Department of Health & Social Care

Annual Review 2022 - 2023 International Health Regulations Strengthening Project

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Contents

Abbreviation list

Abbreviation	Term
ASEAN	Association of Southeast Asian Nations

Abbreviation	Term
DHIS2	District Health Information Software 2
DHSC	Department for Health and Social Care
EOC	Emergency Operations Centre
IDSR	Integrated Disease Surveillance and Response
IHR-SP	International Health Regulations Strengthening Project
JEE	Joint External Evaluation
MREL	Monitoring, Research, Evaluation and Learning
PHEOC	Public Health Emergency Operations Centre
UKHSA	UK Health Security Agency
SPAR	State Party Self-Assessment Annual Reporting
ToC	Theory of Change
ToT	Training of trainers

1. Summary and overview

Project title: International Health Regulations Strengthening (IHR-S) Project

Project value (full life): £52,000,000 (2016 - 2025)

Review period: 1 April 2022 - 31 March 2023

Project's start date: 1 April 2016

Project's end date: 31 March 2025

Summary of Project Performance

Year	2020 / 21	2021 / 22	2022 / 23
Project Score	A	B	A+
Risk rating	Amber – Green	Amber - Green	Amber - Green

1.1 Outline of project

The International Health Regulations (IHR) Strengthening Project (IHR-SP) launched in 2016 with UK Aid funding from the Department of Health and Social Care to provide expert

technical assistance to selected countries and regions to improve their compliance with the International Health Regulations (2005).

The project is delivered by UK Health Security Agency (UKHSA) an executive agency of the UK Department of Health and Social Care. UKHSA provides evidence-based scientific expertise and support to government, local government, the NHS, Parliament, industry and the public.

The project works in partnership with National Public Health Institutes, ministries of health and regional organisations, to support public health system strengthening and IHR implementation. Taking a One Health and an all-hazards approach, the IHR-SP 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.

To achieve its aims, the IHR-SP focuses on 3 key priority areas:

1. to build technical capabilities of public health institutions and public health bodies

2. to strengthen leadership and management capabilities as well as support workforce development of partner countries and organisations

3. to further develop sustainable resilient public health systems and networks

The IHR-SP works bilaterally with 4 priority partner countries and with 3 regions. These include Nigeria, Pakistan, Ethiopia, Zambia, Africa (primarily through Africa CDC), the Eastern Mediterranean and Indo Pacific regions.

1.2 Summary of progress

The IHR-SP has continued to make excellent progress against a number of outputs, and has taken significant steps to improve monitoring, evaluation and learning processes and set direction for this phase through a strategic narrative document.

1.3 Progress against recommendations

Recommendation from last year	Progress	Current status
Communicate stories of impact to develop strategic understanding of the project's value: share 3 stories of impact within UKHSA and other government stakeholders including DHSC and partner countries and regions by the end of 22/23	63 news articles were published via the Global Health Network Knowledge Hub, with over 900 unique page views on average per month, globally. The Project raised its profile on Twitter, working closely with UKHSA internal comms and with partners such as National Public Health Institutes (NPHI) and FCDO post accounts. Visibility was also raised through 'lunch and learn' events, presentations and attendance at conferences	Achieved
Consolidate Monitoring, Evaluation and Learning (MREL) processes: improved logframe signed off by DHSC by Q2 22/23. Share quarterly logframe progress reports with Project Board members from Q2 onwards.	Significant progress was made on consolidating MREL processes, with an MREL lead and team appointed during 2022-23. The logframe was revised and signed off in September 2022. Quarterly logframe progress reports and a monitoring system were introduced in November and shared with Project Board members.	Achieved
Strategic expansion at regional, national, and sub-national levels: scope at least one partner organisation in the Indo-Pacific Region by end of 22/23.	Strategic expansion of the project was achieved at regional, national and sub-national levels. Regional: strong working relationships were established with ASEAN. A regional lead was recruited and a technical team will soon be in place in Thailand. Good links were made with the FCDO regional health team for SE Asia. Technical delivery began, through the ASEAN Emergency Operation Centres	Achieved

Recommendation from last year	Progress	Current status
	network. National: Activities in Nigeria were expanded to include radiation, chemicals and environment, following a scoping mission in 2022/23. Sub-national: Pakistan and Nigeria delivered technical activities to strengthen the connections between sub-national and national levels.	
Knowledge sharing between partner countries: develop a plan for knowledge exchange trips between partner institutions by Q2 22/23, with at least 3 trips taking place in 22/23, leading to changes in practices in partner countries.	Several cross-project initiatives were completed, including 3 knowledge exchange trips between Pakistan and Zambia, Nigeria and Pakistan, and between Nigeria and UKHSA UK colleagues. A project management knowledge exchange week was held in Zambia with representatives from all countries. Subsequent changes of practice included a change of approach in Nigeria, with a shift to operating at a subnational level, and the adoption of new project management tools and contract management approaches in Ethiopia and Nigeria.	Achieved
High level project management: ensure the project is fully compliant with the Foreign, Commonwealth and Development Office's (FCDO's) Programme Operating Framework (PrOF) by end of 22/23, including completing a climate risk	The Project Management team completed all requests to date for enhanced compliance with the FCDO PrOF, including completing an asset register and implementing a revised risk management process. DHSC completed a climate risk assessment for the IHR-SP which rated the project as low risk.	Achieved

Recommendation from last year	Progress	Current status
assessment.		
Financial management: ensure there is a robust budget tracking process in place at the end of the year, including local delegated spending. Reduce underspends to ensure spend is at least 90% of budget at the end of the financial year.	The project spent 85% of the total budget in 22/23. While spend did not reach 90% of budget, strategies have been put in place to reduce future underspends, including altering country budget allocations for 23-24.	Not achieved
Consolidating external networks to maximise impact and deliver shared objectives: demonstrate input into FCDO country plans, to FCDO's Advancing Health Security in Africa Programme and to the UK's	The IHR-SP continued to consolidate external networks, including by strengthening the relationships between country leads and Heads of Mission. Country leads fed into FCDO-led country level strategic plans: The IHR-SP team contributed to shaping FCDO's regional health programmes in both Africa and the Indo Pacific to ensure alignment and best use of x-HMG resource.	Achieved

Recommendation from last year	Progress	Current status
contributions to the Global Health Security Agenda by end 22/23.		

1.4 Major project-wide lessons and recommendations

Strategic expansion: Strengthen partnerships with Thailand, Indonesia and the Association of Southeast Asian Nations (ASEAN) with a strategic workplan shared by end of Q3. By end Q4, make a decision about partnership with an additional country in Africa or elsewhere.

Financial management (continued from previous year): Reduce underspends to ensure spend is at least 90% of budget at the end of the financial year through overprogramming and realistic financial forecasting. Undertake a light touch VFM assessment in Q1 of FY23/24 with an action plan shared with DHSC to follow up on any recommendations.

Climate: Ensure the project's relevance with climate adaptation is captured in reporting.

Governance: Review programme governance and assurance mechanisms to streamline internal decision-making processes, including considering where delegation may be possible. Present a summary to project Board by end Q3 and implement changes by end Q4.

Measuring impact: Commission an impact-focused external evaluation by end Q2. Additional mechanisms for measuring project impact will be undertaken. Revise logframe targets.

Sustainability and equity: Complete a sustainability and equity plan, to be signed off by end Q2. The plan should consider partner perspectives, including alignment with the New Public Health Order for Africa and similar regional plans, e.g. from the WHO Regional Office for the Eastern Mediterranean (EMRO) and ASEAN.

Gender: Include expectations about improving gender equity and representation in future MoUs or updated agreements with country partners.

Knowledge sharing: Continue to share examples of best practice, including using the website as a community of practice to ensure lessons learned and best practice examples are shared widely, with 2 short case studies shared with DHSC by end Q4

Business continuity: As the project has grown significantly in size, review high-level staffing plan and project structure and continue development of team members, recognising the growth of the team and importance of maintaining and further developing senior technical relationships.

2. Theory of Change

2.1 Summary of changes

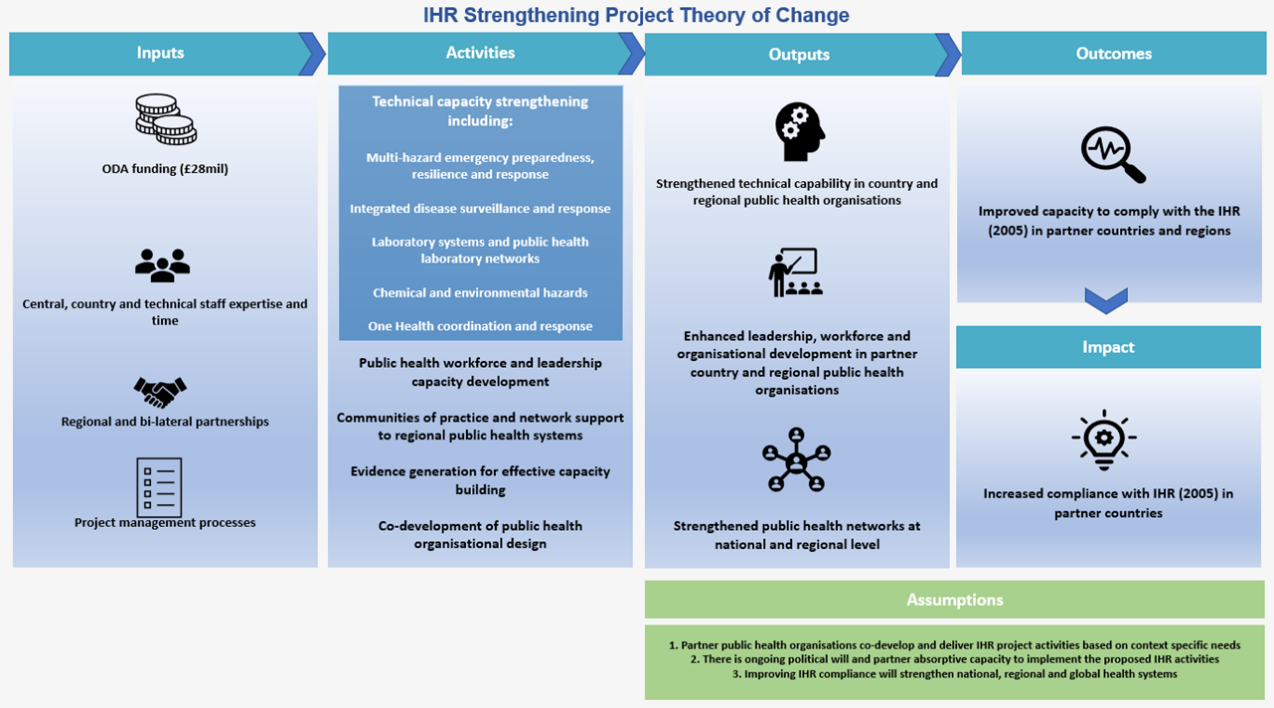

Figure 1 - The IHR-SP Theory of Change (ToC) demonstrates how planned activities will contribute to achieving outputs and outcomes. The 3 intended outputs are strengthened technical capability in country and regional public health organisations; enhanced leadership, workforce and organisational development in partner countries and regional public health organisations; and strengthened public health networks at national and regional levels. The intended outcome of these is improved capacity to comply with IHR (2005), with the impact of increased compliance in partner countries and regions.

Following wide consultation, the project's Theory of Change (ToC) was revised for the 2022/23 project cycle and signed off by end of the first quarter. Outputs from the previous ToC were redefined as activities and the project's outputs and outcomes were subsequently redeveloped to reflect and measure the project's impact. Assumptions were

tested to see if they held true and those within the project's control were removed. Overall, the ToC was greatly simplified, and changes aimed to more clearly articulate how the project's inputs link to the intended outcome and impact.

In Q4 of this review period, the inputs in the ToC were further adjusted to better reflect financial, human and other resources mobilised to support activities.

2.2 Project's progress

At the end of the first year of this project cycle, good progress had been made. The project met or surpassed all output level indicator targets for the review period (Y1) and is therefore on track to meet the expected outcome and impact by the end of the project cycle, and within the allocated budget. Ahead of 2023-24, priority-focused roadmaps for each work stream were agreed, to ensure continued progress towards the overarching project outcomes and impact aims.

The project team continued to see clear indications of training and capacity building activities conducted through the project taking root and bringing about organisational and system change that will increase partner's capacity to comply with IHR. For example, there was:

- improved multi sector One Health coordination reported following a train the trainer workshop on One Health joint risk assessments in Nigeria

- implementation of core surveillance and outbreak management systems and processes following Integrated Disease Surveillance and Response (IDSR) training which was then used during the Pakistan floods in 2022

- increased operational readiness in responding to public health emergencies following incident management training in Ethiopia.

The project continues to be highly valued by partners, with one representative in Nigeria stating: "I would say UKHSA is one partner right now that if we have One Health activities... Or we have other activities that are just not One Health, or maybe have things to with IHR, they are one of the partners that we would always, always reach out to, plus, we've seen the contribution. And then it's quite evident, even for the country, to see the contribution of UKHSA."

The commitment made in the project's business case to improve gender equality outcomes through disaggregating data and monitoring gender representation in project activities is progressing well, and the project team takes opportunities to advocate for gender equality. Further steps will be taken in 2023-24 to focus on equity and inclusion. However, the project faces limitations in its ability to influence the gender balance of its

activities, as imbalances are often linked to wider context-specific and cultural inequalities beyond its control. Detailed evidence of how the project is achieving its desired outcomes and impact will be delivered through an external evaluation – details of this are in section 8.1 of this review.

2.3 Changes to the logframe

Over Q1-Q2, the project logframe was reviewed and a new significantly improved version was completed and signed off in September 2022. This was to align the logframe with DHSC guidelines and to ensure that indicators (and associated targets) were SMART (specific, measurable, achievable, realistic, timely). Indicators now consist of a mixture of qualitative and quantitative approaches and 'means of verification' have been updated to reflect this. Targets from this review period were created using estimates from previous years' delivery and using country team insight and planning processes. These high-level targets were limited by incomplete verifiable knowledge of the total public health workforce in each country and region (a task that is beyond the scope of this project). However, for each learning activity a bespoke learning needs assessment was introduced in FY22-23 to ensure the needs of partners and participants are targeted and incorporated.

3. Detailed output scoring

Many of the following tables contain overall progress indicators. Please see Annex 1 for disaggregated data.

3.1 Output 1

Strengthened technical capability in country and regional public health organisations

Output number: 1

Output score: A+

Impact weighting (%): 33%

Weighting revised since last AR? Unchanged

Risk rating: Green – minimal disruption

Indicator(s)	Milestone for the review	Progress
Number of partner country stakeholders trained in IHR core capacity areas	1100 (baseline of 1000)	Surpassed (+234%) Actual: 3675
1.2 Number of core products co-developed in IHR core capacity areas	>30 (baseline of 25)	Surpassed (+110%) Actual: 63
1.3 Proportion (%) of trained stakeholders demonstrating new/improved technical skills or applying new/improved knowledge in IHR core capacity areas	60% (baseline of 0)	Surpassed (+50%) Actual: 90%
1.4 Changes in technical practices resulting from project's capability strengthening	40% of sample demonstrating organisational (level 3 - see annex 2 for definitions) change (baseline of 0)	Surpassed (+150%) 100% (4 deep dive samples - see case study 1 for an example)
1.5. Number of IHR publication or events sharing evidence on improving IHR core capacities that are shared through a variety of fora including peer review journals, conferences, webinars, etc.	>5 (baseline of 5)	Surpassed Actual: 52

3.1.1 Supporting narrative

Output 1 relates to 'strengthened technical capability in country and regional public health organisations' and is measured through 5 indicators. All 5 indicator results for this review period surpassed the initial targets set. Minimal challenges were faced in the delivery or monitoring of activities under this output. This review period, the project surpassed its target of number of stakeholders trained in IHR core capacity areas by 234%. Existing

targets being surpassed may be related to an underestimation of the initial targets, greater data flow and quality due to the new MREL system, the impact of having additional staff in-country conducting activities, and (in relation to indicator 1.1) the high training requirements associated with the IDSR roll-out in Pakistan.

Activities delivered and monitored under this output were conducted in line with quality assured public health standards and, where possible, aligned with external quality assurance metrics too. For example, work conducted with the Copperbelt Microbiology Network (CBMT) in Zambia to improve quality control within laboratories contributes to official laboratory accreditation and efforts to meet International Organization for Standardization (ISO) standards (both of which are externally evaluated). Similarly, in Nigeria, NCDC labs has received WHO-recognised four-star lab quality rating, following IHR-SP support. Ethiopia's laboratories are now also working towards WHO-approved accreditation. These external standards validate and quality assure the achievement of IHR-SP outputs.

Examples of training impact include:

- Training on 'enhancing surveillance and laboratory diagnosis of Diphtheria' was conducted by the IHR-SP in Nigeria. A few months following the training an outbreak of Diphtheria was announced by the Nigeria Centre for Disease Control (NCDC). Experts within NCDC reported that the training sessions provided by the IHR-SP enhanced their ability to respond to the outbreak. This illustrates how training provided by the Project is put into practice to increase capacity and bring about real-world change.

Case Study 1: 'Integrated Disease Surveillance and Response (IDSR)' Emergency Application and Associated Training

To strengthen disease surveillance and response in Pakistan, the IHR-SP supported the roll-out of training on IDSR software, including 'DHIS-2'.

The IDSR system is built inside software called DHIS-2. Routine surveillance data for 33 priority diseases are collected weekly in all 54 districts in the country using the IDSR system and supervised by the National Institutes of Health, Pakistan (NIH).

In July 2022, the National Disaster Management Authority (NDMA) in Pakistan declared an emergency following heavy flooding and resulting loss of life. Considering the high risk of water, food and vector borne disease in flood relief camps, timely and reliable disease data was vital to guide response activities. NDMA, the National Ministry of Health Service Regulations & Coordination (MoNHSR&C) and the National Institute of Health (NIH) requested the IHR-SP to assist in establishing disease data flow from affected areas.

The IDSR provincial and district focal persons of affected districts and IHR-SP in-country surveillance and epidemiology team were included in a technical working group to propose and agree next steps. The technical working group decided to establish real-time data flow of 5 priority flooding-related diseases on to digital platform DHIS-2. DHIS-2 was adapted to collect and communicate data daily, rather than the normal weekly basis. New dashboards in DHIS-2 were developed by the IHR-SP in-country IT team to produce flood disease analysis. New training sessions on this updated DHIS-2 system were planned on an emergency basis. Training on the new system was rolled out on a large scale on an emergency basis and included development of tools, training plans, curriculum, trainers and logistics. The analysed data was presented to stakeholders at NDMA, MoNHSR&C and NIH to guide informed decision making. The national and provincial departments of health appreciated the role of the UKHSA IHR project to implement emergency surveillance and response system, ultimately saving lives.

The MREL team conducted a qualitative assessment of one of these training sessions. Through this, 82% of respondents identified that organisational change had occurred following the training (and 100% had applied the knowledge they gained in their daily work).

Case Study 2: Laboratory training aids MPox identification in Ethiopia

To increase MPox laboratory detection capacity, the IHR laboratory team and Ethiopian Public Health Institute (EPHI) provided MPox training to 32 laboratory professionals from 12 regional laboratories across Ethiopia. As a result, the EPHI delivered the first MPox test in Ethiopia and has now delivered over 1200 tests.

The training included sample collection, sample types, collection procedures, how to pack and transport the sample and safety precautions during sample collection and transportation processes. MPox molecular detection (Rt-PCR) training was also provided to 10 laboratory personnel from EPHI and 4 regional laboratories for 3 days from August 24 to 25, 2022. This training covered both theoretical and practical sessions. It included how to use pipettes, how to process and extract samples, reagent preparation and result interpretation, all whilst complying with biosafety. Both trainings were well received by the participants, and training will continue to be rolled out for other regions.

A robust and reliable public health laboratory service is essential for disease control to enable the timely detection and confirmation of various pathogens, e.g. MPox or Viral haemorrhagic fevers, that in turn allows for timely response. This aligns with WHO Africa’s 7-1-7 target for rapid improvement of early disease detection. This strengthening work supported the improvement of laboratory service performance.

Relating to indicator 1.4 'changes in technical practices resulting from project's capability strengthening', the project used 'deep dive' qualitative reviews to assess the level of

change achieved through the project's activities. On average, 86% of participants interviewed reported that organisational level of capacity had increased as a result of project activities. The associated deep dive reports can be located as appendices to this document.

Linked to indicator 1.5, IHR-SP was able to contribute to the wider global health security discourse and research base through the publication of several articles. A recent example included a paper published in the PLOS Global Public Health journal entitled 'The role of international support programmes in global health security capacity building; A scoping review'. Publications and events also shared evidence on improving IHR core capacities, such as creating and presenting posters on activities conducted through the IHR-SP at public health conferences.

3.1.2 Changes to the output

In addition to those outlined in section 2.3, proposed changes to indicators under this output (output 1) will be made to the technical definitions of the indicators so that it is clearer which activities are in scope to be measured, as well as the introduction of one new indicator:

- Indicator 1.6 (NEW): This indicator will now measure the number of 'events sharing evidence on improving IHR core capacities' (separated out from Number of publications in indicator 1.5). New technical definition and targets will be developed for this indicator.

3.1.3 Recommendations

4. While training targets were exceeded, training of trainer (ToT) activities only accounted for 5% of output 1 activities. Given the sustainability benefits of ToT activities, **the project team will encourage teams to increase the proportion of this type of training in 2023/24.**

5. Quarter 4 of 2022/23 was particularly active for delivery of output 1, with significant spend incurred in the final months of the financial year. This was partially due to activities having been unavoidably delayed earlier in the year, due to factors such as political instability, which affected both Pakistan and Nigeria. **IHR-SP will take action in 2023-24 ahead to spread activities more evenly, to avoid pressure and regulate spending.**

6. Currently, the MREL team captures key data about IHR-SP supported events/publications through the project's indicator/results tracker. **The MREL team will expand the data captured on events/publications by introducing a 'contribution story' tool.** The tool will ask country-based teams to detail the ways in which the IHR-SP contributed to an event or publication and the subsequent result

(e.g., IHR-SP co-wrote a paper and it was published). This will be used to capture greater understanding of the contribution being made by IHR-SP to publications/event. It will also enhance the project's understanding of the benefit of the product/event to the resulting user.

3.2 Output 2

Enhanced leadership, workforce and organisational development in partner country and regional public health organisations

Output number: 2

Output score: A+

Impact weighting (%): 33%

Weighting revised since last AR? Unchanged

Risk rating: Amber-green **-** some minor disruption/delays

Indicator(s)	Milestone for the review	Progress
2.1. Number of partner country stakeholders trained/mentored in public health leadership skills and theory	150 (baseline of 100)	Surpassed (+44%) Actual: 216
2.2. Number of core products co-developed in workforce development	>10 (baseline of 10)	Surpassed (+190%) Actual: 29
2.3. Proportion (%) of trained staff demonstrating new/improved leadership skills or applying new/improved governance processes	60% (baseline of 0)	Surpassed (+60%) Actual: 96%

Indicator(s)	Milestone for the review	Progress
2.4. Changes in workforce and leadership practices resulting from project's activities	1 example of organisational (level 3) change - see annex 2 for definitions) (1 cohort due to operational constraints) (baseline of 0)	Achieved (100%) (Please see supporting narrative regarding mentoring training in Ethiopia laboratories)

3.2.1 Supporting narrative

Due to staff changes both within the workforce development team and among NPHI leadership teams there were some delays to the delivery of this output, including to leadership training. As a result, the risk rating is amber-green. Despite this, the project surpassed its target of number of stakeholders trained in IHR core capacity areas by 21%.

Examples of impact under this output include:

- In support of the 2023 Zambia Field Epidemiology Training Programme (FETP), the IHR-SP provided leadership and management training under the core competency of Emergency Preparedness. The module was well received by participants and 100% reported that they will be able to use their learning in their jobs.

- Members of the Ethiopian Public Health Institute who mentor laboratory staff were provided with training to develop their mentorship skills. Training was tailored to the topic of mentorship and provided training on ‘how to listen effectively’, ‘how to provide feedback’ and ‘building relationships’, amongst other topics. A qualitative review of this training found that 100% of those sampled had applied their new skills and knowledge, with 55% identifying that organisational level change had occurred following the training.

3.2.2 Changes to the output

In addition to those outlined in section 2.3, proposed changes to indicators under this output are the introduction of:

- Indicator 2.5 (NEW) This indicator will measure the number of ‘number of publications sharing evidence on changes in workforce and leadership practices in public health’. New technical definition and targets will be developed for this indicator.

- Indicator 2.6 (NEW) This indicator will measure the number of ‘events sharing evidence on changes in workforce and leadership practices in public health’’. New technical definition and targets will be developed for this indicator.

3.2.3 Recommendations

Recommendation 3 from section 3.1.3 is also relevant to this output. In addition:

7. **A greater variety of training will be delivered in relation to the topic of leadership.** This would include expanding training to reflect different types of leadership support such as mentoring, peer to peer support and coaching. This change would require an expanded technical definition within the relevant indicator (2.1).

8. High levels of delivery through training events in this review period resulted in a greater focus on delivery of output 1 than outputs 2 and 3**. IHR-SP will spread training delivery equally across all quarters** so that:

- there is reduced delivery burden in Q4 ahead of the year-end
- greater capacity exists throughout the year for focus on output 2 and 3 activities

9. In consultation with workforce development specialists, **the approach to leadership training will be reviewed** based on learning and feedback from NPHI partners.

3.3 Output 3

Strengthened public health networks at national and regional level

Output number: 3

Output score: A+

Impact weighting (%): 33%

Weighting revised since last AR? Unchanged

Risk rating: Green – minimal disruption

Indicator(s)	Milestone for the review	Progress
3.1. Number of public health networks supported across country, regional and global levels	>3 new networks supported	Surpassed Actual: 28 new, 53 supported networks overall
Proportion of network stakeholders who report value in network activities and/or achieving changes in public health practices	60% (baseline of 0)	Surpassed Actual: 95% (based on 57% survey response rate)
Changes in practices resulting from public health networks	One example of network activities leading to changes in public health practices in stakeholder organisations (level 3 - see annex 2 for definitions) change (1 cohort due to operational constraints) (baseline of 0)	Achieved (See case study 3 for an example)

3.3.1 Supporting narrative

In this review period, 28 new networks were supported by the project, with 53 networks supported overall (including continued support to existing networks). Networks supported by the project range across 8 IHR core capacity areas. By providing support to already established networks, the IHR-SP aims to increase network sustainability and longevity.

Key activity contributing to the strengthening of public health networks at national and regional level during the review period included:

Support to the Africa CDC FETP technical working group: The African Union Agenda 2063 and the Africa Health Strategy 2016-2039 clearly identify strong human resources for health as an essential requirement for Africa to achieve universal healthcare and health security. Referencing this, Africa CDC aims to develop a continental ‘African Epidemic Services’ workforce, consisting of 3 tracks, including epidemiology. To facilitate development of the epidemiology track (modelled on the Field Epidemiology Training Programme) by September 2023, the IHR-SP provided technical and administrative

support to Africa CDC to develop a Technical Working Group to routinely bring together key stakeholders.

Case Study 3: Copperbelt Microbiology Network (CBMT), Zambia

In November 2021, Arthur Davidson Children's Hospital (ADCH), requested support from IHR-SP to provide mentorship in microbiology to their laboratory following a Southern African Development Community Accreditation Services laboratory accreditation inspection non-conformance. Mentorship was provided by UKHSA during December 2021 and January 2022 and was well received by the laboratory management and staff. Using the skills and advice provided by UKHSA mentors, staff from the ADCH went on to form the Copperbelt Microbiology Network (CBMT) in June 2022. The CBMT provides 5 laboratories in the Copperbelt region of Zambia with training, mentorship and technical assistance. The overall aim of the network is to improve the quality management of microbiology practices, referral practices and equipment of labs in the CBMT to support labs in achieving accreditation. The CBMT continues to receive input and support from UKHSA – both through in-country technical staff and training logistics support. Increased quality in microbiology practices aims to improve clinical and public health outcomes. 100% of CBMT members (including lab managers) described seeing organisational change as a result of the activities of the network, including improved coordination between labs and increased laboratory performance.

3.3.2 Changes to the output

In addition to those outlined in section 2.3, the new proposed indicators under this output are:

- Indicator 3.4 (NEW) This indicator will measure the number of 'number of publications sharing evidence on value of networks and/or resulting changes in public health practices'. New technical definition and targets will be developed for this indicator.

- Indicator 3.5 (NEW) This indicator will measure the 'number of events sharing the value of networks and/or resulting changes in public health practices'. New technical definition and targets will be developed for this indicator.

3.3.3 Recommendations related to output 3

- When reviewing activity conducted in 2022-23, several country teams noted that their activities were not always well balanced across the 3 logframe outputs, with a lesser focus on networks and leadership. **The project team will encourage a more even spread of activities across outputs to increase delivery to these areas**.

- The IHR-SP's work on supporting networks is not yet well-understood across HMG. **The project team will take steps to raise the profile of the networks it supports and find opportunities to contribute soft intelligence gathered through networks to further x-HMG global health security objectives, where relevant.**

4. Project performance not captured by outputs

During the review period progress was made in several areas that could not be captured by logframe outputs. These included:

4.1 Mentoring and leadership

- In December 2022, representatives of the IHR-SP team attended the 2nd International Conference on Public Health in Africa (CPHIA) in Kigali, hosted by the African Union and Africa Centres for Disease Control and Prevention (Africa CDC) in partnership with the Government of Rwanda. The IHR-SP team, in collaboration with Africa CDC, organised an official side event at the conference on 'Strengthening and Developing Mentorship for Public Health Workforce in Africa'. The sessions aimed to initiate, establish and encourage dialogue on mentoring for the public health workforce in Africa, and create a functional network of public health mentors for Africa.

- Female leadership across the project was promoted in 2022/23 through the selection of emerging female leaders for the Kofi Annan Leadership Fellowship. Over half the fellows supported by the IHR-SP on the fellowship programme were women.

4.2 Diplomacy and contributing to wider HMG global health outputs

Country leads in Ethiopia, Zambia and Nigeria provided expert input into wider HMG global health security programming through enhanced engagement with local FCDO health programmes and with the Fleming Fund. For example, in Ethiopia the country lead supported the FCDO country planning process, including priority setting. In Zambia the country lead provided technical assistance to FCDO following the closure of the health programme. The IHR-SP Project Lead was a member of the Fleming Fund Project Board. This raised IHR-SP visibility, facilitated knowledge exchange and contributed to the achievement of cross-government global health objectives.

The senior leadership team provided technical expertise, advice and guidance to support partners, enhance the UK's reputation and influence as a key player in global health security and raised awareness of the IHR-SP project among other HMG departments and international stakeholders. Examples included scoping for the project's expansion to the

Indo-Pacific region, contributing to the ASEAN regional health plan and engaging with plans for FCDO's Advancing Health Security in Africa Programme.

The IHR-SP leadership team worked closely with other UK global health security programme teams in order to share expertise, coordinate resources and maximise impact. For example, planning began with UK-PHRST for coordinated leadership development and capacity building activities with Africa CDC in 2023-24.

4.3 Project expansion

Diplomatic and technical engagement with ASEAN progressed to identify potential workstreams the IHR-SP could support in 2023/24. It was agreed that the IHR-SP's involvement will focus on providing technical expertise on global health security and will work predominantly at a regional level. Activities are likely to include:

1. Conducting a feasibility study for the creation of an ASEAN Health Security Unit (likely to be led by the IHR-SP)

2. As part of Indonesia's ASEAN presidency, supporting Indonesia's One Health priorities, including providing expert input to an ASEAN One Health Declaration.

3. Supporting the ASEAN EOC Network with a focus on CBRN hazards and PHEM training.

4.4 FCDO Programme Operating Framework

In 2022/23, the IHR-S project team worked with DHSC to ensure the project meets compliance standards with the FCDO Programme Operating Framework which details how ODA projects should operate. DHSC has assessed that the IHR-SP is now in compliance with the guidance.

4.5 Climate Risk Assessment

DHSC has conducted a climate and environment risk assessment (CERA) for the IHR-SP to demonstrate compliance with UK government directive to ensure to align all Official Development Assistance (ODA) to the goals of the United Nations Framework Convention on Climate Change (UNFCCC) Paris Agreement. The level of risk posed by the project's activities is assessed as low. The project will continue to monitor associated climate risks in accordance with the Green Finance Strategy.

To supplement the CERA, the IHR-SP would like to highlight the significance of the project's contribution to climate adaptation.

The links between the effects of climate change and infectious disease outbreaks are widely accepted. This is evidenced by a growing body of research which highlights the strong correlation between climate change and the incidence of human pathogenic disease. Climate change and natural disasters have increased the likelihood of water-borne, food-borne (very high confidence) and vector-borne (high confidence) pathogen transmission, with predictions indicating a continued rise in the near-term.

The project makes a significant contribution to climate change adaptation efforts due to its primary focus on supporting countries to prepare, prevent, detect and respond to disease outbreaks and health threats and the proven links between climate change and an increased likelihood of these occurring. For example, in 2022 the IHR-SP provided support to Pakistan's Ministry of Health (MoH) with the devastating floods which have been linked to climate change due to extreme weather conditions. The IHR-SP supported the response by developing a standardised flooding specific tool to facilitate reporting of diseases which are directly associated with the floods (e.g., Cholera). Additionally, the IHR-SP trained 112 staff across 48 districts to use this tool accurately and this became the MoH's preferred tool for reporting on their daily national flooding dashboard.

The IHR-SP has taken environmental protection into consideration for the ongoing phase of activity and produced a sustainability plan which describes the project's commitment to monitor the environmental impacts of its work, mitigate against the risk of negative impacts and advocate internally and externally for sustainability. As part of the IHR-SP's CRA, DHSC has assessed that the project activities do not negatively impact the categories defined in the FCDO Programme Operating Framework. An assessment of the impact of the project on these categories is included below:

- **Greenhouse Gases:** Project implementation could contribute to carbon emissions as a result of flights to and from partner countries where work is taking place. Carbon offsetting practices are in place and monitored to mitigate and ensure minimal impact on the environment.

- **Biodiversity and land degradation:** No associated risk. There are interlinkages between infectious diseases, wildlife and land degradation due to proximity-based transmission. Through reducing the impact of infectious diseases, the IHR-SP adapts to the impacts of land degradation and biodiversity related climate change.

- **Biohazard waste:** No associated risk. Biohazard waste is disposed of in line with environmental policy.

- **Water quality:** No associated risk. Infectious diseases can be transmitted through poor quality water which the IHR-SP can help address by improving country compliance with IHR (2005).

5. Risk

5.1 Overall risk rating

Amber - green

Risk management processes during this financial year have been greatly improved. The IHR-SP continued to maintain a risk register which was routinely reviewed internally and with DHSC on a quarterly basis. The IHR-SP is committed to sharing any potential risks with DHSC at the earliest opportunity. We hold regular quarterly meetings to discuss the risk register, and to share plans to mitigate against potential issues. The introduction of quarterly risk meetings has significantly improved the project risk register. Significant risks to the programme were escalated to the Senior Leadership Team, the Global Operations directorate, and to DHSC Global Health Security Programme Board, when needed.

5.2 Overview of project risk

While the achievement of outputs across the project was good in 2022-23, the project had an amber-green risk rating due to issues emerging in Q3 and Q4 that threatened the project's ability to deliver activities. These included the continued impact of the transition to UKHSA, such as changes to commercial policies and recruitment delays (with implications for spending); and changes in NPHI and regional organisation leadership, which risked affecting partnerships and delivery. Several key risks for the reporting period along with the mitigation taken are outlined below.

Risk description 1: The IHR-SP is unable to fully utilise funds due to corporate delays (e.g., with commercial contracts, procurement and recruitment) leading to an underspend and inability to deliver all planned activities.

Mitigation strategy: The impact on operational processes such as recruitment, commercial, finance and procurement were closely monitored. The IHR-SP Senior Leadership Team monitored and engaged with relevant UKHSA and DHSC departments to flag concerns and ensure any delays were minimised. Vacancies were filled where possible and business cases to justify external recruitment (required due to existing HR policies) were used where internal recruitment failed. The project raised issues related to financial forecasts and provided timely actuals data to DHSC early and used both internal and external influence to mitigate against impact on delivery, repurposing funds where necessary.

Residual risk rating: Amber

Risk description 2: Impact of civil unrest, corruption, natural disaster or change in government in partner countries

Mitigation strategy: The IHR-SP continued to adopt FCDO guidance and protocols regarding any political development, security hazards and/or natural disasters in partner countries to ensure staff safety. To minimise the impact of these on project delivery, the IHR-SP fostered strong relationships with government departments both in the UK and abroad, rather than with individuals alone, to ensure networks did not fail. Regular situational and political economy analysis was conducted to predict issues.

Residual risk rating: Amber - green

Risk description 3: Lack of country/regional partner engagement, especially due to changes in leadership, could impact on ability to carry out planned activities

Mitigation strategy: The project maintained close and ongoing dialogue with country partners to ensure activities were demand-driven and tailored to country needs to encourage engagement. The project kept in touch with other partners and donors to avoid duplication of activities and adapted plans where necessary to meet partner needs. The IHR-SP will engage early with new NPHI or regional leaders, to introduce the project and maintain good links.

Residual risk rating: Amber - green

6. Project management

The IHR-SP has made significant progress against its objectives over the past 12 months.

6.1 Delivery against planned timeframe

The IHR Strengthening Project has made significant progress in the past 12 months, which is broadly in line with the timescales in the business case. Delivery of project activities was concentrated in Q4 and teams are being encouraged to spread delivery more evenly across the year in 23/24.

6.2 Performance of partnerships

DHSC Global Health Security team and the IHR-S project team continued to build on a well-established, supportive partnership in 2022/23. Both formal and informal communication was used on a regular basis to share updates and monitor progress as

required. DHSC appreciates the open and collaborative way UKHSA project leads have approached the relationship, particularly in testing ideas and plans with us at an early stage.

The MREL lead contributed significantly to finalisation of the year 7 Logframe in 2022/23 which was well welcomed by the project team and DHSC alike. Greater clarity of the output and outcome indicators have led to clearer, more informative progress updates.

In addition, the DHSC Global Health Security team visited the in-country IHR-SP team in Pakistan in 2022 to meet UKHSA and FCDO colleagues to discuss ongoing work and progress. They also met Pakistani health leaders in Islamabad and Lahore to discuss the project and reinforce the benefits of the bilateral technical relationship. The visit was welcomed by Pakistani partners and the IHR-S team and DHSC was impressed with the strength of the relationships and quality of the outputs and outcomes of the project teams activities.

Recruitment delays continued to impact delivery deadlines and contributed to underspends. The IHR-S project team updates DHSC with progress on filling vacancies and on the impact of failure to recruit on project delivery.

The IHR-SP team experienced some delays working with the commercial team to manage third party suppliers which was identified as a risk in 2023/23 which has been escalated to an active issue for 2023/24. Lessons have been learnt from this and additional scrutiny has been implemented as a result. Aside from this, third party partner relations have been generally good.

6.3 Asset monitoring and control

The IHR-SP team follows UKHSA wide Non-current Asset Policy which provides guidance on the correct accounting treatment for project assets to ensure compliance with recognised financial standards.

The IHR-SP team has shared the Oracle project ledger (asset inventory) with DHSC. The ledger details documentation of purchased and donated assets, at any given point in time. The asset ledger enables the project team to track the status, procurement date, location, price, and current value of each project asset tracked for effective logistical oversight.

The financial accounting team is 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 asset register remains accurate, and an independent audit trail exists to support this.

DHSC GHS team has assessed that the current IHR-SP asset management and disposal practices are consistent with DHSC expectations and wider FCDO operating framework requirements.

7. Financial performance

7.1 Value for Money

The IHR-SP conducted a qualitative self-assessment of value for money (VfM) at the end of Quarter 4. A sample of project team members based in the UK, overseas and those from subject matter expert groups took part in a structured discussion facilitated by the MREL team. The discussion focused on the project's systems, processes and tools for achieving its objectives, through the lens of VfM. The key points that emerged are outlined below with additional commentary by the central project and MREL team, organised by the '4E's approach:

Economy

- The IHR-SP applied both UKHSA and project-specific policies and controls to financial processes to ensure cost-effective spending. The UKHSA tendering policy required 3 quotes to be provided for all spending over a specific threshold and assured an unbiased approach to procurement of high-value suppliers. This process ensured the IHR-SP received the best services at the best price.

- The IHR-SP conducted open tenders, which do not require the use of a particular framework, to allow the team to receive bids from local country-based suppliers, with an understanding of the context, who would otherwise not be able to access international frameworks. This enabled the project to be more nimble, effective and invest in the local economy.

- In FY22-23 the internal financial approval system (where spending is reviewed and approved) was improved to enhance empowerment and flexibility at country-level. As a result, there was greater internal clarity on the processes for travel approval. There were also improvements in the way in which country-based teams coordinated with the UK project team. This reduced duplication of effort and allowed for quicker travel booking decisions. This often saved the project money on travel bookings, avoided unnecessary cancellation/change charges and saved staff time (resulting in saved costs).

- Country-based teams continued to expand during FY22-23. The increased presence of in-country subject matter expertise meant that the project relied less on importing UK-based experts to conduct activities in partner countries. This reduced related travel

costs and the resulting carbon footprint. This continued to improve the project's economy.

- Use of an external travel/logistics provider had several advantages for the project in terms of reduced administrative time spent on these activities. However, logistics providers were unable to take advantage of subsidised rates for FCDO/UK Government with hotels and travel providers. The Global Operations directorate at UKHSA will address this by seeking opportunities for individual agreements with hotels used regularly by the project.

Recommendations to improve the project's VfM under 'Economy' included:

- **IHR-SP will continue to expand the use of 'flexi' tickets/bookings where possible with the associated vendor**. The IHR-SP will review associated policies to facilitate this.

- **IHR-SP will continue to build project management and technical capacity at the country team level in order to reduce reliance on travel.**

Efficiency

The meeting and surpassing of the project targets shows efficient conversion of inputs into outputs under this project. Planning against the logframe and the introduction of a new 'priorities' method for organising delivery will further improve efficiency in upcoming project cycles.

In the review period, the proportion of IHR-SP staff located in partner countries increased significantly. Country-based staff with subject matter expertise were able to embed within partner organisations and build effective relationships to support sustainable capacity building. This improved the efficiency of delivery of tailored training and activities in line with the project workplan. Greater in-person presence of advisors helped to build bridges between the project and partners, and between the UK and in-country teams which additionally enhanced efficiency.

The project facilitated opportunities for collaboration, knowledge exchange and communication between country teams, to allow the application of project management and technical approaches from one country to another.

The project provided accommodation and travel reimbursement for participants of training but not per diems for attendance; a key difference to other stakeholders across partner countries and regions. This policy sometimes resulted in partners being less willing to conduct activities in conjunction with UKHSA, in favour of other stakeholders and donors who do provide per diems. Related to this, and other logistical considerations, discussions will continue in 2023-24 to review the current policy.

The project team will work with commercial colleagues to introduce longer-term and higher-value contracts with local suppliers to avoid frequent time-consuming re-tendering processes which have the potential to interrupt and delay workplan delivery.

Some recommendations to improve the project's VfM under 'Efficiency' included:

- **IHR-SP will create an online library to share training tools and content across countries and subject matter expert areas**. This will reduce duplication of effort, enhance quality standardisation and save time.

- **IHR-SP will prioritise increasing the parity between Global Ops, UKHSA and FCDO policies (especially in relation to international operations/travel) to improve project efficiency.** Currently navigating different policies, rules and processes is time-consuming, impacting the eventual speed and efficiency of delivery.

Effectiveness

- With the logframe and associated indicators in place, the team established a robust mechanism to demonstrate evidenced results. This improvement facilitated demonstration of results against indicators in an accessible and transparent way. In future, it will also help to build evidence of the translation of outputs into fulfilling outcomes.

- One of the most sustainable and cost-effective components of the project was the strength of the relationships established over time between UKHSA and NPHI partners. The role of the country leads and SLT was designed to build influence through diplomacy, demonstrated through one-to-one support, advocacy, and networking, combined with technical expertise. With trusting professional relationships in place, IHR-SP staff were then able to advise on and shape technical policies and practice among partners, thus contributing to the achievement of project outcomes.

Equity

- The IHR-SP's logframe, and associated results disaggregation criteria, include a requirement for all training results to be disaggregated by gender. Equal gender representation was prioritised when organising MREL qualitative reviews to ensure findings and feedback were reflective of the entire community who benefited from the activity. This included prioritising a balance of male and female voices in focus group discussions, alongside or ahead of geographical and job role considerations. Representation of both genders equally within training and event attendance was conveyed as a project priority to partners when attendance lists were prepared, and the IHR-SP took opportunities to advocate for gender equity when possible. In-country teams began a practice of retaining a training register of those the project is aware

would benefit from technical training. This increased the project's ability to reach all those who require training regardless of the associated demographics.

- Project activities were conducted in accessible locations, and support with transportation and accommodation was provided to attendees. This was to increase the inclusivity of training opportunities and widen the geographical distribution of benefits.

Some recommendations to improve the project's VfM under 'Equity' included:

- The IHR-SP has limited influence over who country partners invite to attend training and therefore equity of training provision. **The IHR-SP will encourage equity in training attendance including through using training registers, advocacy and diplomacy.** In addition, any future MoUs or agreements between UKHSA and NPHI partners will highlight the importance of promoting gender equity in training activities.

- Training accessibility for remotely located staff was a challenge for the project. **The IHR-SP will consider using remote, internet-based delivery in addition to in-person delivery, for events and training in future**. However, the barrier of accessibility to internet in rural locations remains problematic.

- **The IHR-SP will refresh the internal sustainability and equity plan for the project in the upcoming project cycle.**

7.2 Quality of financial management

The IHR-S project spend was £7.6 million (85%) of the total £9 million budget.

Prolonged vacancies and inability to deliver planned activities due to this, were a significant contributing factor to the underspend. The IHR-SP team updates DHSC with progress on filling vacancies and on the impact of failure to recruit on project delivery.

In 2022-23, the IHR-S project team made significant progress in devolving aspects of financial management to from the UK to in-country team, including the responsibility for managing country workplan budgets, which has increased transparency and autonomy at country level. Budget tracking processes were introduced including a 'probability of spend' monitoring mechanism and a financial 'buddy' system to monitor and ensure robust forecasting and expenditure reporting from the in-country teams, in conjunction with the UK-based IHR-S project team.

The IHR-SP team provides regular forecasts and actual spend data to DHSC on a quarterly basis. The IHR-SP team also provides ad-hoc financial data, when possible,

should DHSC request it. When accurate financial data cannot be supplied on a non-routine basis, the IHR-SP team provides rationale and offers alternatives to DHSC.

Quarterly finance meetings are hosted by DHSC and are well attended by IHR-SP colleagues to discuss expenditure incurred, remaining quarterly forecasts, risks or assumptions built into forecasts, and agree contingency plans for potential underspends. The IHR-SP's RAG rated forecasts have helped DHSC manage expectations with the level of underspend and has allowed the team to promptly consider repurposing of funds. Discussions are productive, with all parties committed to resolving any issues in pragmatic ways.

Recommendation for 23/24: The IHR-SP should use overprogramming more as a tool to manage the risk of potential underspends. This would be appropriate given the likelihood of underspend occurring and the prolonged vacancies in IHR-SP. IHR-SP should also consider planning activities that have scope to be scaled up or down to enable more efficient budget management. Further devolution of financial management to in country teams should be implemented to improve budget control and the accuracy of forecasting, with the central team retaining oversight across the portfolio. Workplans should be front-loaded to avoid slippage in the final quarter of 2023/24.

Date of last narrative financial report: 25 May 2023

8. Monitoring Evaluation and Learning

8.1 Evaluation

During the review period work was undertaken to design an approach to the external evaluation for this project cycle. The evaluation will assess and analyse evidence of the achievement of the project's outcome and impact. The relevant indicators will be:

Result	Indicator
Impact	Changes in Joint External Evaluation (JEE) scores in partner countries
Outcome	Changes in State Party Self-Assessment Annual Reporting (SPAR) scores in partner countries

Evaluation will build upon the previous work undertaken by Itad, the IHR-SP's external evaluator. The proposed evaluation process for this cycle will take a phased approach. Phase 1 will focus on collecting evidence in relation to the outcome indicator, and phase 2 will focus on evidence for the impact indicator.

The phased approach will enable evidence of outcomes to be collected before the start of business planning processes for future funding cycles, whilst also allowing for an ‘end-line’ evaluation process closer to the end of the cycle when more results will be available. This approach will provide results from phase one in Q3 of year three.

Procurement of an external provider to conduct the evaluation will be arranged by the IHR-SP team in 2023/24 with support from UKHSA Global Operations MREL team.

Additional internal evaluations, such as value for money assessments, internal reviews of project management processes and qualitative data collection and analysis were conducted throughout 2022/23.

8.2 Monitoring

During the review period, the IHR-SP set-up a new MREL system to facilitate reporting on logframe indicators. Country-based project officers collected data on project activities on a monthly/quarterly basis (as required) and submitted it through an online excel-based results tracking matrix. The data was reviewed and quality assured by UK-based MREL staff and inconsistencies were resolved in communication with country teams. Resulting data was shared in quarterly project board updates to DHSC, and in internal team meetings to update the wider project team on progress being made towards indicator targets.

To assess the influence of training on knowledge, implementation of learning and resultant organisational change, the MREL team undertook 5 ‘deep dives’ (DDs) over Q4 of FY22/23. The deep dives formed the monitoring process for indicators 1.4, 2.4 and 3.3. Deep dives were scheduled to begin from Q3 and were due to be completed across all countries and regions for each indicator. However, due to several operational and security issues fewer than planned were completed. To mitigate these challenges for 2023-2024 plans are in place to recruit country based MREL staff. The addition of new MREL personnel in-country will increase the capacity of the MREL team to conduct further DDs in coming years and mitigate risks associated with travel and security issues. An additional challenge was that the logframe stipulated that DDs should be conducted 3 to 6 months following the implementation of a training. As the logframe was finalised in Q2, the 3 to 6 month review period resulted in DDs being conducted in Q4 for this review period. This is recognised as a limitation (particularly in relation to results for indicators 2.4 and 3.3) at this milestone, however an increased number of DDs are anticipated in the next financial year. The DDs that were completed were well received by participants and IHR-SP staff alike.

In addition to monitoring results against the logframe, the project introduced new tools and processes for monitoring progress against workplans and financial monitoring. Regarding progress monitoring, country and regional teams were asked to complete a new quarterly

narrative report organised by ‘priorities’ under each logframe output, with financial progress per priority updated by the central team at the end of the quarter. Activities undertaken under each umbrella ‘priority’ were tracked by tools such as GANTT charts which are owned by country and regional teams. These new processes helped to enhance financial management and transparency and allowed teams to plan, deliver and report in an agile way. These new processes will be further enhanced in the next year through the creation of a new PMO.

8.3 Learning

Numerous new or strengthened learning processes were used over this review period:

- Evaluation and Learning Forums (ELF) were held every 6 weeks. ELF provided an open forum for sharing results and examples of best practice from within the project and from external speakers. The forum provided a regular opportunity for country teams to engage and share cross-project learning and recommendations. To guide the content delivered at ELF, a set of internal learning questions (ILQs) were created via a participatory workshop. ILQs will be revised for the new financial year.

- Learning exchange opportunities were integrated into agendas of in-person events (including country lead weeks where all country leads come to the UK). Learning workshops used tools such as ‘most significant change’ processes and presentations to engage and action learning.

- The MREL team had the opportunity to travel to conduct in-person feedback and wash-up sessions for activities, providing learning reflections back to the wider team. In-country visits also provided the MREL team with the opportunity to share and answer questions on MREL processes in person and further build the wider project’s MREL capacity.

- A ‘learning loop’ process was developed to guide staff through the steps required to organise events and training sessions. Organisers were required to produce a concept note and objectives for the event/training. A follow-up survey with all training participants (3 to 6 months after the fact) asked whether the objectives of the training were met. Individual feedback forms, facilitation feedback sessions at events and reports on combined feedback provide opportunities for reflection and action. Concept note requirements will be further developed for 2023/24.

- During the qualitative reviews (deep dives), suggestions and lessons for improvement of training sessions (from a logistical and content perspective) were recorded in a learning log to be actioned systematically by the relevant teams.

Lessons identified and actioned over the past year included:

- A 360-degree review was conducted for the entire IHR-SP team and a working group was established to take forward the recommendations and feedback. Actions included organising a learning exchange week for project officers to facilitate exchange of project management best practice. The project management team also advocated for changes to Global Operations policies, highlighting the need for greater parity with FCDO policies for overseas deployments, for example.

- The MREL team observed that in some qualitative reviews conducted this quarter the sample of participants did not reflect the geographic spread of those trained. This was due to travel restricting those in more rural areas from attending an interview in the capital city. **Subsequently, where possible, MREL activities in-country should be designed to coincide with project delivery activities**. The benefit of this practice is that participants are already in a location for a network meeting/training. This will reduce travel frequency and time off work for participants and increase greater equity and inclusion in MREL activities.

- Based on successes this year, the MREL team concluded that physical attendance of MREL staff at relevant IHR-SP events/training is beneficial, as it increases contextual awareness and understanding among the MREL team and increases the visibility of MREL activities. This, in turn, enhanced the MREL team's ability to effectively plan targeted MREL activities, including qualitative reviews (deep dives). **The MREL team will seek further opportunities to attend activities in the upcoming project year.**

- Because of the size and wide geographical reach of the project, ensuring strong working relationships internally could be challenging. The project team has initiated regular (monthly) meet ups for **the central team in London and bi-annual whole team away days for the global team. The project team is also committed to increasing cross-project learning by setting up learning exchanges and joint trainings for project country teams.**

- Lessons and recommendations related to financial management and output delivery are noted in section 7.2, and section 3 respectively.

Contributions to the global evidence base:

- Several peer reviewed papers have been published this year drawing on experience from the IHR-SP and contributing to the global evidence base. For example, members of the IHR-SP authored a paper published in the PLOS Global Public Health journal entitled 'the role of international support programmes in global health security capacity building; A scoping review'' several members of the IHR-SP team were also authors on the Lancet series on One Health and Global Health Security .

- As detailed in section 1.3, the IHR-SP team also presented and provided evidence of best practice at conferences and international meetings, including at the Conference on Public Health in Africa (CPHIA) Rwanda, the UKHSA Annual Conference and to the steering group of Global Health Security Agenda (GHSA).

- There is potential to increase the visibility of activities and share stories and findings more effectively. A new communications specialist will be recruited, shared with the UK-PHRST to increase communications outputs and advise on a long-term strategy. **The project team will also seek out opportunities to learn and share examples of best practice to the wider UK government global health security community e.g., via GHSA fora.**

Annex 1: Disaggregation

Output indicator full disaggregation breakdown

3.1 Output 1

Strengthened technical capability in country and regional public health organisations

Indicator(s)	Milestone for the review	Progress
1.1. Number of partner country stakeholders trained in IHR core capacity areas	1100 (baseline of 1000)	Surpassed (+234%) Actual: 3675 Disaggregation **By gender:** Male: 2454 (67%); Female: 987 (27%); Undisclosed: 234 (6%) **By stakeholders:** Not available this year **By type of training**: After action reviews: 68 (2%) Simulation Exercise: 74 (2%) Technical training: 3345 (91%) Training of trainer (ToT): 188 (5%) **By Country/Region**: Africa CDC: 314 (9%) Ethiopia: 308 (8%)

Indicator(s)	Milestone for the review	Progress
		Nigeria: 257 (7%) Pakistan: 2542 (69%) Zambia: 254 (7%) **By IHR core capacity area:** Chemical events:82 (2%) Emergency preparedness: 205 (6%) Emergency response operations: 13 (<1%) Emergency response operations and emergency preparedness: 69 (2%) Human resources: 68 (2%) National laboratory system: 551 (15%) National laboratory system and human resources: 26 (<1%) Surveillance: 2576 (70%) Zoonotic events: 85 (2%)
1.2. Number of core products co-developed in IHR core capacity areas	>30 (baseline of 25)	Surpassed (+110%) Actual: 63 Disaggregation By core product:

Indicator(s)	Milestone for the review	Progress
		Guideline: 12 (19%) Implementation plan: 2 (3%) Learning management systems: 4 (6%) National action plan: 2 (3%) Quality manual: 4 (6%) Standard Operating Procedures: 22 (35%) Strategy: 9 (14%) Other: 8 (14%) By co-developed/revised/ approved/implemented/resourced and budgeted: Co-developed: 21 (33%) Implemented: 36 (58%) Revised: 2 (3%) Approved: 4 (6%) By Country/Region Africa CDC: 2 (3%) Ethiopia: 8 (13%) Nigeria: 18 (29%) Pakistan: 15 (24%)

Indicator(s)	Milestone for the review	Progress
		Zambia: 20 (31%) By IHR core capacity area Chemical events: 1 (1.5%) Coordination and National Focal Point communications: 1 (1.5%) Emergency preparedness: 4 (6%) National laboratory system: 32 (51%) National laboratory system and surveillance: 2 (3%) Surveillance:15 (24%) Surveillance, emergency preparedness and emergency response operations: 2 (3%) Surveillance and Emergency response operations: 1 (1.5%) Zoonotic events: 5 (8%)
1.3. Proportion (%) of trained stakeholders demonstrating new/improved technical skills or applying new/improved knowledge in IHR core capacity areas	60% (baseline of 0)	Surpassed (+50%) Actual: 90% Disaggregation **By gender** Male: 91% Female: 94%

Indicator(s)	Milestone for the review	Progress
		Undisclosed: 100% **By stakeholders:** Not available this year **By Country/Region:** Africa CDC: 100% Ethiopia: 100% Nigeria: 96% Pakistan: 88% Zambia: 82% **By IHR core capacity area** Chemical events: 63% Human resources: 100% National Laboratory System: 94% Surveillance: 88%
1.4. Changes in technical practices resulting from project's capability strengthening	40% of sample demonstrating level 3 change (baseline of 0)	Surpassed (+150%) 100% (4 deep dive samples) Disaggregation **By Country/Region:** Pakistan: 1

Indicator(s)	Milestone for the review	Progress
		Ethiopia: 1 Zambia: 1 Nigeria: 1 **By IHR core capacity area** Surveillance: 1 Risk Assessment: 1 Emergency Response operations, Emergency Preparedness: 1 National Laboratory System: 1
1.5. Number of IHR publication or events sharing evidence on improving IHR core capacities that are shared through a variety of fora including peer review journals, conferences, webinars, etc.	>5 (baseline of 5)	Surpassed Actual: 52 Disaggregation **By Country/Region:** Africa CDC: 7 (13%) EMR: 1 (2%) Ethiopia: 4 (8%) Nigeria: 10 (19%) Pakistan: 10 (19%) Zambia: 20 (39%)

Indicator(s)	Milestone for the review	Progress
		By IHR core capacity area: Chemical events: 3 (5%) Coordination and National Focal Point Communications: 1 (2%) Coordination and National Focal Point communications, linking public health and security authorities: 1 (2%) Emergency preparedness: 1 (2%) Emergency preparedness and emergency response operations: 1 (2%) Emergency response operations: 2 (3%) Human resources: 9 (17%) National laboratory systems: 20 (38%) Surveillance: 9 (17%) Zoonotic events: 7 (13%)

3.2 Output 2

Enhanced leadership, workforce and organisational development in partner country and regional public health organisations

Indicator(s)	Milestone for the review	Progress
2.1. Number of partner country stakeholders trained/mentored in public health leadership skills and theory	150 (baseline of 100)	Surpassed (+44%) Actual: 216 Disaggregated **By gender:** Male: 121 (56%); Female: 60 (28%); Undisclosed: 35 (16%) **By stakeholders:** Not available this year **By type of training:** Technical training: 216 (100%) **By Country/Region:** Africa CDC: 55 (25%) Ethiopia: 75 (35%) Nigeria: 29 (13%) Pakistan: 17 (8%) Zambia: 40 (19%)
2.2. Number of core products co-developed in workforce development	>10 (baseline of 10)	Surpassed (+190%) Actual: 29 Disaggregation **By core product:** Implementation: 6 (21%) Learning management systems: 2 (7%) Standard Operating Procedures: 1

Indicator(s)	Milestone for the review	Progress
		(3%) Strategy: 7 (24%) Other: 13 (45%) **By co-developed/revised/ approved/implemented/resourced and budgeted:** Co-developed: 2 (7%) Implemented: 21 (72%) Revised: 2 (7%) Approved: 4 (14%) **By Country/Region** Ethiopia: 1 (3%) Nigeria: 23 (80%) Pakistan: 3 (10%) Zambia: 2 (7%)
2.3. Proportion (%) of trained staff demonstrating new/improved leadership skills or applying new/improved governance processes	60% (baseline of 0)	**Surpassed (+60%)** **Actual: 96%** **Disaggregation** **By gender** Male: 100% Female: 75% Undisclosed: 100% **By stakeholders:**

Indicator(s)	Milestone for the review	Progress
		Not available this year **By Country/Region:** Nigeria: 100% Ethiopia: 95%
2.4. Changes in workforce and leadership practices resulting from project's activities	1 example of level 3 change (1 cohort due to operational constraints) (baseline of 0)	Achieved (100%) Actual: 1 Disaggregation **By country/region:** Ethiopia: 1

3.3 Output 3

Strengthened public health networks at national and regional level

Indicator(s)	Milestone for the review	Progress
3.1. Number of public health networks supported across country, regional and global levels	>3 new networks supported	Surpassed Actual: 28 new, 53 supported networks overall Disaggregation **By country/region:** Africa CDC: 3 (11%) EMR: 1 (4%)

Indicator(s)	Milestone for the review	Progress
		Ethiopia: 4 (14%) Nigeria: 8 (28%) Pakistan: 7 (25%) Zambia: 5 (18%) **By IHR core capacity area:** Chemical events: 1 (4%) Coordination and National Focal Point communications: 11 (38%) Emergency response operations: Human resources: 3 (11%) Linking public health and security authorities: 1 (4%) National laboratory system: 7 (25%) Risk communication: Surveillance: 1 (4%) Zoonotic events: 4 (14%)
Proportion of network stakeholders who report value in network activities and/or achieving changes in public health practices	60% (baseline of 0)	Surpassed Actual: 95% (based on 57% survey response rate) Disaggregation **By Country/Region:**

Indicator(s)	Milestone for the review	Progress
		Nigeria: 95% **By IHR core capacity area:** Risk Assessment: 1
Changes in practices resulting from public health networks	One example of level 3 change (1 cohort due to operational constraints) (baseline of 0)	Achieved Actual: 1 Disaggregation **By country/region:** Zambia: 1

Annex 2: Change description

Change description definitions

Three indicators in the logframe (1.4, 2.4 and 3.3) relate to qualitative assessment of changes in practices resulting from project capability strengthening/activities/networks respectively. These qualitative indicators use an ordinal scale to demonstrate depth of change. Changes are assessed using a standardised scale (as below) which is refined per technical area.

- Level 1 refers to change seen in individual/team (depending on activity) understanding and confidence in technical capacity area and the self-reported value of the activity.

- Level 2 refers to changes resulting from application of new technical skills/knowledge at an individual/team level.

- Level 3 refer to changes seen at the organisational level which embed new technical expertise/practices and move to sustainable approaches of increasing/sustaining technical capacity. Examples of organisational change include the following:

These generic change descriptors were tailored to be specific to each activity or network which was the subject of a qualitative review. Some examples from the network review of the Copperbelt Microbiology Network (see relevant annexed report for full context) completed in this financial year for level three include:

- Development of regional inter-lab comparison (microbiology) to assess performance (coordination) in place and working well [PH practice].

- QMS accreditation process improvement (providing evidence of improvement in QMS processes through audits) [PH practice].

- Increased visibility to MoH/ increased funding obtained for provision of reagents/ infrastructure/ equipment/ specialised technical lab trainings.

- Enhanced contribution to the surveillance system [regional impact].

- Scale up of network approach/expansion of the network across Zambia (e.g., northern region).

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