Learning brief

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Adaptive Programming for Global Health Security Programmes:

Lessons from the Public Health England International Health Regulations Strengthening Project

This Learning Brief is the first in a series to pull out areas of interest to a wide range of people in the global health security sector from the independent midterm evaluation of the Public Health England (PHE) International Health Regulations (IHR) Strengthening Project.

The following key requirements for GHS programmes seeking to utilise adaptive programming principles in project design and implementation were identified, based on a review of adaptive programming literature and the PHE IHR Project experience:

Key requirements for GHS Programmes seeking to utilise adaptive programming		
	A flexible and tailored approach	It is critically important to have flexible and tailored approaches to meet the needs of different and changing contexts, especially when supporting emergency preparedness and response efforts
	An iterative Theory of Change as a strong foundation	An agreed Theory of Change that underpins a programme's result framework and guides country work plans is needed to help ensure that assumptions on what drives change are tested and adjusted as needed
	Robust and ongoing evidence	Robust and regularly available evidence that can inform course correction is needed to support programme learning and adaptation

The PHE IHR Strengthening Project

The Department of Health and Social Care (DHSC) International Health Regulations (IHR)[1] Strengthening Project[2], delivered by Public Health England (PHE) as part of the Global Health Security (GHS) Programme, aims to build health system capacity in six countries and at regional level in Africa and Asia, with a view to improving GHS. PHE has been allocated £16 million of UK Official Development Assistance (ODA), over a five year period (April 2016 – March 2021), to contribute to GHS action at national, regional and global levels and lead to measurable strengthening of public health systems in six countries (Nigeria, Ethiopia, Sierra Leone, Myanmar, Pakistan and Zambia) and within Africa CDC.

PHE IHR Project Third Party Monitoring and Evaluation

Complementing PHE's own system for monitoring and evaluating its activities, Itad's monitoring and evaluation function serves three main functions: as independent monitor, as evaluator and as learning partner. In this way, Itad plays a formative learning role as well as a summative accountability role, working closely and symbiotically with the IHR M&E system. The mixed methods midterm evaluation of the PHE IHR Project took place from February 2019 to October 2019, and provided a midcourse check against progress towards outcome and impact targets as well as facilitating learning and informing improvements in project decisions and performance.[3] This is the first in a series of learning briefs to pull out areas of interest from the evaluation to the broader global heath security sector.

One of the areas explored during the mid-term evaluation of the PHE IHR Project was how and to what extent the project aligns well with the tenets of 'adaptive programming', a strand of international development programme operations that has created interest in development agencies. The IHR Project team has described their approach to be flexible and adaptive to rapidly changing situations[4]. The PHE IHR Project Theory of Change suggests that the project will provide a 'menu' of areas that the different PHE teams may support in countries, while the business case also indicates that the project approach is to ensure there is joint work planning so that the support is tailored to each country's context and needs[5].

What is Adaptive Programming?

'Adaptive programming' is described in the literature as development programme planning and implementation that is knowledge driven, politically savvy and able to adjust the ways of working in line with what has been shown to be more effective in the given circumstances. As development problems are typically complex and processes of change are highly uncertain, it is essential to allow for cycles of doing, failing, adapting, learning and (eventually) getting better results."[6] This is particularly true for programmes that seek to support and address rapid onset health crises, such as the COVID-19 pandemic. The Overseas Development Institute (ODI) has described three key features needed by projects to be adaptive: a) be problem-driven and politically informed, b) allow teams to be adaptive and entrepreneurial and c) be locally led[7]. To this is added the need to have good routine monitoring systems feeding into learning and good communications across teams, with foundations in a regularly reviewed Theory of Change[8,9].

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[1] The World Health organisation developed the IHR (2005) to "prevent, protect against, control and provide a public health response to the international spread of disease". All signatory countries (196) have agreed to implement the IHR and undergo a Joint External Evaluation to identify areas where they are performing well and where they need to improve disease prevention, surveillance, response and control measures. See footnote 10 and https://www.who.int/health-topics/international-health-regulations#tab=tab_1 for further info.

[2] Henceforth referred to as the "PHE IHR Project"

[3] Itad (2020) Mid-Term Evaluation: Public Health England International Health Regulation Project Third Party Monitoring and Evaluation, Brighton

[4] From 'kick off' meeting minutes – February 2019

[5] PHE IHR Project Business Case 2016 p19

[6] Wild et al (2015) 'Adapting development Improving services to the poor', ODI Report.

[7] Tulloch, O. (2015) What does 'adaptive programming' mean in the health sector?

[8] Op cit

[9] Cooke, K. (2018) How to set up and manage an adaptive project. Oxford Policy Management. https://www.opml.co.uk/files/Publications/8617-action-on-climate-today-act/act-adaptive-project-management.pdf?noredirect=1

Lessons Learned for Global Health Security Programmes

Design to be flexible, tailored and adaptive

It is critically important to have flexible and tailored approaches to meet the needs of different and changing contexts, especially when supporting emergency preparedness and response efforts. This has become acutely apparent during the COVID-19 pandemic. The PHE IHR Project was designed to be flexible and to align its support to country needs as defined by the results of each of their Joint External Evaluations (JEE)[10] and PHE scoping missions to each country. Each country not only has had different needs, but also has had a different understanding of, and interest in prioritising IHR commitments. Each has also had different experiences of working with Public Health England and UK Government development assistance. The PHE IHR Project leads based in country and other technical specialists mostly based in the UK have cultivated a good relationship with their national public health institute and Ministry of Health counterparts, which in turn has allowed them to develop and adjust work plans according to each country's situation. This has included not only postponing technical support for training workshops due to national counterparts having to respond to an epidemic outbreak, but also adjusting the content of their technical support when outbreaks happen.

The above highlights areas of success in terms of the PHE IHR Project's overall flexibility and adaptiveness. However, other key areas identified as necessary for a programme to be truly adaptive have been less evident. While a Theory of Change (TOC) and logframe were in place from the beginning of the Project, these were not reviewed prior to work-planning process beginning. As a result, the fluid and flexible work planning processes often failed to link with the TOC, logframe and overall project design, and contributed to an overall disconnect in terms of ensuring that PHE IHR Project activities at country and regional level were contributing to the envisaged overall PHE IHR Project outcomes and impact.

Use a Theory of Change to guide the definition of outcomes and results

The PHE IHR Project has had a TOC since its inception but had not reviewed and adapted it to changes on the ground by the time the midterm evaluation started. Itad's evaluation team facilitated a TOC workshop for the PHE team early in the development of the midterm evaluation process, having identified that there was a 'gap' in the construction of the TOC and results framework in terms of how a range of project inputs, processes and outputs would create the changes needed to achieve outcomes. Over the course of the midterm review period the review team continued to suggest adjustments to the PHE IHR Project TOC, work-planning processes and results framework, and provided an assessment of the underlying assumptions underpinning the IHR Project TOC. Having a PHE IHR Project supported by a strong and iterative TOC with fully fleshed-out assumptions will highlight where adaptive management is required, especially if any of these assumptions fail to hold. This work will guide the implementation and monitoring of the project through the remainder of the current period and during any second phase that may be funded after 2021.

Programme learning and adaptation relies on having robust and regularly available evidence that can inform course correction

The PHE IHR Project monitoring system was set up to track progress on project activities against the relevant workplans, using an online database that all project teams could input into, and to some extent the project logframe. Activity tracking was partially done against the different project indicators, though often also cutting across several different indicators. The midterm evaluation team realised early on that, without a system deliberately set up to translate activities into outputs and then into outcomes, it was challenging to measure what the project had achieved beyond implementing a set of workplans. So while the project is operationally very flexible (as it needs to be given that the aim is to support stakeholders in

[10] The IHR Joint External Evaluations (JEE) are voluntary, multi-sectoral reviews of country capacities to prevent, prepare for, detect and respond to public health emergencies. See https://www.who.int/ihr/procedures/joint-external-evaluations/en/ for further information and the standardised evaluation tool.

countries who are constantly on-call to respond to disease outbreaks), it hasn't had the necessary output and outcome data available to help reflect on whether the PHE IHR Project is doing its work in the best way so as to embed lasting capacity across the in-country teams they support.

Reflection on Adaptive Programming within the PHE IHR Strengthening Project

While this Learning Brief focuses on broader lessons for GHS Programmes, a final reflection on the PHE IHR Project's progress to date in terms of being adaptive is appropriate. There are many features of the IHR Project which indicate that it has strived to be adaptive in line with the three key features outlined by ODI: it is driven by the problems highlighted by the JEEs and prioritised by partners; it has allowed teams to be adaptive and entrepreneurial in response to outbreaks and partners' needs; and it has been to a considerable extent led by country and regional partners. However, the other key areas identified as necessary for a programme to be truly adaptive have been less evident to date: the TOC and associated results framework were not routinely reviewed prior to the midterm evaluation and were thus not supporting a cross-IHR Project understanding of how activities at country and regional level have been contributing to change at outcome and impact level. These are areas that the IHR Project team are working on for the remainder of this current phase, as indicated in the box below.

The PHE IHR Project team's ongoing work to support adaptive programming

The PHE IHR Project Senior Leadership team provided the following overview outlining the steps they have taken in response to the midterm evaluation in relation to adaptive programming

The PHE IHR Project since inception has had flexible and tailored workplans for each country based on expressed need and changing context, with local stakeholder input central to each workplan. This has been most recently highlighted during the COVID-19 pandemic, where country leads and delivery teams have adapted and repurposed their workplans to best support each country's COVID-19 response. Based on Itad's midterm evaluation feedback we have reviewed our processes to further the Adaptive Programming approach.

The Theory of Change has been revised alongside the logframe and the indicators we use to monitor and evaluate the project. Henceforth these will be reviewed iteratively and adapted accordingly. The project is working closely with the delivery teams to improve understanding of the role of the Theory of Change and results chain, to ensure that activities and inputs remain aligned with the project goals. We are also working on demonstrating how the outputs and outcomes we have been monitoring progress against and translate into impacts through, for example, assessing training effectiveness. As the project nears the end of this funding cycle, we will be capturing much more of this through various planned evidence generating activities.

Staff at Nigeria CDC taking part in training by the PHE IHR Project (Credit: PHE IHR Project)