Learning brief

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Coordination and alignment with relevant global and UK IHR interventions:

Lessons from the Public Health England International Health Regulations Strengthening Project

This is the second Learning Brief 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.

Key messages

In the context of COVID-19, and with the UK government making Global Health Security (GHS) a priority for its G7 Presidency next year, it is timely to reflect on lessons from the PHE IHR Project's role in relation to other GHS interventions and actors. Key points include:

- The strategic approach and focus of the PHE IHR Project – in terms of aligning with priorities set out in the Joint External Evaluations (JEEs) and National Action Plans for Health Security (NAPHS) - makes sense, although it is important to recognise that PHE does not aim to or have the capacity and resources to cover all domains.
- In the context of supporting ambitious, broad-ranging NAPHS, it is important to work in collaboration with other partners to provide strategic, coherent, coordinated support. This requires clear roles in terms of scope and focus from all collaborating partners, as well as active cooperation.
- Key partners feel that the effectiveness of the PHE IHR Project's technical assistance efforts would be enhanced by providing access to programme funds to support the activities that Technical Advisors recommend to governments. PHE has recently secured approval to make capital investments and uses this flexibility on a case by case basis. There are potential pros and cons that PHE is aware of in moving towards use of programme funds.
- Whichever strategic direction PHE decides to take going forward, it will need to ensure the right staff and right connections are in place to maximise the impact of coherent international support to IHR capacity strengthening.
- Complementary adaptive management processes need to be reviewed and strengthened to ensure that PHE adapts to the changing roles and focus of country- and global- partners' working on IHR.

The PHE IHR Strengthening Project

The Department of Health and Social Care's (DHSC) International Health Regulations (IHR)[1] Strengthening Project[2], delivered by Public Health England (PHE) as part of the 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 mid-course 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 second in a series of learning briefs to pull out areas of interest from the evaluation to the broader global health security sector.

The mid-term evaluation of the PHE IHR Project explored a number of areas that are relevant to the project's role in relation to other relevant global and UK GHS interventions. These include, amongst others, whether project activities are aligned, complementary to and coherent with other relevant UK ODA and international health security programmes. The PHE IHR Project business case makes clear references to coherence, alignment and coordination. The importance of coordinated cross-government action is highlighted to mobilise expertise from ten government departments, including with major IHR-related projects such as the Tackling Deadly Diseases in Africa Programme (TDDAP) and the Fleming Fund, as well as complementary support to key institutions at regional and global levels. There is, though, only a limited description of how this coordination will happen, for example in outline terms in the PHE IHR Project Theory of Change (ToC), which features intermediate outcomes such as 'shared understanding of priorities, goals, activities, resources and timeframe' and 'Plans provide the basis of coordinated support by stakeholders'. With the end of the current phase of the PHE IHR Project fast approaching, and in the context of the trends described below, it is a good time to take stock of any implications for the design of a second phase of UK / PHE support to strengthening IHR core capacities.

Global and UK domestic trends relating to IHR

The PHE IHR Project is funded by DHSC from its GHS portfolio, and reflects a strong commitment by the UK government to protect, promote and project its national security, economic and influence goals.[4] In the context of COVID-19, and changes in the way that the UK uses ODA to strengthen health systems in developing countries, the roles of UK government departments and programmes are evolving. This evolution is captured in a GHS Programme Theory of Change, which is designed to provide strategic direction and focus. The PHE IHR Project needs to reflect on the implications of these UK domestic agendas for its work with LMICs. It also requires systems that enable it to adapt its activities to maximise coherence and effectiveness based on new evidence.

[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". See https://www.who.int/health-topics/international-health-regulations#tab=tab_1 for further info.
[2] Henceforth referred to as the "PHE IHR Project" or "IHR Project"
[3] Itad (2020) Mid-Term Evaluation: Public Health England International Health Regulation Project Third Party Monitoring and Evaluation, Brighton
4 For example in the Fusion doctrine; GHS is also an emerging priority of the new Foreign, Commonwealth and Development Office

Ongoing changes in global architecture and the scope and influence of key actors working on GHS further emphasise the need for effective adaptation. In particular, there are anticipated changes in the breadth and depth of the country-level activities of the US Center for Disease Control and Prevention (US CDC) given budget cuts;[5] and questions about the impact that WHO funding cuts will have on its operations.[6] Uncertainties around the role of these two key partners may have implications for PHE's role, both in terms of the gaps that PHE can fill, and/or in terms of the strategic collaborations that PHE can make (e.g. to form a tripartite agreement with WHO and US CDC) to ensure resilient, effective international support to countries' efforts to strengthen their IHR capacities.

Lessons learned for relevant Global and UK Health Security Programmes

Does the PHE IHR Project's approach and strategic focus make sense in the context of the IHR and GHSA?

The PHE IHR Project seeks to strengthen countries' capacities to identify and respond to emerging threats. The approach draws on Joint External Evaluation (JEE) assessments[7], and aligns with National Action Plans for Health Security (NAPHS)[8] combined with consultations with national stakeholders to identify priorities. To avoid duplication, PHE also takes into consideration the interventions of other international agencies, including UK government partners. PHE works flexibly to respond to new priorities when contexts change, for example when an outbreak occurs. Ongoing engagement with IHR stakeholders in each country takes place through country-owned mechanisms, such as IHR technical working groups. This makes sense as a broad approach, although there are some lessons that bear further consideration, outlined below.

Limitations in focusing on JEE and NAPHS

Experience suggests the need for caution in using national health plans based on JEEs, such as NAPHS, as the basis for coordination. Such plans can be overly ambitious, and not well prioritised[9]; as a result they are not necessarily feasible to deliver. As a result, the IHR Project uses these as a starting point for alignment to prompt discussion with partners on their priorities. There is a risk that PHE spread their support too thinly if responding across too many areas, although it is clear that PHE seeks to identify priority areas from within JEEs that align with partner needs and PHE's capacity to respond. This is less of an issue where there has historically been a focus on a particular area, for example in Pakistan where PHE focuses on IDSR (Integrated Disease Surveillance and Response) only and its overlaps with public health laboratories, emergency preparedness and multisector working.

Model of technical assistance used to support capacity development

Technical assistance is a core offer from PHE across all workstreams of the PHE IHR Project, and there is strong demand for PHE's technical assistance. Some country-level stakeholders raised questions about whether PHE's technical assistance model (predominantly London-based, and short-term) is the most suitable, expressing a desire for longer-term, country-based support. A differentiated and more bespoke approach to delivery of technical assistance may be more appropriate in line with a country's capacity or maturity. There is also evidence that the standard PHE model is itself adapting in some countries - the IHR Project Equity and Sustainability Plan sets out a transition to longer term deployments and building in-country technical capacity based on feedback from in-country stakeholders, Itad and the maturity of the

[5] https://edition.cnn.com/2018/02/03/health/cdc-slashes-global-epidemic-programs-outrage/index.html
[6] https://news.un.org/en/story/2020/04/1061822
[7] 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.
[8] National Action Planning for Health Security (NAPHS) is a country owned, multi-year, planning process that can accelerate the implementation of IHR core capacities, and is based on a One Health for all-hazards, whole-of-government approach. It captures national priorities for health security, brings sectors together, identifies partners and allocates resources for health security capacity development. See https://www.who.int/ihr/procedures/health-security-national-action-plan/en/ for further information.
[9] https://openknowledge.worldbank.org/bitstream/handle/10986/28064/595570NWP0ieg0wp401public10BOX358284B.pdf?sequence=1&isAllowed=y

project in many partner countries. This is demonstrated by Nigeria and Pakistan, the countries with the longest engagement thus far, having multiple locally engaged technical experts. In any event, the impact of COVID-19 made remote support the only feasible option for a time, except where locally appointed staff are based in PHE country offices; and as with any such project, this is likely to have affected the extent to which PHE is able to make progress against its capacity building objectives.

What role could PHE play on IHR to maximise collaboration with other partners[10] at country level?

In the context of supporting ambitious, broad-ranging NAPHS, it is important to work in collaboration with other partners to provide strategic, coherent, coordinated support. This requires clear roles in terms of scope and focus from all collaborating partners. A number of related considerations arise from the midterm evaluation which are outlined in the following paragraphs.

Is technical assistance enough or does PHE also need complementary programme funds?

Whilst currently PHE support is focused on the provision of technical assistance in most countries, some key partners feel that PHE should have access to programme funds to support implementation of the solutions it advises governments to adopt, which would improve the effectiveness of the PHE IHR Project. There is some debate within PHE on the pros and cons of providing programme funds, for example if this were to detract from provision of technical assistance. There is evidence that capacity building activities could be more effective if PHE also provided some of the necessary equipment and materials (e.g. laboratory equipment and reagents in Nigeria[11]) and, whilst some changes have been made to the Business Case to introduce this flexibility for small amounts of funds to cover the cost of supplies needed for the delivery of technical work, there is need for a clear policy on how to address this gap.

This debate on programme funds is linked to the strategic positioning that PHE takes (or is able to take in future), particularly in the context of UK government coordination which has been highlighted as a priority by ICAI[12]. PHE is an executive agency of DHSC and the IHR Project is part of DHSC's GHS portfolio of projects under UK Aid. The IHR Project's model offers the technical expertise available within PHE to provide technical assistance. This can be complimented by investment through other government departments e.g. FCDO[13]. Yet there is scope to clarify how interventions by different HMG actors relate to each other, such as how FCDO's (DFID[14] at the time of the midterm evaluation) funding for GHS and work of GHS advisers relate to PHE's work on IHR. And there is also scope for PHE to strengthen its engagement with HMG funding for GHS through multilateral agencies such as GAVI and the Global Fund. IHR stakeholders in the midterm evaluation questioned whether the current PHE model allows them to be both a strategic adviser and to manage substantial programme funds. If PHE continues to focus on technical assistance it is important to have a) the right staff; and b) the right connections in place.

Right staff : The importance of PHE IHR Project Country Leads

The position of IHR Project Country Leads has become critical to ensure project success, including through establishing strong working relationships with a wide range of stakeholders. Country Leads, who are also Senior Health Advisers, have the credibility and expertise to play a key role in coordination and to play an 'entrepreneurial' role in creating and guiding strategic partnerships between relevant GHS-focused partners and interventions. There are examples of where this is starting to happen, for example in Ethiopia where the Country Lead was asked by the FCO (Foreign and Commonwealth Office, now FCDO) to be the UK government's GHS coordinator. However, experience from aid effectiveness coordination mechanisms

[10] In particular US-CDC, WHO and DFID/FCO (now FCDO: UK government Foreign, Commonwealth and Development Office, since September 2020)
[11] It is, however, important to note that the IHR project position on provision of consumables, such as reagents, is to only do this as an exception in an emergency, instead supporting partners through linking them to sustainable sources of consumables or flagging the need for such to more appropriate supporting partners. This position is designed to promote sustainability of PHE support and avoid creating dependencies.
[12] https://icai.independent.gov.uk/report/global-health-threats/
[13] Foreign, Commonwealth and Development Office, formed out of the former Department for International Development (DFID) and Foreign and Commonwealth Office (FCO)
[14] UK Department for International Development

underlines the time and energy required to play pivotal coordination roles effectively[15], and it will be important to reflect on whether Country Leads have the time and space to do this – particularly in view of the greater range of functions that Country Leads are responsible for, compared to what was initially envisaged.

Right connections: coordination mechanisms

In the context of the Fusion agenda[16], and with the merger of DFID and FCO, coordination between UK government partners is increasingly important. PHE needs to work with other parts of UK government to agree its strategic niche and identify mutually beneficial arrangements and relationships. For example, the project can benefit from the FCDO's diplomatic access, and the FCDO benefits from having entry points to talk to senior government decision makers when raising project-related concerns. However, PHE's experience underlines that it takes time both to fully identify and agree with partners how the PHE IHR Project can best add value, and for partners to understand PHE's offer. At the same time, the right coordination mechanisms need to be in place to help establish division of labour and collaborations: evidence from the midterm evaluation was mixed on the extent to which current coordination mechanisms are appropriate. Whilst they exist in London (the PHE IHR Project board and the DHSC GHS Programme Board) there are questions about whether these could be used more effectively. And whilst *formal* cross-UK government coordination mechanisms are limited at country level,[17] there are other *informal* ways (for example through co-locating DFID (now FCDO) and PHE) in place in most countries which have proved effective[18] and mostly driven by the Country Lead's own initiative. What seems clear, as also identified in the PHE IHR Project annual reviews, is the need for PHE and indeed DHSC to implement a more intentional and strategic approach to coordination and alignment, including through the PHE IHR Project ToC.

What implications do global IHR monitoring mechanisms have for the PHE IHR Project and vice versa

The PHE IHR Project Business Case sets out the expectation for the project to lead to *inter alia* a significant increase in IHR compliance, as measured through country JEEs. However, JEEs are voluntary and have neither been routinely updated (conducted for a second time since original assessments in 2016/17) nor is there any guarantee that they will be by the end of the project. As a result, assessing the extent to which the IHR Project has contributed to the achievement of outcomes and impact is challenging. As an alternative, the project plans to use the IHR State Party Self-Assessment Annual Reporting tool (SPAR)[19] to track country progress. This will give valuable information changes in outcomes against the 13 IHR core capacities, but less on contextual factors (such as changes in interventions being implemented by other partners) that are relevant in terms of supporting outcome-level change and identifying PHE's contribution. Having robust adaptive management procedures in place will be important to support this process, and is the subject of a separate learning brief[20].

[15] Whilst little has been published on the topic, this point is based on personal observations from the evaluation team and some references in literature on Sector Wide Approaches (Walford, HLSP Institute (2007): "A review of health sector wide approaches in Africa", Accessed 20 Aug 2020 from https://www.mottmac.com/ download/file/6107?cultureId=127)

[16] HM Government (2015): "National Security Strategy and Strategic Defence and Security Review 2015", accessed 20 Aug 2020 from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/705347/6.4391_CO_National-Security-Review_web.pdf

[17] With the exception of Ethiopia, where there was more deliberate effort to go beyond just DFID/PHE dynamics.

[18] For example in Pakistan and in Nigeria, where efforts on collaborative working by the PHE IHR Country Leads and teams have been recognised by the respective British High Commissioners

[19] https://extranet.who.int/sph/news/ihr-self-assessment-annual-reporting-tool-spar-2018

[20] Itad (2020): "Adaptive Programming for Global Health Security Programmes: Lessons from the Public Health England International Health Regulations Strengthening Project"

The PHE IHR Project team's reflection on coordination and alignment with global and UK IHR interventions

The PHE IHR Project Senior Leadership team provided the following reflection based on the findings of the midterm evaluation as framed within this learning brief, and developments over recent months

The PHE IHR Project has focused on JEEs and NAPHS as the starting point for our programming as this forms the foundation of how compliance with IHR is assessed worldwide. Building on this, we engage in a two way dialogue with partners to identify priority areas, updating these iteratively. These are captured in our scoping reports and work plans, and the subsequent domains of activity we engage in are priorities that the project and our partners have the capability and resources to focus on.

Following an extensive consultation during our scoping exercise, the project provides predominantly technical assistance. In response to dynamic feedback on project delivery, approval was obtained to allow small amounts of funds for supporting activities through the provision of relevant equipment, which is further evidence of the adaptive approach we have taken and continue to implement. There is certainly a tricky balance between support for development and creating dependence, one which the project will continue to manoeuvre through.

The recent creation of the FCDO and resulting changing portfolios across HMG may also alter the landscape of UK work around IHR. While the changes create new challenges, the UK government's commitment to GHS is expected to increase rather than decline, and so these changes are an opportunity to build stronger collaboration and to directly influence the UK government's diplomatic priorities. This is already being demonstrated in the engagement with FCDO in the COVID response in some PHE IHR Project countries. As a result of this engagement, the Project has been nominated for a Civil Service Award for Collaboration by the Ambassador in Ethiopia and the British High Commissioners in Pakistan and Nigeria. It is also important to note that the IHR Project is only a small part of the DHSC Global Health Security portfolio, which engages both bilaterally and multilaterally with a range of stakeholders. As part of the DHSC GHS portfolio the IHR Project is linked into other projects, the DHSC governance structures and cross-HMG working, facilitating collaboration, coordination and alignment.

Nigeria CDC Laboratory staff. Photo courtesy of PHE IHR Project