INTERNATIONAL HEALTH REGULATIONS (2005)

Technical consultation on monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005)

Key points and recommendations
Technical Consultation on monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005)

20-22 October 2015

Key points and recommendations
Acknowledgments

WHO gratefully acknowledges the participation and support of following key IHR (2005) partners: the European Centre for Disease Prevention and Control, the Food and Agriculture Organization, the Global Health Security Agenda, the International Civil Aviation Organization, and the World Organisation for Animal Health. Funding support from the governments of the United Kingdom and the United States of America is also gratefully acknowledged.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>APSED</td>
<td>Asia Pacific Strategy for Emerging Diseases</td>
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<td>Ebola</td>
<td>Ebola viral disease</td>
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<td>ECDC</td>
<td>European Centre for Disease Prevention and Control</td>
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<td>GHSA</td>
<td>Global Health Security Agenda</td>
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<td>IHR</td>
<td>International Health Regulations</td>
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<td>JEE</td>
<td>WHO Joint External Evaluation</td>
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<td>MERS-CoV</td>
<td>Middle-East respiratory syndrome coronavirus</td>
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<td>NFP</td>
<td>National Focal Point</td>
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<td>OIE</td>
<td>World Organisation for Animal Health</td>
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<tr>
<td>PHEIC</td>
<td>public health emergencies of international concern</td>
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<tr>
<td>PVS</td>
<td>performance of veterinary services</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1. **Background**

Recent outbreaks of Ebola viral disease (Ebola) in West Africa and Middle-East respiratory syndrome coronavirus (MERS-CoV) in the Republic of Korea, along with associated assessments, have reinforced the reality that the world remains vulnerable to emerging infectious diseases. It is also apparent from these and other public health events that the annual IHR self-assessment monitoring framework cannot, alone, reflect a country’s functional capacities required under the International Health Regulations (2005).

It was therefore important to develop an improved monitoring and assessment framework to determine the needed enhancements of core capacities and their likely sustainability. In 2015, the Sixth-eighth World Health Assembly endorsed the recommendations of the 2014 International Health Regulations (IHR) Review Committee to strengthen the IHR monitoring and evaluation process. This would also improve confidence and trust in the assessment of IHR core capacities.

In response, the World Health Organization (WHO) proposed a new framework for the period post-2015, described in “Development, monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005) – Concept note”. The new framework promotes better monitoring and evaluation of IHR core capacities post-2015 and proposes a four-pronged approach, based on resolutions WHA 65.23 and the IHR Review Committee. It also aims to promote the mutual accountability of States Parties and the Secretariat for improved global public health security.

It will achieve this by encouraging transparent reporting, promoting wide information sharing, and facilitating regular open and respectful dialogue to build inter-State Party trust in an environment of universal vulnerability. This framework covers implementation of the IHR (2005) as a whole and, depending on the aspect considered, proposes both quantitative and qualitative assessment approaches. It aims to reflect an international consensus on the form and frequency of self-assessments, joint external evaluations, after-action reviews and exercises. The framework also seeks to incorporate – and not duplicate – work by other allied partners and institutions.

This framework has been considered and supported by all five WHO Regional Committees that have met so far in 2015. The framework will be proposed to all States Parties, through WHO governing bodies, for consideration by the Sixty-ninth session of the World Health Assembly in May 2016.

2. **Objectives of the consultation**

WHO held a technical consultation on the proposed new framework on 20–22 October 2015 in Lyon, France. Participants included a range of experts from States Parties, international organizations, technical partners, and WHO regional offices and headquarters (see Annex 2 for a list of attendees). The group was asked to develop further the conceptual and operational aspects of the framework,

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including joint external evaluation tools – a new assessment approach called for by the IHR Review Committee. It was anticipated that the discussions would lead to a practical approach to integrating existing IHR-related work and experience.

Expected outcomes

The main deliverables for this technical consultation were:

i) recommendations for improving the IHR (2005) core capacity assessments;

ii) a tool that integrates the Global Health Security Agenda (GHSA) and WHO IHR approaches; and

iii) outlines for a supporting information policy, an implementation road map and a communication statement on these improvements.

3. Meeting structure and participation

The meeting was structured around presentations by key participants, followed by a series of working groups focused on the expected outcomes. Plenary session discussions were held to build a consensus (see Annex 1 for the programme). WHO headquarters presented a summary of the IHR post-2015 monitoring and evaluation concept paper. WHO regional offices presented the Regional Committee responses to this draft paper and provided an update on regional initiatives to strengthen existing IHR monitoring and evaluation arrangements. The international partners provided an overview of their institutional monitoring and evaluation systems and shared lessons from operating these systems.

4. Meeting highlights

The context

In a context setting session it was stressed that the world was confronted by an increasing number of global health security risks and related public health emergencies of international concern (PHEIC). There was clear evidence that national capacities were not able to keep pace with national needs to manage these emergencies efficiently and effectively; assessments of the recent Ebola outbreak had confirmed this situation.

Certain IHR strategic approaches for monitoring and evaluation had not proven adequately effective; particularly the sole reliance on self-assessments.

The outbreaks of Ebola in West Africa had stimulated unprecedented attention on global health security. However, while this provides a window of opportunity for those seeking to improve IHR core capacities, the global health security community must urgently harness this heightened interest.
The proposed IHR post-2015 monitoring and evaluation framework

The suggested IHR post-2015 monitoring and evaluation framework provides a strengthened basis to: support national health sector strategic planning and health systems activities; and promote mutual accountability and trust among States Parties for global health security. The framework has the following four components:

Self-administered annual reporting tool

- All core capacity assessments are structured against five levels of capacity or ability; and annual progress is assessed against the description of the capacity level.
- These assessments are central to ongoing improvement based on regular self-observed progress, identifying opportunities and taking action to fine-tune annual or multi-year IHR core capacity building programmes.
- These assessments are for annual reporting to the Health Assembly (Article 54, IHR (2005)).

After-action reviews

- It is suggested that these reviews, which could also be interim reviews, assess real-life events and hence serve as tests of system functionality.
- They could be structured against IHR (2005) core capacities, or functions.
- Such reviews may be conducted as self-assessments, jointly with international partners, with peers from other States Parties, or led by WHO, depending on the nature of the public health event being assessed.
- It is considered important to note key findings and recommendations, and subsequently to track implementation of the recommended actions.

Exercises

- Whether an exercise is purely theoretical table-top in nature, seeks to simulate a real life event in the field, or combines elements or both, it should seek to test the functionality of a system in a non-event environment, or when a significant change in procedure or staff has been introduced.
- The scope could vary from testing the functioning of the whole system to address a public health emergency, to testing particular parts of the system, e.g. the responsibilities of the IHR National Focal Point (NFP).
- As with after-action reviews, the exercises could be conducted as self-assessments, jointly with international partners, with peers from other States Parties, or led by WHO.
- It is also considered important to note key findings and recommendations, and subsequently to track implementation of the recommended actions.

External evaluations

- The assessments should: be voluntary to respect Member State sovereignty; follow good practice standards to enable comparability across State Parties; involve external expertise to promote confidence in the findings; require certain commitments from States Parties to facilitate the evaluation mission; and encourage States Parties and their key technical and
funding partners to address gaps in capacity and implement recommendations.

- It is recognized that a range of existing tools may be utilized, such as those developed by international organizations like the World Organisation for Animal Health (OIE), partners like GHSA, and the joint APSED programme of the WHO Regional Offices of South-East Asia and the Western Pacific.

- The evaluation system would require some technical and logistical support from WHO headquarters to: develop good practice guidance; facilitate resource mobilization; promote sharing of the reports and relevant information; and act as custodian and administrator of the system.

**WHO regional offices**

WHO regional offices provided an update on their Regional Committee’s reaction to the proposed new IHR post-2015 monitoring and evaluation framework. Any recent initiatives that the region had taken to strengthen IHR monitoring and evaluation were also presented.

**Africa**

The Regional Committee had not yet met in 2015 to consider the framework. However, the Ebola outbreak had demonstrated that the self-assessment system was not sufficient to monitor and evaluate public health emergencies effectively. Annual self-assessment reporting compliance for IHR (2005) is limited to only 17–18 States Parties. This is due to poor availability of data, which has prevented the IHR-NFPs from completing the annual questionnaire with confidence. However, informal discussions indicate that the NFP would adopt the proposed monitoring and evaluation framework.

**Americas**

Some States Parties developed assessment tools that had been used prior to the introduction of the original IHR reporting tool. It was noted that the current annual IHR questionnaire was not approved by the Regional Committee and the Health Assembly, which has led to limited ownership at the regional level.

As part of the Ebola preparedness assessment process, field-work has indicated significant gaps in core IHR capacities.

Regional consultations on the proposed new monitoring and evaluation framework, in September–October 2015 agreed with: its underlying principles; the need for an annual self-assessment process; the value of after-action reviews, albeit with some operational management issues; the value of simulation exercises; and evaluations, if they are voluntary and involve regional peers. In parallel, consideration was required of the overall State Party management burden.

It was suggested that the new IHR framework should foster mutual accountability, dialogue and transparency, and use both quantitative and qualitative data.

**South-East Asia**

Feedback on the framework from the Regional Committee was not obtained directly due to a full
agenda; individual State Party comments were therefore sought directly.

In summary, States Parties agreed on the proposed monitoring and evaluation framework, the need to strengthen annual self-assessments, and after-action reviews of outbreaks and PHEICs. In this respect, assessing core capacities for emergencies for all hazards should be a priority. Periodic simulation exercises need to be standardized and required by all State Parties; voluntary periodic evaluations were also supported provided they are conducted by a regional body of experts. While it was considered that WHO should lead the independent evaluations, it should be recognized that the Region has been conducting joint regional assessments of Ebola preparedness, and that the system would require some training of the regional body of specialists.

**Eastern Mediterranean**

In summary, State Party feedback on the proposed framework: recognized the importance of continuing annual self-assessments; noted the need to review the length and to consider some improved specificity of the annual assessment; suggested that after action-reviews should be of real events; recognized that simulation exercises provide a important tool for assessing preparedness; and noted the challenge of accessing some countries for independent evaluations.

The IHR monitoring and evaluation system improvements reported by the Region included: better compliance in terms of timing of sharing information related to PHEICs; preparation of country profiles based on IHR data and Ebola preparedness assessments; submission of a technical paper on a new approach to IHR self-assessments; and a proposal to establish a Regional IHR assessment commission and a regional task force with representatives from WHO and other key international implementing partners.

**Europe**

State Party feedback on the proposed framework included: willingness to pilot the new process; support to continued emphasis on self-assessment; recognition of the need for a more functional assessment approach; observation of the need to simplify, and potentially reduce the application, of some tools; proposal to use the after action-review tool as a useful learning mechanism based on assessing capacity functionality; recommendation that the simulation exercises have standardized tools and frequency (e.g. IHR NFP every three years); and support to the concept of conducting independent evaluation using a standard and transparent approach.

The Regional Committee added that independent evaluations should go beyond a simple assessment of progress, e.g. they should also identify and share good practices, and use the results of the many existing WHO assessments such as those on external quality assurance of laboratories and points of entry. The simulation exercises were considered useful; however, the annual self-assessment process should be simplified, and the gaps in the GHSA country assessment tool need to be recognized. Finally, the Regional Committee noted the desirability of more intercountry collaboration in the exchange of technical experts to support this monitoring and evaluation work.

**Western Pacific**

The Regional Committee noted that the process of strengthening IHR monitoring and evaluation capacities had been going on for 10 years through the Asia Pacific Strategy for Emerging Diseases (APSED) programme (joint programme of the WHO South-East Asia and Western Pacific Regional
Offices). Moreover, an annual Technical Advisory Group meeting has been an important forum for strengthening regional monitoring of progress and recommending future capacity-building priorities. A formal evaluation of the bi-regional APSED programme has been finalized, and planning for the next phase has started.

It was suggested that key concepts for a future monitoring and evaluation framework should include: the need for a common direction; testing the functionality of systems and not just their existence; clarity about the purpose of assessments; the importance of ensuring country ownership; and the need for a solid evidence base.

Specific responses to the Concept Note were that the current annual self-assessment tool needed more consistency in interpreting the questions, and that the after-action reviews should test the functionality of systems and not apportion blame to individuals. The annual simulation exercise of IHR NFP functionality (IHR Exercise Crystal conducted in the Western Pacific Region) was working well; furthermore evaluations should use the long established OECD criteria for evaluating development assistance. It was also considered that joint evaluations required a combination of external and local expertise to promote adequate familiarity with the programme and ownership of the eventual findings.

Additional comments included the need to build on existing tools and systems, and to be clear why particular tools are used, and their inter-connectedness. While State Party ownership should be promoted, a mechanism was needed to manage the overall monitoring and evaluation system.

Finally, The Western Pacific Regional Office would continue to use APSED to build core capacities; to pilot joint evaluations and monitoring and evaluation tools; encourage after-action reviews; conduct annual IHR NFP simulation exercises; strengthen the annual self-assessment system; and seek opportunities to work with the GHSA.

Discussion

It was concluded that building IHR core capacities was a long-term process requiring enhanced monitoring and evaluation tools – building minimum core capacities for small States Parties and overseas territories was particularly challenging and requires specific attention (however, assessing core capacities in small State Parties should not focus on compliance). Assessing the functionality of systems/capacities should be defined for particular situations; in particular achieving core capacities for chemical and radiological risks was considered an unfinished agenda. Clarifying the definition of “independent” should ensure that evaluation assessments involved external as well as internal experts. In general, using complementary networks, e.g. the WHO Global Outbreak Alert and Response Network or the International Food Safety Authorities Network, would help build IHR core capacities, and creating links with other international sectoral organizations would minimize the risk of duplicate assessment and reporting processes.

In summary, the updates indicated that many interesting initiatives were being pursued to support country assessments of IHR core capacities. There was consistent recognition that annual IHR self-assessments were not currently providing a reliable appraisal of core capacities and thus needed to be modified and supplemented with other tools that better tested functionality of capacities. Hence, with a few qualifications, there was widespread support for the suggested post-2015 IHR monitoring and evaluation framework, which would be piloted by several regions over the next year.
International Organizations

A range of international organizations and partners, including those listed below, provided an overview of their monitoring and evaluation framework.

Global Health Security Agenda (GHSA)

GHSA considers itself an ‘IHR accelerator’ programme, not an alternative to IHR, and is working with over 60 countries to strengthen global health security. GHSA assistance is structured around 11 action packages and three areas of action – prevention, detection and response.

The GHSA country assessment tool provides a scalable, independent assessment tool and is essentially a joint assessment tool used by peers to assess peers. It establishes baselines, identifies gaps for improvement and assesses capacity-building progress. The tool was piloted in five countries between January and June 2015, subsequently revised, and was about to be rolled out into a mature phase of conducting more evaluations.

GHSA evaluations mobilize a team of five or more vetted independent experts from partner countries, who undertake a one-week mission to the country. Essentially, the experts independently assess the country’s progress against the assessment tool it completed during an earlier self-assessment process. Preliminary feedback is provided before the experts depart, who aim to finalize the report within one month.

European Centre for Disease Prevention and Control (ECDC)

ECDC undertakes disease programme assessments that are characterized as proactive and conducted in “peace-time”. The assessments require an invitation from the country and are based on pre-agreed terms of reference. Following semi-structured interviews over 4–5 days, a report is provided outlining strengths, weaknesses and recommendations for country feedback; follow-up action is the responsibility of the country.

The Antimicrobial Resistance Healthcare and Associated Infections assessment tool, developed in 2005/2006, is structured around 10 technical topics; each technical topic provides a description, questions and indicators, and uses information from TESSy, the European Union surveillance system.

The generic country assessment process has been used to assess five accession countries and one member state since 2011, primarily to assess the capacity of countries to detect, report and control communicable diseases. It also assesses supporting infrastructure, follows management of individual cases, and assesses system structure, functions, efficiency and effectiveness, sensitivity, integration and sustainability. The country system is first assessed based on a self-administered questionnaire, before a field visit involving expert teams to follow patients in 4–5 representative areas and apply “acid-tests” of system functionality. The teams work closely with country counterparts and agree on an action plan.

It is recognized that there is no fully sufficient set of standards for communicable disease surveillance, early detection and response. For all indicators, the assessment compares the country with the European Union average as a benchmark. Analyses differentiate between the normal “peace-time” situation and emergency situations. These situations are assessed through the results of simulation exercises, critical incident reviews, self-assessments of emergency preparedness and
the existence of training programmes.

Lessons learnt from ECDC’s systems are that country assessments significantly improve analysis compared with self-assessments. In particular, the pathway of patient analysis provides more targeted results than national-level discussions, and the application of “acid-tests” has enabled better system descriptions. However, there are a number of unresolved issues like the development of suitable acid-tests; the paucity of reliable evidence; the need for more user-friendly questionnaires; and ensuring subsequent remedial action is taken by countries.

**World Organisation for Animal Health (OIE)**

OIE is an international standards setting organization for animal health. As part of this work it has established the international standards on the quality of veterinary services.

The ‘PVS Pathway’ involves conducting a performance of veterinary services (PVS) evaluation to assess capacities. This comprises a PVS gap analysis, technical assistance in the form of capacity-building, specific assistance and projects to prepare legislation, establishing public-private partnerships, building laboratory capacity and supporting veterinary education. An evaluation is then conducted to assess progress.

The PVS evaluation is a voluntary process based on agreed inter-governmental standards that continue to evolve (6th iteration), and requires a financial contribution by the country. The process uses an assessor manual, external, trained PVS experts, a standard report format, and involves an external peer review of the draft report. The PVS evaluation tool assesses 47 different competencies at 1–5 capacity levels of advancement.

A PVS gap analysis, conducted after the evaluation, helps develop strategic and technical priorities for capacity-building and estimates a 5-year budget to address these priorities. PVS Evaluation follow-up missions are conducted about every 3 to 5 years to assess progress.

Of the 180 member countries, about 75% have requested an evaluation and of these about 80% have subsequently undertaken the gap analysis. Since 2006, OIE has invested about Euro 9.5 million in funding this scheme.

**Food and Agriculture Organization (FAO)**

Three of FAO’s five objectives are related at least indirectly to human health. FAO has not been closely involved with IHR, but wants to promote closer links with the One-Health Initiative.

A number of FAO activities that may already be able to contribute to IHR-related work include the following:

- **FAOSTAT**, the statistical division of FAO, which maintains good statistics on animal diseases;
- **Codex alimentarius**, while not an international standard-setting organization, provides a collection of internationally adopted food standards;
- the Global Early Warning System, a joint FAO, OIE and WHO initiative to strengthen global early warning of major animal diseases, including zoonoses;
- the Crisis Management Centre, launched in 2006, is FAO’s rapid response mechanism to
animal disease emergencies; and

- regular FAO assessments for specific diseases and evaluations of the overall programme of assistance to a country.

It was noted that while IHR is an overarching framework, environmental aspects appear to be missing and it arguably needs more emphasis on food.

**International Civil Aviation Organization (ICAO) Aviation Medicine**

The Universal Safety Oversight Audit Programme – Continuous Monitoring Approach has its origins in the 1992 Chicago Convention after growing concerns about safety in the aviation industry. Launched in 1996 and voluntary since 1999, its aim is to implement safety-related standards and recommended practices. By 2010, it had undertaken over 350 audits with over 160 follow-ups. The system is considered a success by the member states.

The process of the Programme is simple. The technical, ISO certified, audits are essentially voluntary and remains confidential, although summaries have been made public since 2013. Audits focus on the national regulatory authorities and not the actual airports or airlines, are funded from the ICAO budget, and are based on a Memorandum of Understanding that gives ICAO a legal mandate to audit. Their primary purpose is to identify needs for assistance and capacity-building programmes.

There is potential for cooperation with WHO–IHR on information gathered through this process, subject to a formal Memorandum of Understanding.

**Discussion**

In summary, the monitoring and evaluation systems of international organizations, often in place for up to a decade, comprise various tools for both annual standard self-assessments and independent reviews, evaluations and audits, and generally provide a subsequent pathway to build capacities. Some common, but certainly not universal, aspects of these systems include voluntary reviews or evaluations; the involvement of multiple stakeholders; use of a mixture of independent peers and local experts; the sharing of results with other States Parties; the use of standardized tools/reports; and the support and coordination of a central professional group.

**Group Work**

For much of the Consultation, participants worked in groups to address the overall WHO assessment process, the self-administered annual reporting tool, communications and release of information, and the timeline for implementing the new process. The agreed aim of the groups was to focus on developing the WHO Joint External Evaluation (JEE) tool. The experience gained in the GHSA and other assessments would also be useful in the development of the JEE tool. While the groups did not always reach a conclusion to their discussions, the summary of their findings is provided below.

**Group 1 – IHR Monitoring and Evaluation Framework for Post-2015**

- Discussions predominantly focused on the evaluation tool of the proposed new Framework, as well as some discussion on the after-action reviews and exercises.

- The name Joint External Evaluation (JEE) was suggested for this process. ‘Evaluation’ has been an internationally established term for over 30 years and reflects a much more robust
and periodic analysis than regular monitoring arrangements. The term reflects the need for an objective process that can be relied on by the international community for an accurate assessment of core capacities and the identification of gaps in capacity. The term ‘external’ reflects the need to involve a group of predominantly, but not totally, external technical specialists to promote objectivity and greater confidence in the findings. The term ‘joint’ is used to communicate the essential cooperative and collegiate approach that underpins the process to promote effectiveness of the mission and ownership of the eventual conclusions and recommendations.

- Governance arrangements need considerable thought to develop the Framework and to prepare for the Sixth-ninth World Health Assembly. Parallel decisions need to be made on arrangements for WHO support and coordination to the process, division of labour between WHO headquarters and regions, suggested funding arrangements, and ongoing cooperation and coordination arrangements with GHSA.

- Team and mission management arrangements are needed to establish a roster of vetted technical specialists; develop a range of solid yet pragmatic good practice guidance, formats and tools; train or sensitize consultants; and recognize the importance of team leaders and their special skill set.

- Incentives for the participation of States Parties can be created by promoting the involvement of key technical and funding partners, and ensuring that the mission has a high profile with key domestic decision-makers.

- Transparency of the process and its results should be promoted by assessment teams sharing key conclusions before leaving the country. While final reports should be made available to the public, it is recognized that they will most likely need State Party clearance to promote adequate ownership of the findings.

- The significant logistical and funding implications imply that JEE evaluations may only be held every five years. The external evaluation process as part of the overall IHR monitoring and evaluation framework will need to be regularly reviewed by WHO. The first such process review is suggested to take place after two years, and every four years thereafter.

- Examples of evaluation prerequisites were that States Parties would be volunteers; provide certain in-country logistical support; prepare an action plan to implement recommendations; and report annually on progress on implementing the recommendations.

- Certain links are required, e.g. harmonization of the evaluation and self-administered annual reporting tools, which need to be in a modular format to facilitate more specialized studies. Evaluations require more information than the new technical self-administered annual reporting tool. Finally, the results of after-action reviews and exercises are needed by the evaluation mission as tests of system functionality;

- The following suggestions were made on after-action reviews: undertake review for more than just disease outbreaks, as they have broader application for other IHR aspects; promptly report the most significant PHEIC; encourage after-action reviews for all potential PHEICs in line with Article 7 of IHR; consider review of near critical events (e.g. suspected Ebola cases); develop pragmatic good practice guidance (WHO headquarters).
Regarding exercises, these were not limited to after-action reviews, but could be annual regional or national exercises to test IHR NFP functionality. Pragmatic good practice guidance was needed to promote global comparability of the results of these exercises.

Group 2A – Legislation, coordination and points of entry
- Findings used the IHR framework, combining elements of the GHSA assessment tool.
- Based on IHR core capacities, outcome indicators were proposed using a definition for the five levels of capacity for each indicator, and the level of additional evidence required.
- While accurate or significant opinions on the work on zoonosis were not possible, it was suggested that food safety would be better reflected in the IHR zoonotic core capacity area.
- The important role and obligations of the OIE within the IHR were noted.

Group 2B – Surveillance and response
- Uniting the WHO and GHSA tools enable indicator- and event-based surveillance to be interoperable, electronic, and real-time. The tool integrates and analyses surveillance data and syndromic surveillance systems, and can activate emergency response operations. Group 2B suggested that the abbreviation EOV (Emergency Operations Centre) be renamed public health emergency response, whose mandate would include plans and structures, an operations programme, case management, infection control, disinfection, decontamination and vector control.
- Numerous unresolved issues and questions on information requirements were documented.

Group 2C – Preparedness, risk communication and zoonotic events
- This work was only step 1 towards the tool development. Next steps included clear timelines to refine and complete the JEE tool, and how it sits alongside GHSA, e.g. add IHR and related indicators, attributes, and questions in an annex.
- This partial analysis documented areas covered by the GHSA assessment tool, not included for IHR capacity, and what may be moved to different parts of GHSA framework. Recommendations were made for GHSA to consider, along with a list of detailed tools to be used.

Group 2D – Laboratory and human resources
- The partially completed framework enabled colour coded comments, representing areas needing improvement, areas not represented by GHSA, and comments applicable to all areas of the GHSA assessment tool.
- The group analysed IHR requirements, followed by how the GHSA tool assessed these requirements, and finally summarized what was needed to assess a country’s capacity and hence contribute to global health security.
Numerous, specific comments were offered. Capacity scores, for example, were intended to be an average of different indicators, although some weighting system would be useful. In this respect, advantage should be taken of existing, more detailed tools, such as the WHO Laboratory Assessment Tool. Some important issues are addressed in the technical questions but not in the indicators; human resource development, for example, should be measured by more than one target. In general, functionality is better assessed by simulation exercises rather than training drills; any existing manuals should be identified. GHSA’s attributes on biosafety may need further input from experts. Other points were that diseases should be country-specific; data management should be added; and laboratory networking should be assessed.

Information sharing and reporting

It was important that the proposed new IHR monitoring and evaluation framework addresses the policy considerations related to making available results of the evaluations, and information more generally, to the broader global health security community. A subsequent discussion on information sharing and reporting came to the following conclusions.

- The self-administered annual reporting tool and joint external evaluations both need to cover the full scope of programme management information needs.
- The universal vulnerability of States Parties to emerging infectious diseases and the involvement of considerable external resources for capacity-building makes transparency particularly important. Hence, the information-sharing requirement for States Parties should be set reasonably high.
- The underlying purposes for sharing information are to support immediate international health decision-making; promote confidence and trust among countries; and to support longer-term research needs.
- The information to be shared needs to be both quantitative and qualitative in nature.
- “Dashboards”, with their use of simple traffic-light presentations, are useful for summarizing information. However, such tools also need to provide scope for additional explanations.
- The information presented should not only report a ‘snap-shot’ of the current situation, but also demonstrate trends.
- ‘Portals’ seem appropriate for sharing information at the national, regional and global level. While some information portals will have restricted access, the amount of information withheld from the public should be limited.

Timeline for the Implementation of these findings

A suggested timeline to operationalize the new monitoring and evaluation framework by the next World Health Assembly in May 2016 is outlined below.
Prepare a revised draft of the joint external evaluation and share with all regional offices End November 2015

Provide a briefing to the IHR Review Committee on Ebola

Present the document to the Executive Board. January 2016

Present the document to the Sixth-ninth Health Assembly May 2016

**Final summary points**

- IHR (2005) is recognized as a foundational mandate for the global health security community.

- While the pace of the consultation was very rapid, progress at the regional level and other international developments required a fast development process for the IHR post-2015 monitoring and evaluation framework. This meeting had taken the process a significant step forward.

- The final Joint External Evaluation will be based on IHR (2005) core capacities, incorporating the GHSA country assessment and other relevant tools.

- It should be very clear that this work is not a final product, but will facilitate the presentation of the framework to the WHO governing bodies early next year.

- The agreed communiqué should help clarify the consensus reached during this consultation for external stakeholders.
### Annex 1. Agenda

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<th>Session</th>
<th>Presentation</th>
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<tr>
<td>Opening Session 09:00 – 10:00</td>
<td>Welcome Consultation objectives and house keeping Participants introduction Opening speech IHR Capacity Assessment, Development and Maintenance Participants Dr Keiji Fukuda, Assistant Director General, Health Security</td>
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<tr>
<td>Coffee Break (10:00 – 10:30)</td>
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<td>10:30 – 13:00</td>
<td>IHR Monitoring and Evaluation Framework (IHRMF) post-2015: from concept note to operational framework Regional updates on IHRMF concept note and outcomes of State Parties discussion at Regional Committees 2015 Evaluation approaches by other agencies/sectors/partners IHR Capacity Assessment, Development and Maintenance Six regional offices OIE, FAO, ECDC, GHSA, ICAO</td>
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<td>14:15 – 17:00 (incl. coffee break)</td>
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<td>16:00 – 17:00</td>
<td>Plenary to discuss issues arising from group work All</td>
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<td><strong>Day 2: 21 October</strong></td>
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<tr>
<td>08:30 – 10:00</td>
<td>Global Health Security Agenda and its country assessment tool</td>
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<tr>
<td>10:00 – 12:30 (coffee break incl.)</td>
<td>Group work continues</td>
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<td>Lunch (12:30 – 13:45)</td>
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<tr>
<td>13:30 – 14:00</td>
<td>Discussion of progress with group work</td>
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<tr>
<td>14:00 – 17:30 (coffee break incl.)</td>
<td>Group work continues</td>
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<tr>
<td><strong>Day 3: 22 October</strong></td>
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<tr>
<td>09:30 – 12:30 (incl. coffee break)</td>
<td>Group work plenary presentations</td>
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<tr>
<td>Group Work 1</td>
<td>IHR Monitoring and Evaluation Framework post-2015</td>
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<tr>
<td>Group Work 2</td>
<td>Group Work 2A – Legislation, Coordination and Points of Entry</td>
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<tr>
<td>Group Work 2B</td>
<td>Surveillance and Response</td>
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<tr>
<td>Group Work 2C</td>
<td>Preparedness and Risk Communication</td>
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<td>Group Work 2D</td>
<td>Laboratory and Human Resources</td>
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<tr>
<td>Lunch (12:30 – 13:30)</td>
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<tr>
<td>13:30 – 14:30</td>
<td>Plenary discussion:</td>
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<tr>
<td>- Communication, Information Sharing and Reporting</td>
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<tr>
<td>- Operational timelines</td>
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<tr>
<td>Coffee Break (15:30 – 16:00)</td>
<td></td>
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<tr>
<td>16:00 – 16:45</td>
<td>Conclusion and recommendations</td>
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<tr>
<td></td>
<td>Discussion and closing remarks</td>
</tr>
</tbody>
</table>
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