IHR Strengthening Project Business Case Justification

1. Purpose

1. The IHR Strengthening (IHR-S) Project is seeking approval for its next phase to build on the successes of the first six years of the project in our IHR-S partner countries and organisations in Africa and Asia. The new cycle will expand our maturing public health partnerships and deliver work in new regions, such as the Indo-Pacific, and build on the progress and learning from the COVID-19 pandemic to better tackle current and future global health pandemics and other public health threats.

2. In the 2021 Spending Review, DHSC was allocated £832m of Official Development Assistance (ODA) funding, spread across all ODA programmes. **Of this, the IHR-S Project has been allocated an indicative budget of £28m funding over the next three years from 2022/2023 to 2024/2025. The IHR-S Project is seeking approval to commit up to a maximum of £30m over three years.** This would allow for a small degree of overprogramming at the beginning of the year and aim to mitigate the risk of underspend against the indicative budget at the end of the year. We would manage this risk of a minimal overspend by taking a portfolio approach and slowing down spending as needed. Whilst we have provided a budget for each of the Global Health Security projects, the overall budget allocation to GHS will be managed at the programme level, as agreed with Ministers. Therefore, any over or underspends will be managed across the portfolio throughout the year, reducing the risk further.

3. Indicative figures are set out below:

Headline figures (in £m)	22/23	23/24	24/25	Total
Indicative budget	9	9	10	28
Maximum budget (to allow for overprogramming)	10	10	10	30

2. Strategic Context

Background

The IHR Strengthening Project to date

4. The UK is a signatory to the International Health Regulations (IHR) (2005) and as such is committed to supporting optimal compliance with the IHR both in the UK and globally. Reinforcing the first line of defence at an individual country level is

critical and foundational for global health security (GHS). As the present COVID-19 pandemic has demonstrated, strengthening international capabilities for outbreak preparedness, alert, surveillance and response is vital given that infectious disease outbreaks quickly transcend national borders[1]. Altogether, compliance with the IHR has never been a greater priority to prevent future health threats, including pandemics.[2]

5. The Official Development Assistance (ODA) funded IHR Strengthening Project (hereafter referred to as IHR-S Project), now in its 6th year has been working in six focal countries (Ethiopia, Myanmar, Nigeria, Pakistan, Sierra Leone and Zambia), and through regional multilateral agencies (e.g. Africa Centres for Disease Control and Prevention (Africa CDC), the Eastern Mediterranean Public Health Network (EMPHNET), linking with the World Health Organization (WHO) and its regional offices. When the IHR-S Project was set up, an in-depth country prioritisation process took place to guide the choice of partner countries. Factors included likely impact of the project, ties to facilitate building of strong peer to peer technical relationships, and input from FCDO.

6. Taking a One Health[3], "All Hazards"[4] approach, the IHR-S project works 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 project has a triple mandate to:

    i. Build technical capabilities of public health institutions
    ii. Strengthen leadership to improve multisector coordination
    iii. Develop sustainable resilient public health systems

[1] "The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises; Ch 4: Strengthening the Global and Regional System for Outbreak Preparedness, Alert, and Response", Commission on a Global Health Risk Framework for the Future; National Academy of Medicine, 2016 (link)
[2] "COVID-19: time for paradigm shift in the nexus between local, national and global health", Paul et al., *BMJ Global Health*, 2020 (link)
[3] In a global health security context, One Health (OH) can be defined as a collaborative, synergistic approach which recognises the interconnection between people, animals, plants and their shared environment. OH involves multisectoral, interdisciplinary working on systems strengthening to prevent, prepare, detect, respond to, and recover from threats to human, animal and environmental health. Credit D Morgan.
[4] "An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters": Centers for Medicare and Medicaid Services definition (link)

The Model used in the IHR Strengthening Project

7. The IHR-S Project is delivered for the Department of Health and Social Care (DHSC), by the UK Health Security Agency (UKHSA). The IHR-S project model has been positively evaluated and well received by our partners as highlighted by the third party, external evaluator: "*the IHR Project has positively contributed towards progress in strengthening IHR capacity in all countries and most technical areas in which the Project has been active and should be deemed a success*".[5] The core principle of the model is to work alongside partner National Public Health Institutes (NPHIs) and public health bodies in selected focal LMICs, and regionally through ongoing peer-to-peer engagement and support. Key elements of the model include:

    - Support is based on need expressed by public health partners in LMICs and regions (NPHIs and MoH)
    - Peer to peer two-way learning[6] and sharing through open and honest reflection and discussion
    - Sitting alongside to 'do with' and not 'do for'
    - Senior local and UK technical public health support staff based in country and at regional level are embedded in the public health system
    - Additional support UK-based subject matter experts in public health laboratories; disease surveillance and response; emergency preparedness and response; chemical hazards and incident response; points of entry and public health workforce development and leadership.
    - Linking with the wider global system to be part of a wider system change in preparedness, detection and response

[5]The ITAD endline evaluation (2021)
[6] Appendix 1 – Literature review on evidence for the IHR project's model

8. *This model is based on a two-way dialogue with partners and enables strong, trusted relationships to develop.*[7] *This facilitates a shared understanding of the needs of the public health system and allows UKHSA to match its expertise to the shared objectives and maximise longer-term sustainability.* This is in line with commitments from a recent meeting of the G7 Health Ministers' as they call for "*the work tailored to regional and country contexts and owned by and responsive to the needs and capabilities of countries and regions*".[8]

9. A UK-based project leadership team with technical expertise and project management support together provides the strategic technical and operational direction of the project, oversight of the programme design and oversight of overall delivery. This UK-based team also contributes to and champions partnership and relationship development across HMG and with international partners, to ensure alignment and synergies.

10. A full list of appendices further detailing the IHR-S project model, governance arrangements, sustainability, communications and other operating principles are available upon request (see Appendix 1).

11. From the start of the new project cycle, we will be working in four countries and two regions, with work coming to an end in two countries. The project has been paused in Myanmar since 1st February 2021, in response to the UK Government's decision to suspend indirect support to the Myanmar government following the military coup.[9] In Sierra Leone the project was engaged in a time-limited activity to establish a public health laboratory network. This has now been completed and following the COVID-19 pandemic response, which is being handled by the military, the IHR-S project drew down from Sierra Leone. This has been communicated with UK government partners including FCDO and the DHSC's Fleming Fund, who continue to engage in country, and formal notification of drawdown to the Ministry of Health in Sierra Leone is in process.

Lead government department and other government departments

12. The IHR-S Project is delivered by UKHSA, an executive agency, of the Department of Health and Social Care (DHSC). It is part of DHSC's ODA-funded Global Health Security Programme.

[7] Wilson A, Cartwright C. Thinking differently: lessons learned by international public health specialists while supporting the Integrated Disease Surveillance and Response system in Pakistan. BMJ Global Health 2020;5:e003593. doi:10.1136/ bmjgh-2020-003593

[8] G7 Health Ministers' Meeting, communique, Oxford, 4 June, 2021. (https://www.gov.uk/government/publications/g7-health-ministers-meeting-june-2021-communique/g7-health-ministers-meeting-communique-oxford-4-june-2021)

[9] Minister Nigel Adams updated the House of Commons on the UK government's response to the Myanmar military coup and the unlawful imprisonment of civilians.

13. Oversight and management of the IHR-S Project is provided by the DHSC, as part of the DHSC GHS Programme portfolio. This allows the IHR-S Project to maintain close working relationships across the portfolio and ensure synergy with other UK GHS programmes, specifically the Fleming Fund and the UK Public Health Rapid Support Team (UK-PHRST).

14. Additionally, the IHR-S project works closely and collaboratively with other UK government departments, on an ad hoc basis and through the Global Health Oversight Group, in particular:

    a. **The UK Foreign, Commonwealth and Development Office (FCDO):**

        i. FCDO HQ: The IHR-S project Senior Leadership Team ensures coordination with FCDO colleagues through attendance at HMG Global Health Security Alignment meetings, contributions to briefings, provision of situational intelligence and coordination with specific programmes (e.g. Tackling Deadly Diseases in Africa Programme (TDDAP) and its potential successor programme – the Advancing Health Security in Africa Programme). A representative from FCDO sits on the IHR-S project Board.

        ii. FCDO Country Offices and regional missions: The Senior Public Health Advisers in our IHR countries and regions are part of the One HMG family including the UK mission to the Africa Union. The project aligns with the health pillars within the FCDO country and regional strategic plans, building opportunities for collaboration and sharing public health intelligence with FCDO colleagues.

    b. **Department for Environment, Food & Rural Affairs (DEFRA):**

        i. As a programme with a One Health approach, the IHR-S project alignment with DEFRA and its agencies the Veterinary Medicines Directorate (VMD) and Animal and Plant Health Agency (APHA), is very important. DEFRA representatives have been represented on the IHR-S project Board, and a Framework Agreement to enable cross-working between the two organisations is in place.

3. Case for Change

Business needs

15. In this section, we set out the case for the continuation of the IHR-S project to support low- and middle-income ODA-eligible countries and regional public health institutions and bodies particularly at a time of a global pandemic. Specifically, the Case for Change sets out the need for a further cycle of funding in order to continue to support improvements in global health security and IHR compliance, build on lessons from Covid as well as other recent outbreaks, contribute to the

UK Government priorities, and sustain and build upon gains made between 2016-22.

16. **Table 1** highlights how a continued IHR-S project aligns with wider UK policy and global health priorities.

*Table 1. Key recommendations/commitments from the UK government **International Health Regulations** and global health organisations in line with the IHR-S project*

	Recommendations/commitment in line with the IHR-S project
UK	
UK Government Integrated Review[10]	Global health security is one of the key pillars within the UK Government's Integrated Review (IR) – recognised as one of the most pressing challenges facing our planet and an area where the UK has demonstrated global leadership and world-class expertise. Supporting global health functions is also amongst the most cost-effective options of development assistance for health.[11]
Letter commissioned by the Secretary of State on the purpose of UKHSA	UKHSA would "*have a strong role in global health security, since global and domestic health security are closely linked*." The UKHSA should "*deliver on specific **Official Development Assistance-funded projects**, in particular **the international health regulations strengthening***" so that the UKHSA can "*establish itself as a leading voice on the global stage*".[12]
G7 Health Ministers meeting report (Carbis Bay Progress Report, June 2021)	Acknowledges the IHR-S project's contribution in global health, stating "*The IHR Strengthening Project has worked with Ethiopia, Myanmar, Nigeria, Pakistan, Sierra Leone and Zambia to strengthen IHR compliance post-JEE."*
G7 Foreign and Development Ministers' Meeting in London in May 2021, together with G7 Health Ministers, the FCDO	"*Commits to work in partnership with low- and lower-middle income countries by improving coordination of G7 support for, and collaboration with, public health and health security capacities and their regional bodies in Africa, Asia and other regions, building on the G7 commitment to support implementation of and **compliance with the International Health Regulations (IHR)** in 76 countries*."
G20 Global Health Summit in Rome on 21st May 2021	Leaders of G20 and other states reaffirmed their commitment to efforts to build back better and to **the IHR (2005)**.

[10] **Error! Hyperlink reference not valid.**
[11] Disease Control Priorities, Third Edition, Volume 9 (dcp-3.org)
[12] Letter from Lord Bethell to Dr Jenny Harries, UKHSA chief executive. 13/7/2021

	Recommendations/commitment in line with the IHR-S project
	Amongst the 16 principles of Rome declaration, Principle 2 and 11 highlight the importance of using a multisectoral One Health approach which the IHR-S project has at its centre.
Africa Strategy	The IHR-S project is aligned with the Africa Strategy and contributes to the relevant outcomes.
Indo-Pacific tilt	In 2021, the UK Government announced an increased focus on the Indo-Pacific region, stating "the growing importance of the Indo-Pacific to global prosperity and security, and the emergence of new markets and growth of the global middle class." [13] During the new funding cycle, the IHR-S project will scope and deliver on opportunities to work with FCDO colleagues in UK Mission to ASEAN to strengthen the UK HMG's presence within the ASEAN region as a leading scientific public health agency on IHR and GHS.
UK International Development, Global Health Strategies	The project is well aligned with wider UK strategy, including the International Development Strategy, which sets out the aim of reducing the risk of future global health threats, building stronger health systems, strengthening the WHO and improving global health surveillance and response capability. It aims to harness British expertise to bring benefits across the globe, which aligns with the partnership model of the IHR Strengthening project. The Global Health Strategy also includes global health security priorities.
UK National Risk Register	The UK national risk register has consistently recognised pandemic influenza and emerging infectious diseases as two critical UK civil emergency risks. To mitigate these risks, the UK Government has emphasised the need to collaborate internationally and work on prevention, detection, response, and research.[14] The proposed IHR-S project and its objectives are therefore strongly aligned with UK strategies for national security.

[13] Global Britain in a competitive age. The Integrated Review of Security, Defence, Development and Foreign Policy https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/975077/Global_Britain_in_a_Competitive_Age-_the_Integrated_Review_of_Security__Defence__Development_and_Foreign_Policy.pdf

[14] The UK HMG Integrated Review of Security, Defence, Development and Foreign Policy, vision to "define and strengthen [the UK's] place in the world", including being "a problem-solving and burden-sharing nation" (link)

	Recommendations/commitment in line with the IHR-S project
Global	
Global Health Security Agenda (GHSA) 2024	The UK is strongly supportive of the GHSA and has been accepted as a Steering Group Member for 2022-24. The work of the IHR-S project contributes to the overarching target. In 2021 the UK became a member of the GHSA steering committee. Two of the GHSA objectives are i) to enhance country capacities to prevent, detect and respond to infectious diseases and 2) to promote multi-sectoral engagement and collaboration. The IHR-S project will contribute to these objectives. The project's capacity building activities in the areas of PH Laboratory networks, real time surveillance, Points of Entry; Emergency Preparedness and zoonoses are particularly aligned to the GHSA 2024 target.
IHR (2005)	The IHR are the legally binding instrument for global health security, to which 196 countries, including the UK, are signatory. The project is intrinsically aligned with strengthening compliance with the IHR in partner countries and regions.
WHO IHR Review Committee (as part of several COVID-19 reviews)	The WHO IHR Review Committee reviewed the functioning of the current IHR during the COVID-19 pandemic. The Committee formulated 40 recommendations under ten key areas and called for "*a new era of international cooperation to better support IHR implementation*". The IHR-S project is a collaborative project working alongside public health colleagues in countries and regions and is fully aligned in helping to achieve these IHR review committee recommendations.
Sustainable Development Goals (SDGs)	The IHR-S Project contributes to delivering on the SDGs, in particular SDG 3 (indicator 3.d.1 of target 3.d is to 'Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks').
Health systems strengthening	Functioning health systems have been described as the 'bedrock' of health security, with IHR core capacities also mirroring aspects of the WHO building blocks for health systems. Implementation of, and compliance with, the IHR relies on countries having strong health systems with integrated public health functions. Health system weaknesses also form a barrier to IHR compliance and implementation.

	Recommendations/commitment in line with the IHR-S project
	"*Health system strengthening is not only essential for achieving UHC, but also for advancing GHS. The world will only be prepared for ongoing and future public health threats if effective health systems are in place. Health system strengthening, UHC, and GHS are interdependent.*"[15] Achieving compliance with IHR and improving GHS are intrinsically linked with the development of strong and effective health systems. The FCDO 2021 Health Systems Strengthening Position Paper states "*Strong, resilient health systems are fundamental to achieving national, regional, and global health security… To improve health security, we need stronger, integrated public health functions that protect people from health threats… strong health systems form the foundation that underpins both Universal Health Coverage and Global Health Security… We will not improve overall health outcomes without addressing both UHC and GHS at the same time – it is not a case of 'either/or'."* The interconnections between Global Health Security, Resilient Health Systems and Universal Health Coverage are illustrated in Appendix 4.

Sustaining and building on the gains

17. The IHR-S project was originally funded for a five-year period, from FY 2016/17 to 2020/21 and then extended for an additional year to 2021/22. Over this period, in addition to successes and early evidence of impact, such as working alongside partners to set-up, training and implementation of Integrated Disease Surveillance and Response[16] in Pakistan[17], the project has applied its adaptive programming approach to e.g., pivot activities during the COVID-19 pandemic to flexibly respond to partner need, whilst still meeting its overall outcomes.

[15]G7 Carbis Bay Progress Report: Advancing Universal Health Coverage and global health through strengthening health systems, preparedness and resilience. P-10. Chapter 1. The context for the G7 commitments

[16]https://www.cdc.gov/globalhealth/healthprotection/idsr/index.html#:~:text=The%20Integrated%20Disease%20Surveillance%20and,and%20disability%20in%20African%20countries.

[17] For examples and case studies demonstrating IHR-S project impact and successes, in IHR capacity building activity and partnership building/working, see Appendix 6 and the Itad mid-term evaluation (Appendix 13a; particularly Annex 12 & 13)

18. The IHR-S project successes and learning to date have been captured formally in the first formative end-line evaluation report (Appendix 1), and the annual reviews commissioned by DHSC.[18]

19. Key findings as taken from the end-line evaluation report include:

- "The IHR Project has positively contributed towards progress in strengthening IHR capacity in all countries and most technical areas in which the Project has been active and should be deemed a success."

- "The Project has been highly relevant in supporting country and UK needs, and PHE is a valued source of technical knowledge, skills and experience."

- "The Project has provided support in six selected countries as well as to Africa Centres for Disease Control and Prevention (Africa CDC) and the Eastern Mediterranean Public Health Network (EMPHNET)"

20. In addition, the IHR-S project has supported initial work on the UK's offer of the New Variant Assessment Platform (NVAP) to strengthen surveillance of potential variants of concern in three of its partner countries.

21. The project now has an opportunity to maximise and build on the momentum generated to date, to continue supporting partners achieve long-term, sustainable improvements in public health systems and health security.

Strategic objectives of the next three-year cycle

22. The goal of the IHR-S Project is to enhance GHS and improve compliance with the IHR (2005), in accordance with the expressed need. The IHR-S Project will achieve this by delivering on its triple mandate through the following strategic objectives:

- Continued investment and expansion of in-country and locally employed teams, for effective relationship building and ongoing daily support to embed sustainable capacity building.[19]

- Further developing regional portfolios in Africa and Asia, whilst maintaining its close alignment with national-level IHR action plans. Developing collaborative delivery partnerships with existing regional organisations will support the

[18] International Health Regulations strengthening project Annual Reviews: 2016-18 (link) and 2018-19 (link)
[19] See Itad mid-term evaluation: Limited continuous staff presence in-country has limited partner relationship building (e.g. Zambia, p266) and progress with capacity building, for instance through mentoring and coaching support (e.g. in Ethiopia – p174, Nigeria – p198 & Myanmar – p187); conversely, local-based staff in Pakistan and embedded technical advisers in Nigeria have greatly facilitated engagement and delivery success (p227, p198)

strengthening of their regional coordination function[20] and better enable partner countries to fulfil their existing mandates as regional hubs.[21]

- Consideration of increasing support for developing subnational capabilities in a number of partner countries, in order to develop a line of sight from front-line to regional – a clear and evidenced need.[22, 23, 24]
- Increased collaboration with other UK HMG GHS programmes such as the UK-PHRST and the Fleming Fund, and with FCDO health system strengthening and health security programmes, to optimise the contribution to capacity building and response activities - delivering a truly "One HMG" approach to the UK global health security contributions.[25]
- Further engagement with other focal country government stakeholders with health security responsibilities, e.g., animal and environmental health ministries and agencies in the development of a "One Health" approach to health security.[26]

23. Review and build on the experience of the project's ability to rapidly re-orientate to support the global COVID-19 response, continuing to support NPHIs, regional organisations and UK HMG through the fall-out and recovery from the COVID-19 pandemic[27]. The value of this adapted in-country support during COVID-19 has been recognised by the Heads of Mission in our partner countries.

Benefits

24. The project aims to improve national, regional and global health security and reduce the impact of public health emergencies by strengthening the ability of

[20] For instance, the IHR-S project's support to Africa CDC has been highly welcomed and regarded as very important by Africa CDC and other partners; the relationship with Africa CDC is also appreciated (Itad mid-term evaluation p22, 55 & Annex 13). However, more resourcing is required to build further regional level engagements (p14).
[21] Itad mid-term evaluation recommendation: to "examine and act on opportunities to develop regional IHR capacities, including supporting the Africa CDC regional hubs for southern and western Africa (based in Zambia and Nigeria)" (p69)
[22] See Itad mid-term evaluation p ix, p70 and p201; also Appendix 4 (re evidence for sub-national capacity & system-wide linkages)
[23] Effective international public health surveillance and response "cannot exist sustainably without good national surveillance and response operated by competent public health workforce in core public health positions at national and sub-national levels" (from "Building a public health workforce in Nigeria through experiential training", Oyemakinde et al., *Pan African medical journal*, 2014 (link))
[24] A need for enhanced sub-national engagement to strengthen the public health system has been identified: specifically in Ethiopia, Nigeria and Pakistan (Itad mid-term evaluation pages 176, 201 & 227); also decentralised health systems (e.g. Ethiopia, Pakistan and Zambia) can limit system-wide capacity building and thus whole system strengthening (Annex 12, also p228).
[25] Itad mid-term evaluation findings (p ix and p14): "PHE has worked with other parts of HMG to promote cross-HMG coordination and to ensure its interventions are complementary, coherent and aligned… there are therefore opportunities to strengthen this"
[26] For instance One Health coordination is still rudimentary and/or an identified area of need in several IHR countries; see Itad mid-term evaluation p54, 58, 174, 205.
[27] See Appendix 17 & 'WHO Strategic Partnerships for IHR' portal (link), also Appendix 6; Appendix 7 concerning IHR-S project support to HMG missions.

developing country partners to prevent, detect and respond to public health threats.

25. Strengthened global health security through improved compliance with the International Health Regulations (IHR) reduces the risk of infectious disease epidemics and other public health events impacting directly or indirectly on the UK, boosts economic activity and brings increased prosperity. IHR compliance remains weak in many countries and as COVID has demonstrated, it is clear that global health security is only as strong as the weakest link.

26. In its end line evaluation, the independent external evaluator reported that the IHR Strengthening Project has been a success as it has positively contributed towards progress in strengthening IHR capacity and been highly relevant in supporting partner country and UK needs.[28] This is demonstrated through increases in Electronic State Parties Self-Assessment Annual Reporting Tool (SPAR) scores, used to assess compliance with IHR, across many domains in our partner countries, demonstrating that we are achieving our remit of improving IHR compliance.

27. IHR Strengthening Project will work with 5 countries and 3 regions, including in the Indo-Pacific, to support public health system strengthening and implementation of the IHR.

28. The next phase of the IHR-S Project will:

- Increase the regional presence across the Eastern Mediterranean and Indo-Pacific regions;

- Progress an additional bilateral relationship with another country in the Indo-Pacific region (in consultation including with FCDO ASEAN colleagues). The additional country partner will be determined through a detailed scoping process and informed by regional need.

- Build on successful partnerships to date with Nigeria, Pakistan, Ethiopia, Zambia and the Africa CDC.

29. This aims to bring the following benefits:

Economic

30. It is challenging to measure specific benefits in monetary terms resulting out of IHR compliance. The importance of investing in prevention and preparedness has been illustrated by the COVID-19 pandemic. The Global Preparedness Monitoring Board stated: *‘Expenditures for prevention and preparedness are*

[28]Unpublished ITAD endline evaluation report, September 2021

measured in billions of dollars, the cost of a pandemic in trillions. It would take 500 years to spend as much on investing in preparedness as the world is losing due to COVID-19.' Therefore, investment upfront is likely to result in economic benefit in the long term. The World Economic Forum estimates that the COVID-19 pandemic has cost $11 trillion in terms of response whereas preventing the pandemic through preparedness activities would have cost $5 per person. In addition, studies suggest that supporting global health functions should be prioritised in the global health space, as many countries can benefit from investments in global health, while the impact and cost of inaction in this area can be very high. The Global Health 2035 report by the Lancet Commission on investing in Health, made a case for reorienting official development assistance (ODA) for health to areas where national governments have natural incentives to underinvest, including pandemic preparedness.[29] [30]

Social

31. There are clear social benefits to IHR compliance, including a reduction in illness and death due to disease outbreaks and health threats, both within the affected country and internationally due to limiting the spread of disease. In addition, outbreaks and other health threats disproportionately affect women[31] and other vulnerable groups[32]. On this basis, we are confident that our work does not exacerbate gender inequality or hinder others' attempts at reducing gender equality and may in fact benefit women proportionately more. We therefore consider our work as having the potential to have a high degree of positive impact on gender and other protected characteristics.

Risks

Strategic Risks

32. Several key strategic (external) risks to effective programme delivery have been identified, as summarised below. Programme strategic risks and operational service/delivery risks (see Commercial Case) are captured within the Programme Risk Register, and regularly monitored and reviewed. The IHR-S project will continue to employ adaptive programming and prioritise strong relationship building, which will effectively mitigate against many of the identified risks.

[29] Disease Control Priorities, Third Edition, Volume 9 (dcp-3.org)

[31] UN Policy Brief: the Impact of COVID-19 on women, policy-brief-the-impact-of-covid-19-on-women-en-1.pdf (un.org)

[32] UN framework for the Immediate Social-Economic Respond to COVID-19, UN-Framework-for-the-immediate-socio-economic-response-to-COVID-19.pdf

Risk	Mitigation
Underspends or overspends arising due to difficulties in managing the allocated project budget, including as a result of recruitment delays and further travel restrictions.	There is some flexibility to manage budget at the GHS programme level should overspends arise towards the latter part of the financial year, in part looking to underspends arising elsewhere in the programme. We have identified lower priority activity and staffing beyond the estimated yearly cost of delivering the project that can be added to our current workplans to enhance delivery and mitigate the risk of an underspend. Each activity is costed in advance of delivery giving the project the option to flex in and out activity based on spending.
Evolving public health threats (e.g. including the continued impact of COVID-19) impacting partner capacity to engage and UKHSA ability to deliver, and hence timescales and workplans for delivery.	Adapt and re-focus activities responsive to emerging partner needs in order to achieve the same outcomes through different means. Deliver activities through locally employed expertise with remote support from subject matter experts, taking advantage of e-learning and remote delivery where appropriate.
Political instability, leadership/regime changes and social unrest within IHR-S project focal countries, affecting staff safety/security and ability to travel. For instance, general elections are likely in Nigeria and Pakistan, with ongoing civil unrest in Ethiopia, each of which may affect the ability of the project to deliver.	Build broad relationships with a variety of partners in countries and regions, to create resilience within the system regardless of changes outside of our control.
Changing global geopolitical landscape, institutional leadership and/or political commitment, impacting on or compromising UKHSA global engagement and institutional	Continue to be involved in key multilateral changes to the GHS landscape, such as through the IHR Review Committee. Work across a variety of partners using an adaptive management approach.

partnership building, along with resultant changing priorities for IHR strengthening.	
Staff changes through the transition and creation of the UKHSA, with potential impact on delivery timescales, traction or loss of 'programmatic memory'; affecting partnership building and delivery in country.	Raise any potential issues early with our funders, using both internal and external influence to mitigate against impact on delivery. Build and train workforce within the project to increase programmatic memory.

4. Available Options[33]

No funding

33. No funding would result in closing down the project and ending existing activity.

34. This would result in reputational damage to HMG due to ending existing partnerships and would represent poor value for money due to the difficulty of locking in the gains the project has made through its previous activity.

35. This option is not recommended. Closing down the project would represent poor value for money and would be out of alignment with UK commitments.

Flat funding (approx. £7m/year)

36. This funding scenario covers the minimum required (salaries, in country team costs such as platform costs etc) to continue present level of activity in the existing partner countries and regions.

37. This would enable continuing engagement with partners. However, there would be no additional work or engagement beyond existing countries and regions and no scope for in year increases to respond to revised partner needs unless additional funding was received.

Increased funding (£9-10m/year) – preferred

38. This scenario enables a continuation of current activity, with new activity in the Indo Pacific region and a progression of our present regional activity in Africa and the Eastern Mediterranean Region, including increased activity in Africa CDC

[33] Totals in scenarios below include non-ODA budget for one-HMG platform costs

Regional Collaborating Centres. Increased regional activity is likely to bring increased impact for the Project, as the technical expertise can be amplified more widely within multiple countries in the region.

39. This option is preferred as it would enable to project to build upon the successes of the past 5 years to increase local engagement and activity building upon the strong relationships the project has been able to establish in partner countries. This would also allow the project to engage with emerging government priorities such as the Indo-Pacific tilt and increase its impact through greater regional engagement. A growing body of academic literature has highlighted how regional approaches to global health security would benefit the world as well as the local region. Funding has been secured for this option through the Spending Review process.

Deliver the IHR-S Project through another partner

40. UKHSA contains unique technical expertise required to deliver this work and we have assessed that appointing a new delivery partner would represent in poor value for money. As the UK's national public health institution, UKHSA is uniquely positioned to deliver this work. It is home to world-class expertise in global health and infectious diseases. It provides world-leading science, specialist public health services, research, knowledge and intelligence, through advocacy and partnerships. UKHSA has world leading expertise in IHR domains such as laboratories, surveillance and chemical incident response. Specialist technical support is delivered by public health experts from across the organisation in coordination with local experts based in our partner countries, to meet partner and UK priorities for strengthening IHR compliance. Therefore, this option is not recommended.

41. If a new delivery partner was appointed, there would likely be a gap in delivery due to the competition process to appoint a new delivery partner, as well as a loss of established relationships, resulting in a significant reduction to project outputs, outcomes and impact and therefore poor value for money.

5. Preferred Option

44. A breakdown of funding for the confirmed settlement is presented below. Please note that these figures are estimates only and subject to change as the project responds to partner needs and priorities as they arise.

Delivery costs per country/region				
Country/region[1]	**Year 1**	**Year 2**	**Year 3**	**Total**
Africa CDC/Regional Collaborating Centres	546,330	552,330	559,330	1,657,990
Ethiopia	370,000	376,000	381,000	1,127,000
Nigeria	596,000	609,000	622,000	1,827,000
Pakistan	1,033,300	1,053,000	1,075,000	3,161,300
Zambia	407,000	415,000	423,000	1,245,000
EMR region	292,000	300,000	310,000	902,000
Indo pacific regional and bilateral	402,860	513,670	499,370	1,415,900

[34] DHSC holds a non-ODA budget for one-HMG platform costs.

6. Procurement Route

45. UKHSA uses internal expertise in order to deliver on the IHR-S project as subject matter expertise mostly exists within the organisation. As a result, there is limited procurement across the project.

46. No additional procurement is required for this proposal, as it is for additional time and money to extend work already being delivered using UKHSA's own resources. No new third-party procurement is anticipated. Existing contracts will be extended or adjusted with the purpose of maintaining existing arrangements (with additional time and funding as required) to allow original project objectives to be met.

7. Funding and Affordability

The IHR-S Project has been allocated an indicative budget of £28m RDEL (with a maximum of £30m to cover overprogramming) over the next three years from 2022/2023 to 2024/2025. Whilst this is an ODA project, a small proportion of this funding will be non-ODA to cover one-HMG platform costs (see funding breakdown table above).

Value for money

47. VFM will be measured against the '4Es' – economy, efficiency, effectiveness and equity. The programme will continue to apply the UK ODA VFM guidance, to deliver the best feasible programme.

48. The programme will do this through:

Economy

- UKHSA will use competitive tendering processes in collaboration with FCDO to appoint downstream partners in order to ensure the best value for money logistics providers available.

Efficiency

- Collaborative working internally with other UKHSA and DHSC-funded projects, with FCDO and across HMG and with in-country partners, to achieve greater economy and efficiency.
- Basing more staff (both locally engaged and UK) in partner countries, supplemented by deployments from dedicated technical experts, increasing efficiency, effectiveness, equity and environmental sustainability. This approach was recommended in the Mid-Term Evaluation (MTE).

- Using competitive tendering processes in collaboration with FCDO to ensure the best value for money logistics providers available for the delivery of workshops and to facilitate activity in partner countries.

Effectiveness

- Evidence-based programme design and delivery evaluated through a comprehensive monitoring and evaluation system, including evidence generation, to increase project effectiveness and demonstrate UK leadership on GHS.
- Developing digital platforms to share knowledge and learning resources to increase reach, equity and effectiveness.
- Evidence suggests the project model of peer-to-peer technical assistance is an effective method to increase GHS.[35]

Equity

- Outbreaks and other health threats disproportionately affect women[36] and other vulnerable groups.[37] On this basis, we are confident that our work does not exacerbate gender inequality or hinder others' attempts at reducing gender equality and may in fact benefit women proportionately more.
- The age and gender breakdown of each training event is monitored, and female participation is encouraged and advocated for, being mindful of local context.
- The project has moved towards increasing staff numbers within partner countries as this has been recognised as improving: the quality of engagement, increasing opportunities for experts based in partner countries, and reducing the amount of air travel required.
- The next phase of the project will include implementation of the Sustainability, Equity and Inclusion Plan to address gender equity, equity of opportunity, an inclusive working culture, environmental sustainability etc. This will be renewed for the upcoming project cycle.
- All IHR-S project activity is conducted in line with the International Development (Gender Equality) Act 2014.

Climate

- For 22/23, the project will undertake a climate risk assessment. This will involve looking at potential risk areas such as waste management and offsetting travel emissions. If found to be susceptible to climate risks, the

[35] Mghamba, J. M. et al. Developing a multisectoral National Action Plan for Health Security (NAPHS) to implement the International Health Regulations (IHR 2005) in Tanzania. BMJ Global Health 3, e000600, doi:http://dx.doi.org/10.1136/bmjgh-2017-000600 (2018).
[36] UN Policy Brief: the Impact of COVID-19 on women, policy-brief-the-impact-of-covid-19-on-women-en-1.pdf (un.org)
[37] UN framework for the Immediate Social-Economic Respond to COVID-19, UN-Framework-for-the-immediate-socio-economic-response-to-COVID-19.pdf

project will then undertake a climate risk screening. This will ensure the project will align with the UK's climate and environment commitments.

Useful link: ODA VfM guidance

8. Management Arrangements

Project Management arrangements, finance and PMO support

49. Existing management arrangements will be maintained but will be adapted to fit the new structures in UK public health and across HMG.

- The IHR-S project will continue to be part of the DHSC GHS Programme and provide quarterly progress and finance updates to DHSC. Governance, oversight and scrutiny of all aspects of the project, including accountability for value for money, risk management and monitoring and evaluation, will remain with the IHR Project Board and DHSC GHS Programme Board (chaired by the DHSC Senior Responsible Officer). All governance processes will continue to be supported by finance and commercial expertise within UKHSA and DHSC.

- The IHR project will ensure clear representation within, and alignment with the developing cross HMG Country Strategic plans, while maintaining clear accountability to DHSC as our sponsoring government department.

- The project leadership and management team will be responsible for project development, design, implementation, monitoring and evaluation, and be accountable to UKHSA and DHSC governance bodies.

- Learning from previous funding cycles will influence project planning, delivery and management, in line with a move towards increasing adaptive programming. Annual work plans will be developed and continuously monitored, and work planning processes will be reviewed to increase efficiency. Decision-points and KPIs will be built into all projects to allow for revision, review or termination if key objectives are not being achieved, or significant changes occur.

- Impact will be assessed through continuous monitoring and evaluation of workplan delivery and project processes, including internal and external, and formative and summative evaluations. Recommendations from the end-line evaluation regarding improvements in M&E will be enacted, including a revision of the project theory of change and assumptions.

Risk management

- Robust risk management processes will be embedded within regular governance processes to enable the project leadership and management to identify and assess risks, determine mitigations, manage actions and record contingencies. Strategic/external and internal delivery risks and mitigations will be captured in the project risk register, regularly reviewed and escalated to higher levels of governance (within UKHSA, the IHR Project Board and DHSC GHS Programme), as necessary.

- Internal governance arrangements are illustrated below (Figure 3).

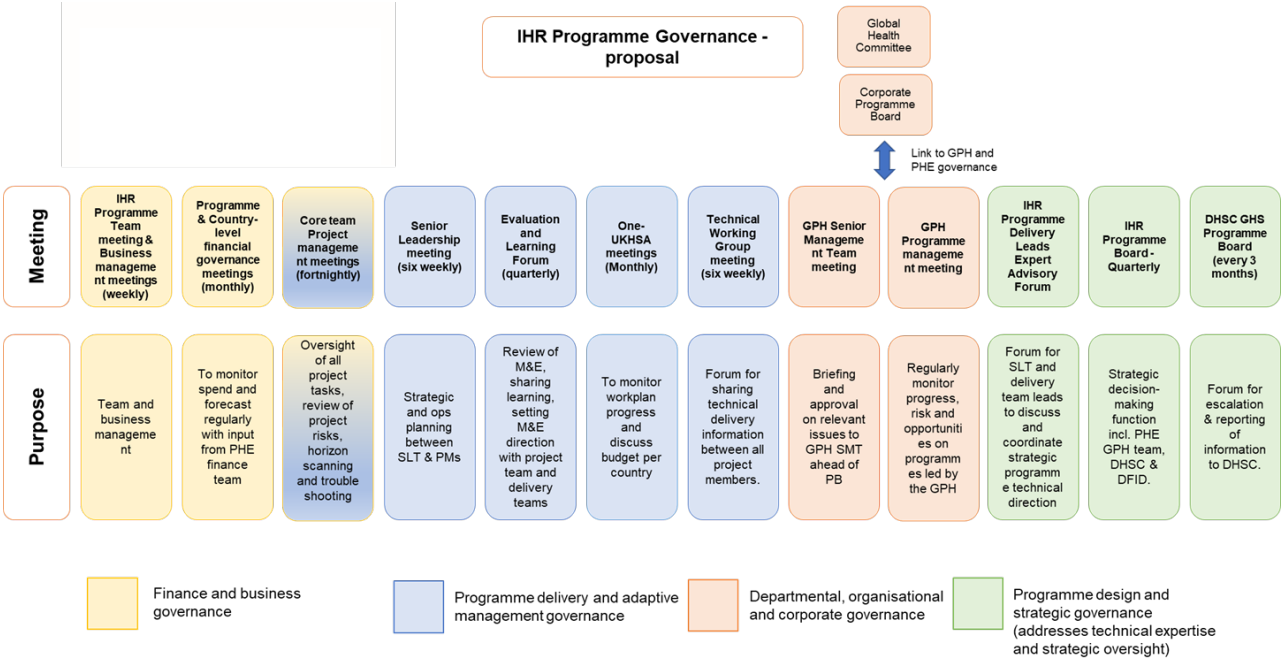

Figure 3: IHR-S Project Proposed Governance Framework

Project deliverables

Country/Region	High level outputs
Africa CDC and Regional Collaborating Centres (RCC)	• Signed MoU with clear deliverables and action plan including staff members to be embedded within the Africa CDC team • Workforce development and leadership support to Africa CDC in operationalising RCCs • Continued capacity building and training on technical areas, including public health laboratories, emergency preparedness and workforce development
Eastern Mediterranean	• Strengthening multi-sector coordination work with multiple Eastern Mediterranean countries • Building a local presence to work alongside EMPHNET in pursuing further work based on expressed partner need
Ethiopia	• Re-engagement with EPHI, including signing an MoU, to re-establish stakeholder relationships and understand partner priorities • Engage with other stakeholders in Ethiopia, including; WHO, Environment Agency, Ministry of Health to broaden impact and reach of the technical support provided in-country. • Working with the Ministry of Health in Ethiopia to create a national approach to poisons
Indo-Pacific	• Developing a local presence, relationships and enabling infrastructure through embedding senior public health expertise • Based on an assessment of IHR Compliance need and ask from partners support capacity building • Scope and establish a new bilateral country relationship in the region including delivery of technical support and establishment of a local team
Nigeria	• Exploration and identification of needs around chemical hazards • Building on the relationship with WAHO to provide public health expertise at a West African regional level • Further capacity building on PH lab networks, surveillance, One Health and emergency preparedness and response
Pakistan	• Enhance IDSR capacity of PH lab networks • Public health epidemiology capacity building and IDSR upscaling

	• System strengthening through workforce development and leadership programmes.
Zambia	• Scale up work with Ministry of Health in Zambia, including around public health laboratories • Work with the Africa CDC Southern RCC to support capacity building and training. • Further system strengthening on PH lab networks, One Health and emergency preparedness and response

50. The above project deliverables outline the high-level objectives the project aims to achieve from 2022-2025. Each country/region has different areas on which the project will aim to work due to the differing systems and partner landscape within each context. The table below outlines the main domains of activity, based on the International Health Regulations Monitoring and Evaluation Framework, for each country/region that we anticipate working in:

	Domain of activity					
Country/ Region	**Workforce development**	**Labs**	**Surveillance**	**Emergency Preparedness**	**One Health**	**Chemicals**
Africa CDC	X			X		
EMR	X					
Ethiopia	X	X		X	X	X
Indo-Pacific	X			X		
Nigeria	X	X	X	X	X	X
Pakistan	X	X	X	X		
Zambia	X	X	X	X	X	X

9. Monitoring and Evaluation

51. The IHR-S projects MREL approach is intended to capture, analyse and interpret data to guide planning, allocation or reallocation of resources, design and implementation of activities and monitor progress. This is essential to providing the IHR-S project team and HMG with the information and understanding they need to make informed decisions about the operation of the project, to improve delivery and ensure effectiveness and impact.

52. MREL activities are governed by an overarching MREL plan (available on request) that has been developed building on lessons learned from the initial funding cycles including recommendations from the DHSC annual reviews and the external mid and end-line evaluations.

53. The DHSC GHS team will be given the opportunity to comment and sign off on project plans where relevant, including any project documents which will be published.

Monitoring and Evaluation Approach

54. An adaptive programming approach will be taken to ensure that MREL principles are embedded within the IHR-S project and can be used to learn from project delivery using an evidence-based approach, inform decision making and assess the effectiveness and impact of the programme.

55. The IHR-S project will use three main guiding principles, based on the current project cycle's end-line evaluation report in order to assess programme success:

    a. Is the project doing the right things?
    Do the activities align with the triple mandate of the programme?

    b. Is the project doing things the right way?
    Are the processes of the programme effective and transparent?

    c. Is the project achieving the right results?
    Are the objectives of the programme being achieved and is there sustainable impact?

56. A theory-based evaluation using a theory of change (ToC) will outline how the project goals can be achieved through outcome pathways linking inputs to activities to outputs and impacts.

57. This approach captures the complexity of a public health system and will help us consider and capture the underpinning assumptions that feed into whether the project will have its intended impacts.

Logical framework indicators

58. The ToC will be complimented by comprehensive logical framework indicators in order to monitor and evaluate progress against the outcomes and impacts. The project's logframe indicators will build upon the existing logframe indicators (Appendix 3) and will include nested, country/region specific, indicators. The detailed indicators will be developed in early FY 22/23 and agreed by DHSC.

59. Data against the logframe indicators will be reported to the quarterly IHR-S Project Board meeting, through the Annual Review and at internal MREL meetings.

Resources

Approximately 5% of the projects budget (£1.53M) will be dedicated to MREL.

	Function	**Resource (£ or FTE staff)**	
IHR-S project MREL team	Design and operationalise a MREL plan. Capturing, analysing and interpreting data to guide planning and help design and implement activities; and to monitor progress and evaluate trainings. Reporting against the project log frame. Undertaking evaluation of training outcomes. Act as liaison with the external evaluators to ensure delivery of the commissioned end-point evaluation.		
Global Operations central MREL team	Guidance, support, standardised tool development and quality assurance	Staff time provided as core service	
End point external evaluation (years 2 and 3)	Ensure that the project is having the intended impact by taking an outcome-focussed approach broadly covering the following areas: **(i)** Assessing the outcomes and impact of the project against the logframe: a. Range/quality of system strengthening activities b. Outputs and outcomes of system strengthening activities, including utilisation and sustainability **(ii)** Key factors which may facilitate or restrict results		£300,000

	(iii) Extent to which the project complements other UK ODA health security programmes and alignment with other GHS activities (iv) Generate additional evidence and insights	

10. Communications

60. The IHR-S project has developed and implemented a Communications, Transparency and Visibility (CTV) plan (available on request). The plan outlines the IHR-S project's systematic approach to ensuring its activities, investments, outputs and outcomes are accessible and visible to all stakeholders and contribute to the body of evidence for effective IHR capacity building and GHS. The plan also ensures a strategic approach to promoting transparency on how UK aid investment through the project is utilised.

Target Audience

61. There are five main audiences and corresponding aims for the project's CTV activities. The aims of engagement with these audience groups are influenced by the nature of IHR-S project and HMG GHS strategic objectives, transparency obligations and MoUs/agreements with partners.

a. Target Audiences

Audience	**Aims of Engagement**
HMG partners (including DHSC)	To showcase UKHSA's technical activity and opportunities for collaboration and engagement, as well as illustrating how the IHR Project aligns with wider UK GHS strategy and vision.

Bilateral partners and international global health security partners	Raise visibility and awareness about what we do, highlight partnership successes and opportunities for further engagement. To provide information on the project's achievements, approach and key global health security developments, promoting opportunities for collaboration, best practice and avoiding duplication.
UKHSA stakeholders (internal)	To connect with UKHSA colleagues providing them with an understanding of the project's goals, activities and successes, to promote cross-UKHSA buy in.
IHR Project Team (internal)	To connect colleagues contributing to IHR Project delivery, creating a have wider cross project understanding of the work being done and encourage their engagement with communications, transparency, and visibility.
General public	To ensure project transparency and demonstrate value for money as mandated for all UK Aid funded programmes by making the project activities, performance, and achievements publicly accessible for scrutiny.

b. Communications tools

Tool		Purpose	Target Audience	Content/Key messages	Frequency
External communications	Knowledge Hub (TGHN)	Showcase project accomplishments, increase visibility, accessibility and engagement with GHS expertise, via external landing page.	All audiences/partners	A centralised resource, with all other external aspects accessible via the hub. The hub will include: - Overview of the project - News, events and case studies - Publications - Project 2 pager and country 2 pagers - Learning resources aimed at capacity strengthening - Communities of practice - Link to Twitter Widget	Bi-weekly or as required - with minimum 3 new pieces of content on the hub per month.
	Social Media	To promote project achievements and successes, increase engagement with partners and technical experts.	All audiences/partners	Tweets promoting webinars, events, partner activity, significant progresses.	As required – aim to have at least one twitter post uploaded per month, dependant on project activity.

	Press Releases	Promote project activity and increase visibility	Bi-lateral partners, HMG partners, general public	High profile IHR project events involving HMG partners, significant announcements (including new partnerships and achievements)	Reactive to project activity.
	Slide Decks and 2 pagers	To disseminate background information about project, progress, strategies and plans	Bi-lateral partners, UKHSA stakeholders, international GHS partners	Overview of project, present progress, direction and decisions.	As required. Standard content to be reviewed every six months
	Annual Review	Showcase project accomplishments and progress, build evidence base	All audiences/partners	Project performance, progress, key achievements, review and evaluation of activity. To be accessible on knowledge hub as well as uploaded to the development tracker.	Annually
	Development Tracker	Project overview and summary, public access to published project documents to meet transparency obligations	Bi-lateral partners, HMG partners, general public	Project performance, progress, key achievements, review and evaluation of activity.	As relevant documents are produced
Internal Communications	IHR Project Newsletter	To disseminate information and updates on project work to UKHSA Global Operations	Global Ops, IHR project team, DHSC and FCDO Project Board members*	Updates on project activity, as well as publications, upcoming events and workshops, wellbeing segment, and monthly media round up.	Monthly

			*N.b this is accessible on the knowledge hub however it's primary audience is within UKHSA		

11. Additional Links

FCDO Programme Operating Framework
ODA value for money guidance
Government Procurement Agreement (WTO)
EU Consolidated Public Sector Procurement Directive (2004)
HM Treasury Green Book

Appendix 1 – List of appendices available on request

1. An evidence review to test the IHR-S project ToC assumptions
2. IHE evidence generation – publications and practices
3. Evidence of impact and case studies
4. Support to HMG international missions
5. COVID-19 preparedness and response support
6. IHR-S project governance framework
7. IHR-S project risk review process
8. IHR-S project sustainability, equity and inclusion plan
9. Communications, visibility and transparency plan
10. Third part contracts management
11. IHR-S project mid-term review
12. IHR-S project MREL plan
13. IHR-S project ToC
14. Cross HMG collaboration and synergies
15. One Health strategic approach
16. AGILE adaptive project management
17. IHR-S end-line review

Appendix 2 – ITAD End line evaluation executive summary

Appendix 3 – IHR Project logframe (summarised)

OUTCOME	OUTCOME INDICATOR	Indicator technical definition	Means of Verification	Planned / Achieved
Improved compliance with the IHR (2005) in partner countries	Improved compliance with the IHR (2005) within partner countries as a result of project activities	Analysis of JEE/SPAR scores (overall average and domain-specific scores) over 3 years to assess compliance with the IHR (2005) within the partner countries. An example of domain specific scores is chemicals and surveillance scores, etc. JEE and SPAR are evaluations conducted by WHO. JEE is an external review of progress towards IHR core capacity implementation, conducted once every 4-5 years (voluntary). SPAR is a country-led multisectoral review of progress towards IHR core capacity implementation, conducted once every year (mandatory)	Joint/external evaluation report with separate sections on each elements	
	Strengthened ability of national structures/partner countries to prevent detect and respond to public health emergencies	Qualitative external assessment of the ability of national structures to deliver on the IHR regulations (2005) National structures includes national public health institutes, ministries of health, universities, etc. Strengthened includes governance and decision making, participation and influence, robust and resilient internal systems, etc.	External evaluation where questions will pay particular attention to inclusivity, sustainability, visibility, equity, and transparency	
OUTPUT 1	INDICATOR 1.1			
Strengthened technical capacity in country and regional public health organisations	Number of partner country stakeholders trained in IHR core competency areas	Total number of stakeholders in partner countries, trained in IHR core competency areas by UKHSA Example of stakeholders include laboratory staff, delegates from across regional partners, epidemiologists, public health professionals across country IHR core competency areas are EPRR, OH, WD, RCE, Labs, surveillance, PoE Disaggregation includes type of training i.e., ToT, technical training, simulation exercise, after action review	The data will be taken from internal system and quarterly reports from the country teams	1000 per annum
	INDICATOR 1.2			
	Number of core products co-developed in IHR core competency areas	Core products are all the documents created as a result of the IHR projects activities in core competency areas. These products include: National action plans, strategies, SOPs, guidelines, and operational tools such as quality manuals, algorithms, implementation plans, learning management systems, workplans, etc. IHR core competency areas include EPRR, OH, WD, RCE, Lab, IDSR/PoE Co-developed products are defined as core technical products that are developed with (not for) partner country stakeholders Disaggregation includes level of finalisation with UKHSA support: revised, co-developed, approved, implemented or resourced/budgeted. Resourced/budgeted refers to activities that have an approved source of finance and resources	The data will be taken from internal system and quarterly reports from the country teams	>25
	INDICATOR 1.3			

	Number/Proportion (%) of trained stakeholders demonstrating new/improved technical skills or applying new/improved knowledge in IHR core competency areas	Stakeholders that have been trained (captured in indicator 1.1) will be revisited 3-6 months after the training A standardised tool will be tailored to identify uptake of knowledge/skills gained in practises. this is through a self-reflection survey followed up by FGDs. A scale will demonstrate how deeply skills have been embedded into practise	The data will be taken from internal system and quarterly reports from the country teams	60%-80%
	INDICATOR 1.4			
	Changes in technical practices resulting from project's capacity strengthening	This is a qualitative indicator using bespoke annual evaluation to assess the changes in technical practices resulting from contribution of activities conducted to strengthen technical capacity in country and regional public health organisations	Bespoke evaluation report	>50%
OUTPUT 2	INDICATOR 2.1			
Enhanced leadership, workforce and organisational development in partner country and regional public health organisations	Number of partner country stakeholders trained/mentored in leadership	Total number of all the stakeholders in partner countries, trained/mentored in leadership Example of stakeholders include delegates from regional partners, public health professionals, public health institute's senior staff/staff, etc. Disaggregation includes type of training i.e., ToT, workforce training, mentorship, etc.	The data will be taken from internal system and quarterly reports from the country teams	100 per annum
	INDICATOR 2.2			
	Number of core products co-developed in workforce development	Core products are all the documents that are created as a result of the IHR-SP activities in leadership, workforce and organisational development. These products include strategies, SOPs, guidelines, and operational tools such as syllabus, modules, workshop programme, organisational core values, workplans, etc. Co-developed products are defined as core technical products that are developed in coordination with partner country stakeholders Disaggregation includes whether the core-product was revised, co-developed, approved, implemented or resourced/budgeted. Resourced/budgeted refers to activities that have an approved source of finance and resources Disaggregation includes whether the core-product was revised, co-developed, approved, implemented or resourced/budgeted. Resourced/budgeted refers to activities that have an approved source of finance and resources	The data will be taken from internal system and quarterly reports from the country teams	>10
	INDICATOR 2.3			
	Number/Proportion (%) of trained staff demonstrating new/improved leadership skills or applying new/improved governance processes	Stakeholders that have been trained (captured in indicator 2.1) will be revisited by the facilitators 3-6 months after the training A standardised tool will be tailored to identify uptake of knowledge/skills gained in practises. this is through a self-reflection survey followed up by FGDs. A scale will demonstrate how deeply skills have been embedded into practise.	The data will be taken from internal system and quarterly reports from the country teams	60%-80%
	INDICATOR 2.4			
	Changes in workforce and leadership practices resulting from project's capacity strengthening	This is a qualitative indicator using bespoke annual evaluation to assess the changes in workforce and leadership practices resulting from contribution of activities conducted to enhance leadership, workforce and organisational development in partner country and regional public health organisations	Bespoke evaluation report	>50%
OUTPUT 3	INDICATOR 3.1			
Strengthened public health systems and networks at national and regional level	Number of IHR publication or events sharing evidence on improving IHR core competencies that are shared through a variety of fora including peer review journals, conferences, webinars, etc.	Total number of publications or events sharing evidence to improve IHR core competencies. It can be shared using variety of forums including but not limited to publications, conferences, webinars, etc. Examples of publications include grey literature, journal publications, articles, presentations, etc.	The data will be taken from internal comms tool that keeps a record of all the publications	>25
	INDICATOR 3.2			
	Number and description of networks supported across country, regional and global levels	This is a mixed-method indicator i.e., it will have quantitative and qualitative data. The *quantitative* data assesses the total number of networks that are supported across country, regional and global levels. These could be formal (i.e., TORs, formal membership, secretariat, etc.) or informal (i.e., community of practise, nascent group, etc.) The *qualitative* data focuses on the description of support and network i.e., which type of network and what kind of support was provided for e.g., facilitation, discussion on national strategy, etc.	The data will be taken from internal system and quarterly reports from the country teams	>10

		Supported is defined as activities around creation, co-ordination, expansion and sustenance of existing and new networks. Examples include but are not limited to co-facilitation and training, digital support, admin support, core products development, new network creation, embedding a network within local system, chairing meetings, etc.		
	INDICATOR 3.3			
	Number of stakeholders report having improved coordination through the network/partnership	Stakeholders are all the individuals who are part of the network/partnership A bespoke suvery/scale will be used annually with the stakeholders asking them to reflect on whether they see improvements in coordination through partnership/network Cut-off for the scale will help determine improvement which will be used to assess the proportion of stakeholders who report having improved coordination through network/partnership	The data will be taken from internal system and cumulative quarterly reports from the country teams	60%-80%
	INDICATOR 3.4			
	Changes in public health practices resulting from networks	This is a qualitative indicator using bespoke annual evaluation to assess the changes in public health practices resulting from contribution of activities conducted to strengthen public health systems and networks at national and regional level	Bespoke evaluation report	>50%

Appendix 4: How Universal Health Coverage, Global Health Security and Health Systems Strengthening efforts are interconnected

Source: FCDO Health Systems Strengthening Position Paper, adapted from Wenham C, Katz R, Birungi C, et al. Global health security and universal health coverage: from a marriage of convenience to a strategic, effective partnership. BMJ Global Health, 2019