INTERNATIONAL HEALTH REGULATIONS (2005)

MONITORING AND EVALUATION FRAMEWORK

World Health Organization

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1 - INTRODUCTION

1.1 BACKGROUND OF THE INTERNATIONAL HEALTH REGULATIONS (2005)

The International Health Regulations (IHR)[1] was first adopted by the World Health Assembly (WHA) in 1969 and covered six diseases. The Regulations were amended in 1973, and again in 1981, to focus on just three: cholera, yellow fever, and plague. In 1995, in consideration of increases in international travel and trade, and the emergence, re-emergence and international spread of diseases and other threats, the WHA called for another substantial revision. This revision extended the scope of the IHR from a limited number of diseases to any potential public health emergency of international concern, irrespective of origin or source, including those involving the natural, accidental or deliberate release of biological, chemical or radio-nuclear materials. The revised IHR, or IHR (2005), entered into force on 15 June 2007. This document henceforth refers to the IHR (2005) as 'the IHR.'

The IHR include several procedures that States Parties are required to comply with for effective implementation of the Regulations. These include:

1. to establish a National IHR Focal Point, available 24/7 for urgent communication with WHO (Article 4);
2. to have or develop and maintain core public health capacities to implement the Regulations effectively, in accordance with Articles 5 and 13;
3. to notify WHO within 24 hours of all events that may constitute a public health emergency of international concern (Article 6), and to respond to WHO's request for verification of information (Article 10);
4. to provide to WHO the public health rationale for additional health measures that significantly interfere with international traffic[2] (Article 43);
5. to report to the World Health Assembly on the implementation of the IHR (Article 54).

This document focuses on obligations related to the establishment of core capacities under articles 5 and 13.

Art: 5 Each State Party shall develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to detect, assess, notify and report events in accordance with these Regulations, as specified in Annex 1.

—and:

Art: 13 ...the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern as set out in Annex 1.

Compliance with the other obligations is monitored by WHO through other mechanisms[3-4,]

1.2 DEVELOPMENT OF THE IHR MONITORING AND EVALUATION FRAMEWORK

States Parties and the Director-General of WHO report annually to the WHA on their progress in implementing the IHR, as required by Article 54 of the IHR and Resolution A61.2 *Implementation of the International Health Regulations (2005)[5]*. States Parties currently report using a self-assessment approach that is facilitated by WHO data collection instruments and supporting tools.

WHO shall collaborate with States Parties, upon requests, to extent the possible, in the evaluation and assessment of their public health capacities in oder to facilitate the effective implementation of these regulations (Article 44).

The IHR Review Committee on Second Extensions for establishing national public health capacities and on IHR implementation (WHA68/22 Add.1[6]) in 2014 recommended that *the Director-General consider a variety of approaches for the shorter- and longer-term assessment and development of IHR core capacities as follows:*

States Parties should urgently: (i) strengthen the current self-assessment system (e.g., if not already done, the annual self-assessment reports and planning processes should be enhanced through multi-sectoral and multi-stakeholder discussions);

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1 - International Health Regulations (2005) (http://www.who.int/ihr/publications/9789241596664/en/ accessed on 12 June 2018)
2 - Significant interference with international traffic "generally means refusal of entry or departure of international travellers, baggage, cargo, containers, goods, and the like, or their delay, for more than 24 hours" (Article 43)
3 - Monitoring compliance with IHR requirements for establishing the national IHR focal points, and for communication and information verification
4 - Monitoring compliance with IHR requirements in relation to additional health measures (Article 43 of (IHR(2005). (Articles: 4, 6-10 of IHR(2005))
5 - WHO. Sixty-First World Health Assembly- Resolutions and Decisions (http://apps.who.int/gb/ebwha/pdf_files/WHA61-REC1/A61_REC1-en.pdf accessed on 12 June 2018)

and (ii) implement in-depth reviews of significant disease outbreaks and public health events. It should promote a more science or evidence-based approach to assessing effective core capacities under "real- life" situations. Simultaneously, the Secretariat should promote a series of regional formal evaluations or meta-evaluations of the outbreak reviews, managed by the regional offices, to facilitate cross-region learning and to distill lessons learned for future IHR programming.

In parallel, and with a longer term vision, the Secretariat should develop through regional consultative mechanisms options to move from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts. These additional approaches should consider, amongst other things, strategic and operational aspects of the IHR, such as the need for high-level political commitment, and a whole of government / multi-sectoral engagement. Any new monitoring and evaluation scheme should be developed with the active involvement of WHO regional offices and subsequently proposed to all States Parties through the WHO governing bodies' process.

The concept note on the development, monitoring and evaluation of functional capacity for implementing the International Health Regulations (2005)[7] was developed in response to the recommendations of the Review Committee report. As part of a global formal consultative process, in July 2015 the concept note was shared with all States Parties to the IHR, by e-mail and via the web.

Discussions on the proposed IHR monitoring and evaluation framework (IHRMEF) during the 2015 Regional Committees showed that all WHO Regions well accepted the underlying principles. The IHR monitoring and evaluation framework consists of 4 components; mandatory annual reporting and three voluntary components, i.e., after action review, simulation exercise and voluntary external evaluation. States Parties expressed the wish that the existing annual reporting questionnaire should be continued in a simplified form. The value of after action reviews

and simulation exercises were well recognised and the importance of an intersectoral approach was emphasized, as was that of strong national ownership of voluntary external evaluations.

The IHR-MEF aims to provide a comprehensive, accurate, country-level overview of the implementation of requirements under the IHR to develop and monitor capacities to detect, monitor and maintain public health capacities and functions (Article 5). This overview contributes to mutual accountability for global public health security among States Parties and the WHO secretariat and helps build trust through transparent reporting, sharing of best practices, and dialogue. It proposes both quantitative and qualitative methods for monitoring, as well as approaches for periodic and continuous evaluations.

1.3 PURPOSE AND SCOPE OF THIS DOCUMENT

This document proposes a framework and processes by which States Parties can monitor and evaluate the implementation of IHR capacities in accordance with the requirements for capacity development outlined in Annex 1 of the IHR. It also contributes to Article 54[8] of the IHR, which calls on States Parties and WHO to report to the WHA on the implementation of the IHR. This framework encourages the use of existing available information from other monitoring and evaluation tools to avoid duplication and to help ensure countries are not overburdened.

This framework is not legally binding. It does, however, represent a consensus of technical expert views drawn globally from the Member States, technical institutions, partners, and WHO Secretariat.

1.4 INTENDED USERS

This document is intended primarily for use by government authorities and other stakeholders including but not limited to public health professionals, national IHR focal points (NFPs), institutions, and partners.

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6 - Implementation of the International Health Regulations (2005 – Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation (http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22Add1-en.pdf accessed on 12 June 2018)

7 - Development, monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005): Concept note (http://www.who.int/ihr/publications/concept_note_201507/en/ accessed on 28 February, 2018)

8 - Resolution 61.2 establishes the periodicity of annual reporting (http://www.who.int/ihr/Processes_of_IHR_Monitoring_framework_and_Indicators.pdf accessed on 12 June 2018)

2. **OBJECTIVES** OF THE **IHR MONITORING** AND **EVALUATION FRAMEWORK**

It is important to note that the processes described in this document are not intended for use in ranking or comparing countries' performances; instead, they are tools to support countries in monitoring their progress in the development and maintenance of the national capacities required by the IHR (2005). The IHRMEF helps countries evaluate their status as regards to implementation of IHR capacities and their functioning, and in doing so helps plan, develop, maintain and enhance these capacities. This document builds on the work of the previously used IHR Core Capacity Monitoring Framework[9], and related recommendations from the Review Committee and the Member States.

With respect to States Parties, this framework aims to:
- Support States Parties in evaluating their status of IHR implementation and determining their progress towards fully developed, sustainable IHR capacities
- Assist States Parties with a qualitative examination of the functionality of IHR capacities
- Provide States Parties with information relevant to the development and maintenance of capacities required under the IHR.
- Help build mutual trust and accountability among States Parties, and
- Provide States Parties with a uniform format for annual reporting to the World Health Assembly on the status of IHR implementation.

With respect to WHO, the IHR MEF aims to:
- Provide a common approach to implementing IHR monitoring and evaluation activities in countries;
- Analyse and disseminate information generated and ensure their use
- Enable WHO to report annually to the World Health Assembly on the status of IHR implementation by States Parties; and
- Enable WHO to better identify possible support for capacity development in countries.

With respect to partner agencies and institutions, the framework aims to:
- Provide a common approach to supporting countries in implementing IHR monitoring and evaluation
- Enable partner agencies and institutions to target and prioritize their support for capacity development in countries, and ensure alignment in this support.

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9 - IHR core capacity monitoring framework: Questionnaire for monitoring progress in the implementation of IHR core capacities in States Parties (http://www.who.int/ihr/publications/WHO-HSE-GCR-2016.16/en/ accessed on 12 October 2018)

3. GUIDING PRINCIPLES OF THE IHR MONITORING AND EVALUATION FRAMEWORK

3.1 MUTUAL ACCOUNTABILITY AND TRANSPARENCY

One of the main principles and goals of the IHR MEF is to promote and ensure the culture of transparency and mutual accountability among States Parties towards global public health security. Timely and accurate annual reporting to the WHA on the status of IHR implementation shows commitment to the IHR. Volunteering to conduct and share the outcomes of after action reviews and simulation exercises demonstrates a country's capacity and determination to prevent the potential spread or spillover of national emergencies beyond its borders, and to share best practices, and participation in a voluntary external evaluation promotes the culture of transparency. By sharing the results of these four components, the best practices, experiences, and lessons will stimulate dialogue and foster trust, cooperation and confidence between States Parties.

3.2 COUNTRY OWNERSHIP, WHO LEADERSHIP, AND ACTIVE PARTNERSHIPS

In engaging with States Parties, WHO is following three principles for assessment, monitoring, and evaluation:
1. Country ownership
2. WHO leadership as custodian of the IHR
3. Active partnership.

Country ownership is critical for the development of sustainable capacity and investment for IHR capacities. It is important that countries commit their domestic resources to evaluation, monitoring, planning, and capacity building. Building and sustaining the core capacities as required under the International Health Regulations (2015) at the national and subnational levels, are the primary responsibility of governments, taking into account their national health, social, economic, health security and political contexts.

WHO leadership: Under the IHR, WHO has a central leadership role in monitoring progress, evaluating outcomes, and reporting. WHO is also responsible for convening and aligning support to address any gaps identified, and for

supporting the building of core capacities.

Active partnership: Many Member States require technical and financial support to assess, build and maintain their core capacities required under the Regulations as essential public health functions of their health systems. The scale of work needed to accelerate and improve IHR capacities is beyond the ability of any single entity, institution or country. Broader strategic partnerships are therefore critical for the successful assessment, implementation, monitoring, and evaluation of the IHR.

3.3 CONTINUUM FROM ASSESSMENTS TO NATIONAL PLANNING AND IMPLEMENTATION

The IHR MEF addresses the monitoring and evaluation of the IHR capacities necessary to address public health risks and hazards; gaps and recommendations should be addressed in a multisectoral national action plan for health security (NAPHS), in line with a One Health approach. The implementation of the plan is a critical step to build Member States' capacity and ensure that they are better prepared and operationally ready to manage any public health risks and events.

For capacity building to be sustainable, NAPHS should be incorporated into the national budget cycle and aligned with the national health strategic plan, rather than being independent of an institutional planning process. Such a plan will facilitate linkages to plans in other relevant sectors and ensure compatibility with national timelines and strategies.

This process is in line with the requirements under article 44 of IHR on *"collaboration and assistance"*.

3.4 MULTI-SECTORAL PARTNERSHIP

Establishing and maintaining IHR capacities of a State Party is a national responsibility. As such, it requires collaboration between all relevant sectors, ministries, agencies and/or other government bodies responsible for the various aspects of implementing the IHR at the national level.

Relevant sectors include, at a minimum, relevant ministries and authorities, or agencies responsible for developing IHR capacities.

Depending on the country and its capacity, these may include (but are not limited to):
• Human health
• Animal health
• Agriculture
• Environment
• Food safety
• Finance
• Transport
• Trade and travel
• Points of entry
• Chemical safety
• Radiation safety
• Security
• Defense
• Regulatory bodies
• The media
• Parliamentarians
• Tourisms
• Others

Other sectors and agencies responsible for implementing aspects of each capacity may be included as needed. These might include private stakeholders such as industry bodies, medical associations and farmers' associations, or representatives of academia, etc. Fundamental to this multisectoral approach is the recognition that risks to human health can emerge not only from other humans, but also from domestic animals, livestock, wildlife, food, chemicals, and/or radiation. Adequate capacity to prevent, detect and respond to events or threats should, therefore, exist within all relevant sectors, and there should be established, functional mechanisms for routine collaboration and coordination between these sectors.

IHR monitoring and evaluation promotes and requires multi-sectoral partnerships with all relevant national stakeholders, and builds on existing sectoral assessments. Within this perspective, the IHR MEF will help to:
• Engage different sectors and stimulate their involvement in implementing the IHR
• Establish or reinforce national coordination mechanisms and identify stakeholders' roles
• Foster planning within the national budget cycle
• Encourage the updating and realignment of plans in various national sectors as a first step towards institutionalizing monitoring and evaluation mechanisms
• Identify gaps and corrective measures at the national or regional level
• Identify milestones to monitor progress.

4. COMPONENTS OF THE IHR MONITORING AND EVALUATION FRAMEWORK

The framework has four components:
1. Annual reporting to the World Health Assembly (mandatory)
2. After action review (voluntary)
3. Simulation exercise (voluntary)
4. Voluntary external evaluation

Developing a single metric to gauge the ability of a country's public health system to manage health security is a complex undertaking. The Review Committee report[6] recommended an action-oriented approach to the periodic evaluation of functional capacities. The instruments developed to support the framework, therefore, incorporate a more functional approach to evaluation.

The four components of IHR monitoring and evaluation framework

	IHR MONITORING AND EVALUATION FRAMEWORK			
	States Parties self-assessment annual reporting (SPAR)	After action reviews (AAR)	Simulation exercices (SimEx)	Voluntary External Evaluations
Purpose	Monitor progress towards implementation of IHR core capacities	Assess the functionality of capacities during real events	Assess the potential functionality of capacities for non-real events	Evaluates objectively IHR contribute to health security
Mandate	Mandatory	Voluntary	Voluntary	Voluntary
Focus	Existence of capacities	Functionality of capacities	Functionality of capacities	Existence of capacities
Periodicity	Annually	Within 3 months of specific real events	Regularly when required as part of the exercise programme	Every 4-5 years
Type	Quantitative	Qualitative	Qualitative	Quantitative

4.1 STATES PARTIES SELF-ASSESSMENT ANNUAL REPORTING

The purpose of the annual IHR States Parties self-assessment annual reporting[10] is to support States Parties and the WHO Secretariat in fulfilling their obligation to report annually to the World Health Assembly on the implementation of the IHR at national, intermediate and community/primary response levels (Annex 1 of the IHR (2005), and Article 54).

The SPAR tool is designed to create a quantitative assessment of progress towards implementing sustainable IHR capacities, identify the priority areas and monitor the implementation of corrective actions to address gaps.

Following the recommendations of the IHR Review Committee, WHO has developed the new tool to make it more concise and exploring ways to make it more evidence-based. The new tool is to be used for subsequent State Party report to the World Health Assembly in 2019.

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10 - WHO. IHR State Party self-assessment annual reporting tool (http://www.who.int/ihr/publications/WHO-WHE-CPI-2018.16/en/ accessed on 12 June 2018)

4.1.1 METHODOLOGICAL APPROACH

The updated IHR States Parties self-assessment annual reporting tool consists of the capacities needed to detect, assess, notify/ report and respond to public health events of national and international concern. These cover:

- IHR legislation and financing
- IHR strategic coordination
- Zoonotic events and the human-animal interface
- Food safety
- Laboratory
- Surveillance
- Human resources
- Emergency preparedness for response
- Health service Provision
- Risk communication
- Points of entry (POE)
- Chemical events
- Radiation emergencies.

These capacities are the results of the interpretation of the requirements in Annex 1A and 1B of the IHR. For each capacity, one to three indicators is used to measure the country's progress towards fully developed and functional IHR capacities. Indicators are further broken down to a number of activities or elements called "attributes," which further define the indicator in five capacity levels. For each indicator, a reporting country selects which of the five levels best describes the country's current point on the continuum of progress.

All attributes in one level should be in place to advance to the next level.

4.1.2 OUTPUTS

The information obtained through the States Parties self-assessment annual reporting tool is submitted by States Parties to the WHO Secretariat. Each year it is analysed and presented by capacity, and country, in a report of the Director-General to WHO governing bodies, and is also published on the WHO Global Health Observatory[11]. This information will also be used to develop regional and country profiles for monitoring progress, developing plans of action to addressed identified gaps, conducting simulation exercises or voluntary external evaluation missions in order to elucidate priorities, and other similar actions.

4.2 AFTER ACTION REVIEW

The Review Committee recommended that the functionality of national capacities should be best shown through how the national emergency management system handles a real public health event. An after action review (AAR) is a qualitative review of the actions taken to respond to an event. It is an in-depth review of the response actions taken during an actual public health event as a means of identifying gaps, lessons and best practices. An AAR offers a structured approach for individuals and organizations involved in the preparedness of and response to the event under review to reflect on their experiences and perceptions of the response, in order to systematically and collectively identify what worked and what did not, why, and how to improve. They aim to identify the actions needed to improve plans and response capabilities for future acute public health events.

More specifically, the objectives of an AAR are:
- To review actions undertaken at each phase of managing a public health event, to identify best practices and gaps
- To demonstrate the functionality of national capacities in preparing for, detecting and responding to a public health event
- To identify the corrective actions needed to institutionalize any lessons emerging from the management of public health events
- To address the challenges made evident through the AAR.

4.2.1 METHODOLOGICAL APPROACH

A full review of a public health event could cover all the actions taken to prepare for, detect, respond to and recover from an acute public health event. The scope of any given review is determined by the nature and magnitude of the event being reviewed, and the perceived opportunities for learning. It is articulated through clear, concise objectives. AARs can address all areas of the response, or they can be targeted on specific functions, to ensure focused discussion around priority learning areas.

Clear identification of the scope and objectives guides the planning process and overall strategy, and help determine the review period, resource requirements, and format. The scope and objectives also help to determine the methodology for information collection used to

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11 - WHO. Global Health Observatory – International Health Regulations http://www.who.int/gho/ihr/en/ (accessed on 12 June 2018)

conduct the review. An AAR generally takes the form of a structured, facilitated discussion with those directly involved in the response—although other forms of data collection, such as interviews or focus group discussions, can also be used to analyse best practices, lessons, and challenges.

For an AAR to be effective, it is recommended to take place within three months of the end of the event, so that the participants' memories are fresh. The frequency of AARs should be determined by national criteria and the frequency of public health events; however, ideally, a country should conduct an AAR after every emergency response, and at least once a year. The starting point of the AAR is to generate a qualitative review of the following:

• What should have happened in terms of the specific tasks during the response, in light of the plans and procedures in place?
• What actually happened during the emergency?
• Did this differ from what should have happened? How and why?
• What worked?
• What did not work?
• What actions need to be taken to strengthen response processes for next time?

Member States should select the event for which the AAR is conducted, although WHO can provide technical advice on request. The following initiation criteria should be considered for the AARs:

• At least one (1) of the thirteen (13) SPAR core capacities is reviewed, validated or tested
• The event was declared as a Public Health Event of International Concern (PHEIC), or was notified to WHO under the IHR (2005) Annex 2, or was a graded emergency under WHO Emergency Response Framework (level 2 or 3)
• When the Public Health Emergency Operations Centre (PHEOC) is activated following the occurrence of a PHE or due to an increased risk of occurrence.
• The event involved coordination and collaboration with sectors that do not routinely collaborate (e.g., chemical or radiological events, food safety event and natural disasters);
• When the AAR was recommended by WHO following an event that constitutes an opportunity for learning and performance improvement.

4.2.2 OUTPUTS

The outcomes and key findings should be recorded in written format capturing the main recommendations. Similarly to the voluntary external evaluation and similar assessments, recommendations from AAR should lead to implemented activities and be incorporated into appropriate planning cycles, such as the National Action Plan for Health Security (NAPHS). The recommendations should be specific, feasible, time-bound, measurable and adequately translated into an action plan, such as the NAPHS. For an AAR to be considered as part of the IHR (2005) monitoring and evaluation process, a minimum set of information should be shared with WHO. It will enhance trust, mutual accountability, and transparency among the Member States, WHO and partners.

An example of an action plan following an AAR and further guidance on the outputs and minimum reporting requirements can be found in the AAR/SimEx Country Implementation Guidance[12].

4.3 SIMULATION EXERCISES

A simulation exercise is a form of practice, training, monitoring or evaluation of capabilities, involving the description or simulation of an emergency to which a described or simulated response is made. SimEx can provide an evidence-based assessment of functional capacities to respond to emergencies and to strengthening preparedness and response. Exercises are useful tools for identifying and assessing levels of preparedness and may be used at each stage of emergency preparedness development to test the practicality, adequacy, sufficiency, and efficiency of proposed plans and procedures.

Exercise recommendations and corrective actions are essential to improve response systems and mechanisms to manage emergencies in the future. In this sense, the simulation exercise is vital components of the emergency preparedness cycle. Simulation exercises are primarily used when no suitable event is available for an AAR. They can also be used to test or validate the capacity to respond to rare events such as chemical and radio-nuclear events as appropriate.

The scope of an exercise could vary from testing the functioning of the whole response system

in addressing a public health emergency, to validating particular functions of it (e.g., the responsibilities of the National IHR Focal Point) or testing it at a particular sub-national level. Exercises can also be used to monitor whether the gaps identified through SPAR, AARs and voluntary external evaluations have been implemented and improved as planned. Simulation exercises are not used exclusively to test one function; rather, they are practical and flexible instruments that can be used and adjusted to test or validate various functionalities of a response system.

4.3.1 SELECTION OF EXERCISES

Exercises can be discussion-based or operations-based. A practical exercise manual is available on the WHO website[13]. Discussion-based exercises familiarize participants with or refine current plans, policies, agreements, and procedures. Discussion-based exercises include table-top exercises. A series of table-top exercises to assist the validation of IHR capacity implementation levels is available on the WHO website . Operations-based exercises validate plans, policies, agreements, and procedures; clarify roles and responsibilities; and identify gaps in an operational environment. Operations-based exercises include drills, functional exercises and field/full-scale exercises.

Simulation exercises are selected and planned according to national priority risks and the national response capacity (national response plans). They are not one-time events but should be undertaken as part of a carefully designed exercise programme that addresses a common strategic objective. Setting up a comprehensive exercise programme is essential for planning simulation exercises. It should be noted that an exercise programme may be part of a planning cycle.

For a SimEx to be considered as part of the IHR voluntary monitoring and evaluation, one or more of the following inclusion criteria should be considered:
- At least one (1) of the thirteen (13) SPAR capacities is reviewed, validated or tested
- The simulated event (scenario) could be notified as an event that may constitute a Public Health Emergency of International Concern (PHEIC) under the IHR decision instrument (annex 2)

- The scope of the simulation exercise includes multiple sectors and/or countries
- Conducting the SimEx was recommended by one of the IHR MEF instruments including SPAR, JEE or AAR

4.3.2 OUTPUTS

The outcomes and key findings should be recorded in written format capturing the main recommendations. Similarly to the voluntary external evaluation and similar assessments, recommendations from SimEx should lead to implemented activities and be incorporated into appropriate planning cycles, such as the National Action Plan for Health Security (NAPHS). The recommendations should be specific, feasible, time-bound, measurable and adequately translated into an action plan, such as the NAPHS. In order for a SimEx to be considered as part of the IHR (2005) monitoring and evaluation process, a minimum set of information should be shared with WHO. This will enhance trust, mutual accountability and transparency among the Member States, WHO and partners.

An example of an action plan following an AAR/SimEx and further guidance on the outputs and minimum reporting requirements can be found in the AAR/SimEx Country Implementation Guidance[14].

4.4 VOLUNTARY EXTERNAL EVALUATION

The Review Committee report recommended that:
…the Secretariat should …move from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts.

The call to move from exclusive self-evaluation to external evaluation follows the recognition that collective implementation of the IHR requires transparency and mutual accountability in the international community.

The purpose of the voluntary external evaluation is to measure country-specific status and progress in achieving the targets set by the IHR. A voluntary external evaluation helps countries identify their most critical gaps and prioritize opportunities for enhanced preparedness and response. It also helps them engage with current and prospective technical and financial partners to mobilize resources.

13 - WHO Simulation Exercise Manual (http://www.who.int/ihr/publications/WHO-WHE-CPI-2017.10/en/ accessed on 12 June 2018)
14 - World Health Organization. Core Capacity Workbook. WHO/HSE/GCR/2015.13 (http://apps.who.int/iris/bitstream/10665/190819/1/WHO_HSE_GCR_2015.13_eng.pdf?ua=1 accessed on 12 June, 2018))

Transparency is essential for attracting resources and directing them to where they are needed most. The voluntary external evaluation process is characterized by some important features, including but not limited to:

1. Voluntary country participation
2. A multisectoral approach
3. An open, collaborative process for assessing capability
4. Possible peer-evaluating-peer approach
5. Use of findings of previous assessments and expert opinion
6. In-depth evaluation of capacities or technical areas.
7. The openness of data and information sharing
8.. The public release of reports.

The voluntary external evaluation is recommended to conduct by evaluators from outside the country or by local independent experts. It is therefore important that voluntary external evaluations are paired with incentives for countries to request them.

4.4.1 METHODOLOGICAL APPROACH

WHO recommends using the Joint External Evaluation (JEE) Tool for the voluntary external evaluation process. The process provides opportunities for technical discussions, advocacy through success stories, and further collaboration with partners. It also provides an important basis for developing and implementing national action plans. It is recommended that this vigorous process can be done only every 4-5 years.

The JEE tool evaluates 19 technical areas:
1. National legislation, policy and financing
2. IHR coordination, communication and advocacy
3. Anti-microbial resistance (AMR)
4. Zoonotic disease
5. Food safety
6. Biosafety and biosecurity
7. Immunization
8. National laboratory systems
9. Real time surveillance (Surveillance in the second edition)
10. Reporting
11. Workforce development (Human resources in the second edition)
12. Preparedness (Emergency preparedness in the second edition)
13. Emergency response operations
14. Linking public health and security authorities
15. Medical countermeasures and personnel deployment

16. Risk communication
17. Points of entry (POE)
18. Chemical events
19. Radiation emergencies.

Each capacity contains one or more indicators, each of which is divided into five levels of achievement, defined through a series of attributes. The implementation status of each capacity is indicated by a score, which reflects the country's level of advancement, its capacity to institutionalize technical area competencies, and ensure that they are sustainable. A host country will have a score out of five that reflects the country's capacity at the time of the review for each indicator.

Depending on the needs and request of the Member States, WHO can recommend other forms of voluntary external evaluations like an in-depth review of the technical area, periodic review of the functional capacities and risk-specific voluntary external evaluation.

4.4.2 PROCESS OF VOLUNTARY EXTERNAL EVALUATION

The voluntary external evaluation is completed in two stages:
1. An initial self-evaluation conducted by the host country
2. An in-country evaluation conducted by an external evaluation team of subject matter experts, done in close collaboration with peer national authorities

The voluntary external evaluation team works in a fully collaborative, peer-to-peer manner with the host country experts to evaluate current capacity. This work includes but is not limited to:
• Identifying strengths and best practices, areas which need strengthening, and the challenges
• Assigning scores
• Identifying the three to five key priority actions for each technical area that will most effectively increase the country's ability to prevent, detect and respond rapidly to health emergencies, whether naturally occurring, deliberate or accidental.

Preliminary results are presented to the host country's high-level representative, typically at the ministerial level, on the final day of the mission. A final draft report is provided to the host country for feedback, usually within two weeks of the end of the mission, after which it is posted online and is publically accessible.

Other types of voluntary external evaluations such as an in-depth external evaluation of capacities like laboratory, surveillance, etc. can be proposed based on the needs and request of the Member States.

4.4.3 OUTPUTS

All the findings and recommendations of the voluntary external evaluation will be made publicly available on the WHO website, subject to the host country's agreement. Countries are encouraged to use these findings to address country-specific priorities and to include them in national health sector planning.

Before committing to a voluntary external evaluation, it is expected that the host government will identify resources to address the gaps and maintain the achievements the evaluation will identify. Technical and financial partners are also expected to commit to supporting States Parties that have conducted some forms of the voluntary external evaluation.

4.5 MONITORING COMPLIANCE WITH OTHER IHR REQUIREMENTS

4.5.1 MONITORING COMPLIANCE WITH IHR REQUIREMENTS FOR ESTABLISHING THE NATIONAL IHR FOCAL POINTS, AND FOR COMMUNICATION AND INFORMATION VERIFICATION

Under Article 4 of the International Health Regulations (2005) (IHR (2005)), all States Parties are required to designate or establish a National IHR Focal Point (NFP, which is a centre that shall be accessible at all times for urgent communication with WHO). There is a system by which WHO, including through the regional IHR contact points, regularly verifies the availability of the NFPs, as well as regularly updating and improving the skills of the NFPs (guidance, exercises).

Under Articles 6 to 10, the NFPs are required to communicate to WHO information about events that may constitute a public health emergency of international concern, as well as to respond within 24 hours to WHO's request for verification of information. Compliance with these requirements can be regularly assessed through analysis of the information collected through the Event Information Site, which is a secure web-based platform established by WHO for communications with NFPs on public health events.

4.5.1 MONITORING COMPLIANCE WITH IHR REQUIREMENTS IN RELATION TO ADDITIONAL HEALTH MEASURES

Under Art 43, States Parties can implement health measures or additional health measures, but these should not be "more restrictive or intrusive than reasonably available alternatives that would achieve the appropriate level of health protection" and must be based on scientific principles and scientific evidence.

If the measures "significantly interfere with international traffic" (i.e., refusal or entry or departure of travelers, goods, cargos, or delay for more than 24h), States Parties are required to inform WHO within 48h and provide WHO with public health rationale and the scientific evidence. WHO is required to share the public health rationale and scientific information to all States Parties through the event information site (EIS) website.

If, after reviewing the public health rationale and scientific evidence, WHO deems the measures not justified, it will request the State Party to review the measures within 3 months (which SPs are obliged to do under Art 43.6).

WHO is implementing a new tool to monitor compliance with the International Health Regulations (2005) (IHR 2005) regarding additional health measures. The tool relies on media reports to identify potential outbreak-related trade and travel sanctions and utilizes a standard set of procedures for verification and compliance. For example, when measures that significantly interfere with international traffic or trade are detected, the WHO will contact the government(s) concerned to obtain formal verification and the scientific justification for why the measures have been implemented. Once verified and assessed, the WHO will share this information with other governments via the organisation's EIS. Where measures are incommensurate with the public health risk, or they significantly interfere with international traffic or trade, the WHO will then work with the government(s) concerned to see them removed or amended. A summary and analysis of these measures are included in the DG IHR Annual report to the WHA.

5. OPERATIONALIZING THE IHR MONITORING AND EVALUATION FRAMEWORK

5.1 ENSURING LINKAGES OF THE FOUR COMPONENTS FOR IHR CAPACITIES

It is important that the results of these four components are viewed holistically and interpreted together to obtain a comprehensive view of the current status of IHR implementation, noting that only the SPAR is mandatory. These components complement each other to evaluate IHR capacities and their functionality, objectively. These evaluation findings of one or all com-ponents and other assessments like risk profiling can serve as one of the bases for countries to develop and implement national action plans in collaboration with multiple sectors, using a One Health approach and strategic partnership. These plans translate priority recommendations of various evaluations' findings into actions to strengthen capacities of the Member States and ensure they are operationally ready for any public health risks and events.
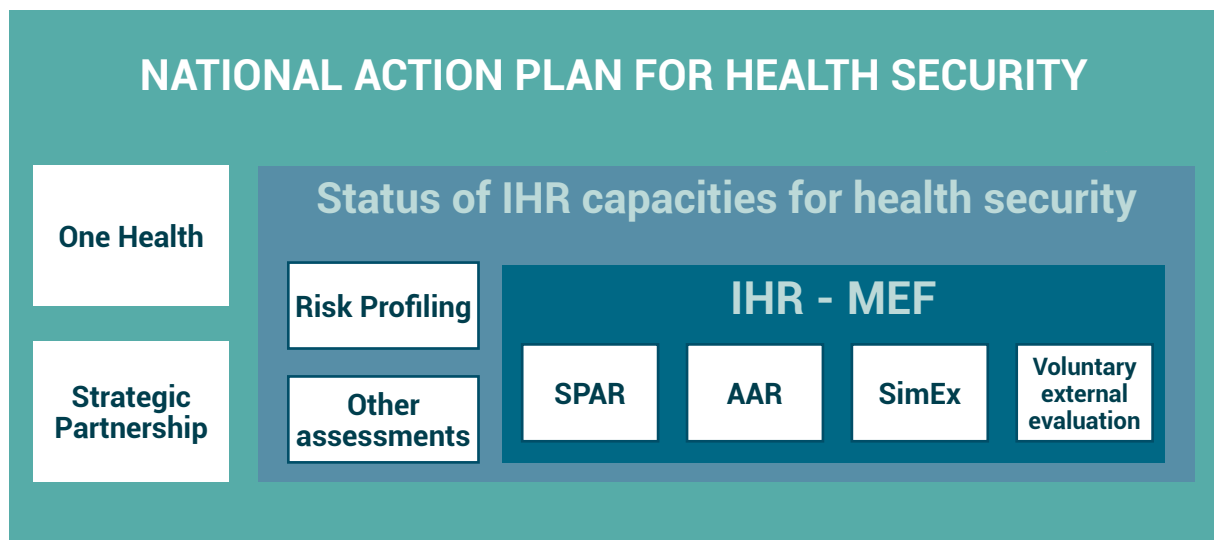
1. The IHR State Parties self-assessment annual reporting can serve to measure the current status of capacity development, providing the context of IHR capacities, annual monitoring of progress of implementation of the national action plan for health security and can provide context for an AAR or simulation exercise.

2. The simulations exercises and the after action reviews contribute to the evaluation of functional capacities based on simulated or real events respectively. They can review the findings of the annual reporting and voluntary external evaluation and prioritize capacity building activities. They can inform preparedness and operational readiness and can guide for corrective actions (testing, and strengthening)

3. The voluntary external evaluation can measure the current status of IHR capacities for health security, and guides the priority actions that are required to strengthen capacities with the support of external expertise and can inform for simulation exercises and after action reviews.

4. Findings of each component can be trian-gulated to evaluate the functional status of IHR capacities along with other assessments and risk profiling.

5.2 IMPLEMENTING THE FRAMEWORK

5.2.1 COORDINATION OF THE IHR MEF AT GLOBAL, REGIONAL AND COUNTRY LEVELS

The IHR MEF is based on the mandatory and three voluntary instruments which provide complementary qualitative and quantitative information for States Parties and the WHO Secretariat, individually or collectively. High-level engagement and commitment for the sustainable implementation of the IHR MEF are therefore crucial. As the custodian organization for the IHR, WHO works to implement the IHR MEF at global, regional and country levels through the strategic partnership with governments, partners and agencies.

5.2.2 BRIDGING THE HUMAN-ANIMAL INTERFACE

WHO and international organizations like the World Organisation for Animal Health (OIE) and the Food and Agriculture Organisation of the United Nations (FAO) are working together to strengthen collaboration across the human and animal health sectors in the implementation of the IHR (2005) for global health security. They have developed the tools and methods that have ensured the contribution of the veterinary sector in each of the components of the IHR MEF. These tools help on the joint review to find the synergies and existing gaps in the coordination between the two sectors, at the local, national and international levels. The International Health Regulations-Performance of Veterinary Services Pathway (IHR-PVS) National Bridging Workshop is one of these tools, which is used in the countries to support the development of roadmaps to strengthen coordination mechanism for the implementation of the IHR (2005) at the human and animal interface.

5.2.3 DATA ANALYSIS AND DISSEMINATION

Data is the basis for all sound public health actions, and the benefits of data-sharing are widely recognized, including scientific and public health benefits. Whenever possible, the WHO promotes the sharing of IHR M&E data and information to enhance transparency, trust, and mutual accountability.

The WHO Secretariat will maintain a database to conduct the analysis of the data from these four components of the IHR MEF, data from risk assessment and other assessments. The primary objective of this analysis is to generate authoritative information to strengthen and sustain IHR capacities for the preparedness. The WHO Secretariat will establish an interactive data query system (Preparedness Dashboard) in a public domain.

5.2.4. EXPERIENCE SHARING AND COMMUNICATION

Sharing lessons and best practices from the four components of the IHR MEF helps foster a transparent collective learning process for each State Party. In line with the principles of transparency and mutual accountability, the WHO Secretariat encourages countries to share the results of the IHR MEF with all other WHO Member States. Capacity scores from the IHR monitoring questionnaires (2010-2016) are available on the Global Health Observatory[15] and reports of the voluntary external evaluation like the JEE reports from those countries that have volunteered are posted on the WHO website[16].

5.2.5 RESOURCES

WHO plays a key role in mobilizing human, financial and logistical resources to implement the components of the IHR MEF. These resources are required to develop tools, guidance and training packages; to conduct missions and workshops; and to disseminate and apply findings. WHO works with various donors, partners, and the Member States to mobilize resources.

5.2.6 PROVISION OF TECHNICAL SUPPORT TO COUNTRIES

A number of the Member States have identified and expressed limitations in their capacity to monitor and evaluate IHR implementation and have requested technical assistance. WHO has responded, in collaboration with its partners, and provides technical assistance in the implementation of the IHR MEF through:

1. Building capacity to implement the components of the IHR MEF by providing the specific guidance and tools and conducting training

15 - WHO- Global Health Observatory, International Health Regulations (http://www.who.int/gho/ihr/en/ accessed on 12 June 2018))
16 - Joint External Evaluation Mission Reports (http://www.who.int/ihr/ procedures/mission-reports/en/ accessed on 12 June 2018)

2. Analysis of data and dissemination of information to assist programme prioritization and decision making

3. Assisting with the development of national action plans for the implementation of IHR capacities.

4. Monitoring and evaluation of the capacity building activities to ensure that countries are operationally ready with tested and updated emergency preparedness and response plan for all types of public health risks or events.

5. Supporting multisectoral partnership by engaging relevant public and non-state actors of the implementation of IHR and health security.

CONTACT DETAILS

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