plans and flexible Agile working.

2. Potential for increased engagement with senior EPHI management. Planned leadership and management training will contribute to progress in this area.

Third party suppliers

The IHR Project has several contracts and formal agreements with third party suppliers, who have delivered a range of activities to support project delivery. Third party supplier activities include:

- providing logistical support in partner countries
- conducting an independent external evaluation

- delivering a health leadership programme to sponsored personnel
- enhancing a global surveillance system designed to monitor emerging diseases

Formal partnerships within the IHR Project work effectively. This is due in part to the number of corporate and project governance processes in place that guide the project's day-to-day engagement with contracted third-party providers. These processes aim not only to ensure the funding spent on third party contracts deliver good value for money, but they also ensure third party providers are meeting their contractual obligations in line with the project's aims and objectives.

Such governance processes are woven into the project's formal engagement with partners from the outset and they include contract specifications validated by corporate finance and procurement teams with PHE. Such processes include contracts partnership mobilisation, and kick-off meetings to communicate expectations and joint ways of working, and regular governance meetings to monitor delivery progress and identify risks, as well as end-of-contract evaluation processes to capture key learning and recognise achievement of stated aims.

Finally, all lessons captured through contractual partnerships are used to inform contract specifications as part of any future competitive open tender processes. For example, this year a number of more efficient ways of working were identified as well as ways to reduce costs (including pegged exchange rates). These are captured in the contract Terms of Reference and will subsequently be embedded into future specifications.

DHSC Global Health Security Programme partnership

The project notes that more regular opportunities for increased coordination across GHS ODA funded projects and wider GHS work would be extremely beneficial to improve the alignment of resources, cross project programme/project delivery awareness, and the promotion of bi-directional benefit. Another key recommendation stated by the Senior Leadership Team is for DHSC GHS to provide an updated version of their Theory of Change. The premise of which would be to ensure continued alignment with the DHSC methods for planning, participation, and the evaluation methodology.

Asset monitoring and control

The asset management policy employed by the IHR Project team, follows practice in line with the PHE wide Non-current Asset Policy. The aim of the PHE policy is to provide guidance on the correct accounting treatment for noncurrent assets to ensure this is achieved in accordance with recognised financial standards and the promotion of consistent treatment throughout PHE.

To ensure alignment with the PHE Non-current Asset Policy, the IHR Project has developed and regularly monitors the Oracle projects ledger. The ledger holds documentation of purchased and donated project assets, at any given point in time. The asset ledger enables the IHR Project to know the status, procurement date, location, price, and current value of each project asset tracked for effective logistical oversight.

Regarding asset controls, the financial accounting team is also responsible for the annual asset verification exercise. The process involves contacting asset custodians to confirm the details of each asset held on Oracle assets (including confirmation of its estimated useful life) and making any necessary amendments. The purpose of this exercise is to ensure that the assets register remains accurate and an independent audit trail exists to support this.

7. Financial performance

Budget

The 20/21 IHR project budget was £6.9m, total spend for the year came in at £5.6m. The majority of the underspend is as a result of travel restrictions, limited face to face delivery and activities being put on hold due to COVID-19. The remainder of the underspend is as a result of recruitment delays and reduced time-carding due to staff being diverted (particularly in the early months) to support the national COVID-19 response. To reduce the risk of an underspend during 21/22, the project has put a greater emphasis on growing the in-country local teams, which should reduce the impact of COVID-19.

Value for money assessment

The IHR Project has taken significant steps to improve and systemise the project assessments for Value for Money (VFM). Work is underway to roll out a scorecard system in coordination with delivery teams to assess VFM performance against a predefined performance indicator and a weighted scoring system. As of March 2021, the first stage of the VFM assessment roll-out has been completed, with the design of a scorecard and accompanying guidance to be finalised in 2021/22.

The means by which the IHR project has ensured VFM, through greater economy, efficiency, effectiveness, equity and sustainability is described here:

Economy

The emphasis on remote delivery has resulted in many outputs being achieved at a lower cost than estimated in the original business case. The project has utilised and developed digital platforms to share knowledge and learning resources. The increased focus on remote delivery has successfully reduced input costs (for example travel costs and staff time), and enhanced value for money of these activities by still producing comparable outcomes. Though it is recognised that face to face delivery is more beneficial than remote, an evaluation of the IHR project remotely delivered activities has demonstrated no change in the quality of the activity delivered due to adaptations. Existing organisation-wide contracts with digital platforms mean this presents minimal set-up costs to the project. This has resulted in savings to the project which have then been repurposed to build up the local technical teams, to support future face-to-face delivery. Remote delivery is also less resource and time intensive and results in a lower carbon footprint.

Efficiency

The model of using subject matter experts within PHE over external consultants has been a conscious decision by the project team and has proved to be an effective model to deliver services and technical resource. Moreover, this approach allows continuity of stakeholder relationships and improves institutional memory for the implementation of activities going forward. The spend on TA varies by country, and includes travel, workshop delivery, and other TA activities.

Furthermore the project's approach for joined-up working, collaboration and use of shared human resources internally, such as Monitoring, Evaluation, and Assurance support staff (e.g. within PHE's Global Public Health Division), with UK government partners (e.g. GHS projects) and in-country partners has achieved greater efficiency, reduced input costs and resulted in greater impact for the resources input.

Effectiveness

The project has established a Ways of Working (WoW) working group to improve effectiveness and share cross-project approaches. The recommendations are fed into the WoW group from a number of channels including technical working groups and evaluation feedback forms. The WoW working group has made a significant contribution to increasing project effectiveness by establishing a clear consultation meeting platform, for process review and horizon scanning for continuous improvement.

Another mechanism employed by the IHR Project, to ensure effectiveness in operational project delivery, is the mainstreaming of adaptive management processes into the project management. The IHR Project established the Adaptive Management Working Group, which aims to identify and adopt new Agile approaches into the delivery team to simplify, reduce error and duplication, and streamline information and project requirements. Examples of Agile practices implemented in the project cycle, include team ownership of data submission on digital platforms through training "Jira champions" and the adaptation of project deliverables to support national responses to the COVID-19 pandemic.

Equity

In the reporting period, the project management team have developed a Sustainability, Inclusion and Equity Plan. It outlines sustainable inclusive and equitable outputs and activities to implement throughout the project cycle. Furthermore, as part of the development of the 2021/22 project logframe, advocacy to promote equity, diversity and equitable opportunities within the public health workforce of partner institutions will be added as a key deliverable output. This will ensure the IHR Project takes effective steps to

ensure equitable opportunities in training delivery, and that equity and inclusion deliverables are reviewed on an ongoing basis for continuous improvement.

The IHR Project monitoring system continues to capture workshop demographic data, on beneficiary gender and age through the standardised participant evaluation form and new facilitator form. They allow the project team to assess the impact of the activities on the different demographic groups.

The project has also taken considerable steps to ensure equity in key project management domains. In strategic planning, the IHR Project continues to utilise peer support groups in each of the theatres of engagement, follow up on training and ensure the learning is maintained amongst the targeted groups. The project also continues to prioritise, and clearly define and label, gender and equity deliverables which focus on enhancing female leadership.

Sustainability

The IHR Project aims to ensure the impacts are retained in partner theatres of engagement through the realisation of long-term benefits. The IHR Project has supported project sustainability measures, which include:

- building expertise inside partner organisations, increasing the capacity of locally employed staff
- reducing the number of short-term visits, using locally employed experts in country where possible

The sustainability model implemented by the IHR Project offers multifaceted benefits, including reducing its carbon footprint and by building on the ground networks, through locally employed staff. Carbon offsetting was taken on by the project to mitigate the carbon footprint created by the project through travel. This is currently on hold as the travel and deployments team transition to a new provider, however will be restarted as soon as feasible.

Quality of financial management

There is a multi-tier approval processes for expenditure and the procurement of goods or services relating to the project. No changes have been made to those practices in the reporting period. All financial information relating to the project continues to be submitted to PHE's Opportunities Assessment Group (OAG). OAG ensures that projected ODA budgets for the project will be sufficient to cover the delivery costs.

A second level for financial performance involves submissions to PHE's Investment and Approval Sub Group (IASG). The IASG streamlines the approval and clearance process for large income-generating proposals. The group is accountable to the Resourcing and Prioritisation Group and ensures that all activities can be delivered operationally, are affordable and represent value for money. These processes are likely to be revised following the transition to UKHSA in October 21 and therefore we can expect to see change from the next funding cycle.

During the course of the reporting period, the project held monthly meetings with finance specialists, to reconcile forecasts and actual spend. A number of automated processes have been introduced to improve the speed at which monthly/quarterly budgets and forecast spend can be turned around and shared with stakeholders, including DHSC.

There are also quarterly meetings between PHE (finance and project team) and the GHS Programme team to examine expenditure and forecasts. Monthly meetings are held with the business management team. Finally, monitoring and reporting mechanisms are implemented to facilitate financial management, supported by specific PHE finance and commercial staff. The systems supported are regularly monitored and reviewed by the project financial team, to ensure they are fit for purpose and are adaptive to how the project evolves.

The Itad midpoint report recommended that financial flexibility and delegated financial responsibility be given to country teams, in order to improve efficiency and effective financial decision-making at country level. From next cycle further processes are being developed to assign Country leads and their support staff delegated responsibility to monitor country workplan activities and associated costs and to procure goods and services to support their country workplans.

8. Monitoring evaluation and learning

Evaluation

Itad began conducting the endpoint external evaluation of the project in November 2020, and it is scheduled for publication in late 2021/22.

The purpose of the endpoint evaluation is to provide a summary of project progression through 1 September 2018 to March 31 2021. The evaluation assesses how the IHR Project has progressed towards meeting the desired outcome and impact targets and informs improvements in project decisions and performance.

The endpoint evaluation utilised a mixed method approach to assessment with data sources comprising the review of project document (809 documents), key informant interviews (111 interviews), and 7 in-depth case studies. The evaluation utilised a matrix scaling system, which reviews the strengths of evidence, and triangulated resources under review to define scores to specific findings.

The summary of findings from the endpoint external evaluation, were shared with the UKHSA during the cocreation workshop in June 2021. During the workshop, Itad shared their initial analysis from the endlpoint phase of the evaluation, and the IHR team were consulted in the workshop on the strategic implications of the findings. The summary of evidence by Itad, painted a very positive picture stating:

> "The project remains highly relevant both in terms of partner country and UK health security priorities and concerns. Amongst the stakeholders that the IHR Project works with it continues to be a highly valued source of technical knowledge, skills, and experience”

Monitoring

The IHR Project has continued to generate standardised monitoring and evaluation assessments and tools to assess the performance of workshops, training, and simulation exercises throughout the reporting period. The monitoring products used within the project for events include participant evaluation forms, pre- and post-assessments, and a recently introduced facilitator observation form. Of the 35 workshops delivered between March 2020 and April 2021 (including remote delivery sessions), the average score for participant evaluation feedback was 4.7 out of 5 when asked whether the knowledge gained from the workshop was useful.

The updated logframe will provide a better overview between available resources, planned activities, and desired changes or results. The updated logframe will be operationalised in the 2021/2022 project cycle. The new facilitator form has provided an effective mechanism for self-assessment on the performance of workshop delivery and capturing recommendations and lessons learned, and it helps with comparing data and results across the project and the dynamic theatres of engagement.

Learning

The IHR Project has successfully embedded effective operational processes over the reporting period to capture and share lessons learned, new evidence, and know-how. Including the development of a new learning and actions page, on the project's internal sharing platform. The learning and actions page has allowed the technical delivery teams to provide feedback on the delivery of training. This information is then disseminated to ensure lessons learned are taken on board in the planning of deliverables and to certify continuous cycles of improvement.

The IHR projects is also supporting project learning by hosting key internal learning forums at key periods in the project cycle. The most notable of which is the Monitoring, and Evaluation Forum. The Monitoring and Evaluation forum takes places on a quarterly basis, and is designed to, provide an opportunity to harmonise to MEL principles across projects; share best bract and lessons learned; and ensure the IHR project MEL processes align to other GPH projects and programmes. The forum is attended by delivery team, country teams and core team members and is an effective opportunity to share cross project knowledge.

To embed learning, another approach taken by the IHR project roll out thematic ways of working training exercises throughout the project cycle. The interactive workshops sessions are designed to provide new information and knowledge on IHR project processes, share experiences, and inspire to embed better working practices. Examples of training sessions delivered in the reporting period, include the theory of change, and logical framework training, and the risk management process.

9. Annexes

Annex One

IHR Strengthening Project Our Work and Theory of Change

Annex Two

ProM report

ProMED-AMR Q3
End of Contract Repor