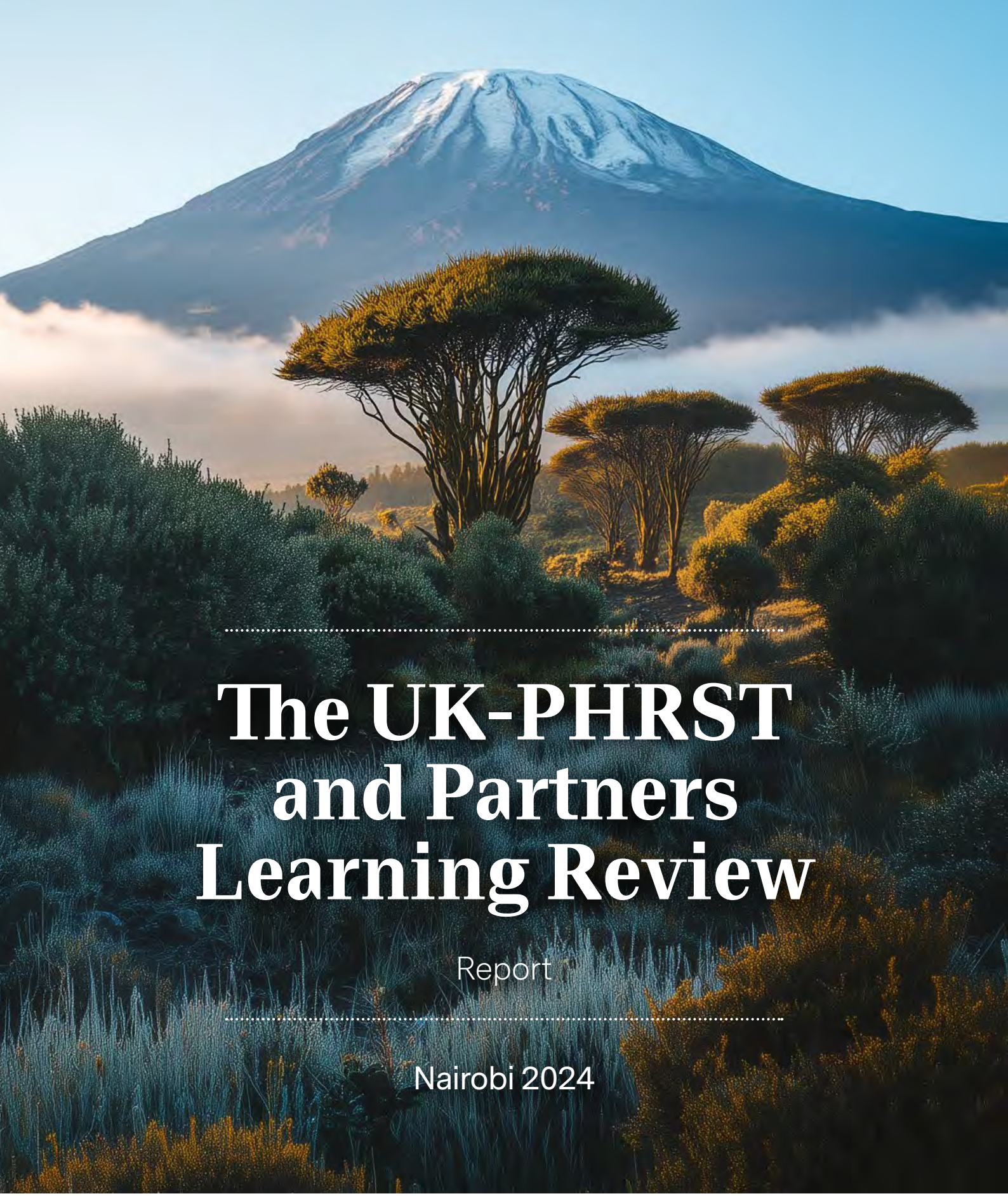

The UK-PHRST and Partners Learning Review

Report

Nairobi 2024

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

UK Health Security Agency

Department of Health & Social Care

UKaid from the British people

NPHI KENYA NATIONAL PUBLIC HEALTH INSTITUTE

Feedback is the breakfast of champions.

Blanchard, Kenneth H. and Spencer Johnson. *The One Minute Manager.* 1st Morrow ed.New York, Morrow, 1982.

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Foreword

Dr Edmund Newman
Director, UK Public Health
Rapid Support Team

The UK Public Health Rapid Support Team (UK-PHRST) has consistently strived to foster equitable partnerships and strengthen global health security through its three pillars: deployment, research, and capacity strengthening. This Learning Review marks another significant milestone in our journey of collaboration and sharing learning, reflecting on our achievements over the past 18 months and identifying strategies to enhance our impact moving forward.

The fourth UK-PHRST Partners' Learning Review, held in Nairobi from June 25-27, 2024, represents more than just a periodic evaluation of our work; it is a testament to our commitment to continuous improvement and meaningful collaboration with our partners. This event brought together a diverse group of stakeholders, including representatives from 11 partner countries, regional bodies, academia, and global health organisations. The presence of such a wide array of participants underscores the importance of our collective effort in tackling public health challenges and highlights the shared commitment to improving global health outcomes in the area of outbreak response and readiness to respond.

Reflecting on the proceedings of this review, it is clear that our approach, grounded in equitable partnership, has yielded substantial progress – with a lot of appreciation for how UK-PHRST works with our partners. The discussions and feedback from our partners have reinforced the value of our work and provided critical insights into how we can continue to evolve and adapt to meet emerging health threats and the changing landscape in which we operate, which is increasingly crowded and complex with many threats now being exacerbated by climate or conflict and humanitarian crises. Notably, the emphasis on sustainable impact and the integration of mental health considerations into our activities stands out as a key area of focus for the future. The discussions also underscored the importance of community engagement and the need to align our efforts with the needs and priorities of the communities we serve.

One of the most profound takeaways from this review is the collective recognition of the importance of equitable partnerships. Our partners have voiced their appreciation for the collaborative approach we have adopted, which ensures that our work is co-created, co-designed, and co-delivered. This model of partnership not only fosters trust and respect but also ensures that the interventions we implement are sustainable and aligned with the local context. The success stories shared during the review are a testament to the effectiveness of this approach.

As we move forward, the recommendations from our partners at this review will serve as a roadmap for enhancing our work: This Learning Review has not only provided an opportunity to reflect on our progress, but also to look ahead with renewed focus and determination. The recommendations and insights gained from this event will shape the next phase of the UK-PHRST's work, ensuring that we continue to build on our strengths while addressing the challenges that lie ahead, to meet the needs of our partners, in a way that delivers good value for money by ensuring sustainable impact.

In conclusion, I would like to extend my heartfelt thanks to all the participants of this review for your engagement. Your contributions have been invaluable in shaping the direction of our work, and your appreciation of UK-PHRST's work has been truly humbling. Together, we will continue to strive towards our shared goal of enhancing global health security and response and making a lasting impact on the communities most affected but infectious disease outbreaks.

Acknowledgements

We wish to express our thanks to the UK-PHRST and Partners for making the Nairobi, Kenya Learning Review such a rich learning experience. In particular we wish to thank the UK-PHRST senior management team for their demonstrated commitment to learning; the Director of the Kenya, National Public Health Institute, Dr Maureen Kamene Kimenye for so gracefully opening the event; panellists, chairs and all others who participated in making this Learning Review such a success. In addition, we are grateful for the efficiency of the UK-PHRST organising team (Lisa Aissaoui, Sam Moreton, and Arthur Steeds) who worked behind the scenes to ensure a fruitful experience for all in attendance; and for the photography skills of UK-PHRST's Communications Officer, Ignatius-Roy Hillcoat-Nalletamby, who took all the photographs at the event.

Contributors to this publication

All participants of this Learning Review contributed to this publication – as panellists and discussants.

This report is authored by Dr Femi Nzegwu.

Department of Health and Social Care Disclaimer

Acronyms

AAR	After Action Reviews
Africa CDC	Africa Centres for Disease Control and Prevention
AVoHC	African Volunteers Health Corps
CTCs	Cholera Treatment Centres
ESAR	East and Southern Africa Region
FCDO	Foreign, Commonwealth and Development Office
GHEC	Global Health Emergency Corps
GOARN OST	The Global Outbreak Alert and Response Network Operational Support Team
GPW 14	The Fourteenth General Programme of Work
GRSS	Government of the Republic of South Sudan
IFRC	International Federation of Red Cross and Red Crescent Societies
IPC	Infection Prevention Control
KEMRI	Kenya Medical Research Institute
MHPSS	Mental Health and Psychosocial Support
MoHs	Ministries of Health
ODA	Official Development Assistance
PHE	Public Health Emergency
RQA	Rapid Qualitative Assessment
SimEx	Simulation Exercise
UHC	Universal Health Care
UK-PHRST	UK Public Health Rapid Support Team
UNICEF	United Nations International Children's Emergency Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WHO AFRO	World Health Organization African Region

If you want to increase the capacity of the world to respond to emergencies in the future, we need to know each other, we need to know how to work with each other and we need to know to respect the knowledge, the advantages and the disadvantages of each partner.

Learning Review participant.

Executive Summary

Executive Summary

The fourth UK-PHRST & Partners' Learning Review was held in Nairobi from 25-27 June, 2024. Co-hosted by the Kenya National Public Health Institute (K-NPHI) and the UK-PHRST, the event was a reflective review of the UK-PHRST and partners' joint work over the preceding 18 months, evaluating our strengths and weaknesses and recommending improved ways of working.

Participants of the review included staff from UK-PHRST (representing the three pillars of our work and senior representation from our technical teams), 11 country partners, director generals from national public health authorities of four countries (Cape Verde, Kenya, Somaliland and Zambia), four regional bodies (Africa CDC, WHO, UNICEF, IFRC), academia, the UK Department of Health and Social Care (DHSC) and the Foreign Commonwealth & Development Office (FCDO). Sixty people registered for the event – an average of fifty people were present over the three days.

Our intent was to carry out a structured, interactive and shared reflective learning exercise to understand the nature of our successes, challenges and what we could do better to work more effectively within our remit of infectious diseases outbreak response/readiness to respond. There were three specific objectives:

1. **Review key learning from the last 18 months of UK-PHRST and partners' collaborative working – to include deployment, research and capacity strengthening and underpinning themes of mental health and partnership.**
2. **Agree ways of working that build on our good practice, minimise and eliminate poor practice and encourage sustainable ways of working.**
3. **Contribute to shaping the next phase of the UK-PHRST's work.**

Dr Ed Newman (director of UK-PHRST) set the scene for the event by presenting an overview of the work of the UK-PHRST since the last review. In his words, the UK-PHRST had called the Learning Review because "we are committed to equitable partnerships and strive to ensure our work across all three pillars of our mandate is in response to needs identified by our partners and that workplans are co-created and co-delivered wherever possible." Dr Kamene Kimenye (director of Kenya-NPHI) opened the event and warmly welcomed members of the review to her country. She shared thirteen key public health issues that she sees as vital to promoting health security nationally, regionally and globally. She also called for a re-focus on the very real threat to global health – non-communicable diseases alongside the emerging threat of climate change. Thom Banks (UK-PHRST Programme Manager & Senior Management Team member) supported by Sarah Armstrong (UK-PHRST Training Manager) and Olive Leonard (UK-PHRST Social Equity & Human Rights Officer) provided the group with an update on the status of recommendations generated in the 2022 review. The 2022 review was held in Cape Town and attracted 36 participants (10 country partners, two regional bodies, four universities and DHSC). Thirty-five recommendations were generated and 20 of these were adopted as priority areas of work.

The significant progress achieved to date in their implementation was presented by the group.

Three panels were held on day 1. **Panel 1** was on capacity strengthening in practice and considered whether and how capacity strengthening activities had been delivered with sustainable impact for outbreak preparedness and response. Panellists were Dr Charles Njuguna (Regional Advisor, Country Readiness Strengthening AFRO), Dr Amal Ali (Technical Advisor to the Director General, Ministry of Health Development, Somaliland), Ms Rachel James (Risk Communication and Community Engagement Coordinator, East and Southern Africa, IFRC) and Dr Radjabu Bigirimana (Technical Officer & AVoHC Programme Lead, Africa CDC). The next panel, **Panel 3** (panel 2 was deferred to day 2) reflected on UK-PHRST's research approach – in particular, how we work together in research partnerships and what methodologies we should use to ensure we achieve impactful research. Panellists were Dr George Githinji (Researcher, Kenya Medical Research Institute & co-PI RaVIG project), Professor Dimie Ogoina (Chief Medical Director of the Niger Delta University Teaching Hospital) and Dr Maria da Luz Lima (President of the National Institute of Public Health of Cape Verde).

Panel 4 on deployments was the last session of the day where panellists reflected on how best to make deployments more context specific to partner needs. Panellists were Professor Roma Chilengi (Director General, Zambia National Public Health Institute – ZNPHI), Dr Martins Livinus (Emergency Preparedness & Response Team Lead, WCO Kenya), Ms Sara Hollis (Team Lead, Health Information & Risk Assessment WHO Nairobi hub – but representing GOARN OST) and Mr Achwanyo Kutjok (Health Advisor, British Embassy, Juba).

Day 2 kicked off with **Panel 5,** a discussion and reflection session on the makings of good partnership between Professor Gwenda Hughes (Deputy Director and head of Research, UK-PHRST) and Dr Chinwe Ochu (Director of Planning, Research and Statistics at the Nigeria CDC) where a candid discussion on the true elements of good partnership were explored. Group work sessions on capacity strengthening, deployments

and research followed in which people were asked to reflect on priorities for improving the work of the pillar being discussed. On research, priorities were to focus on ways of improving impact in the next research plan; on deployment the focus was on enabling greater alignment of deployments objectives with partner needs; and on capacity strengthening as the focus was on improving the impact and sustainability of capacity strengthening activities in the next phase of UK-PHRST's work with partners.

Three parallel panels were held in the afternoon of day 2 – panels 6,7 and 8. **Panel 6** session was introduced and chaired by Dr Nadine Beckmann. Panellists were Dr Gbenga Joseph (Deputy Director, Nigeria Centre for Disease Control), Dr Elizabeth Shayo (Principal Research Scientist, National Institute for Medical Research, Tanzania), Professor Jonas Brant (Professor of Public Health, Epidemiology & Health Surveillance, University of Brasilia) and Dr Anastasiia Atif (Social and Behaviour Change Emergency Specialist, UNICEF).

Dr Newman introduced **Panel 7** with an overview of the global health architecture. The four panellists were Professor Roma Chilengi, Dr Kamene Kimenye, Dr Radjabu Bigirimana and Dr April Baller (IPC & WASH Team Lead, Country Readiness Strengthening Department, WHO Health emergencies programme, Geneva). **Panel 8** on integrating the three pillars of UK-PHRST's work at country level was the last panel of the day. The panel was introduced and chaired by Dr Claire Bayntun (Head of Capacity Strengthening, UK-PHRST). Three panellists reflected on the desirability and feasibility of this at country level. Panellists were Dr Kola Jinadu (Consultant and Technical Officer, WHO), Dr Abdul Sesay (Head of Genomics Strategic Core Platform, MRC Unit The Gambia at LSHTM) and Dr Abiodun Egwuenu (ISID Emerging Leader in International Infectious Diseases & Epidemiologist, NCDC).

Day 3 was devoted to pulling together the final set of recommendations. A summary of discussions in the 5 thematic areas considered on day 2 – capacity strengthening, deployment, research, partnership working and mental health and wellbeing – was shared with the meeting in a plenary session. A detailed discussion ensued from which a final set of recommendations was generated. A gallery walk was then undertaken by all workshop delegates to prioritise the recommendations. Thirteen recommendations were ultimately adopted as the key priorities to incorporate into the work of the UK-PHRST.

The day and event concluded with a conversation about the future and focus of the UK-PHRST and partners' work. The three panellists were Dr Ed Newman, Dr Kamene Kimenye and Dr Charles Njuguna. In their discussion 11 key themes were highlighted as core to our collective efforts to continue to build on our partnership and our joint commitment to work towards a world where global health security threats are minimised.

There was significant appreciation from participants for both the approach and demonstrated impact of the work of the UK-PHRST, including a request to document our approach and share more widely with the sector as an example of good practice.

Background to the review

Background to the review

The fourth UK-PHRST & Partners' Learning Review was held in Nairobi from 25-27 June, 2024. Co-hosted by the Kenya National Public Health Institute (K-NPHI) and the UK-PHRST, the event was a reflective review of the UK-PHRST and partners' joint work over the preceding 18 months, evaluating our strengths and weaknesses and recommending improved ways of working.

Participants of the review included staff from UK-PHRST, 11 country partners, director generals from four countries (Cape Verde, Kenya, Somaliland, Zambia), four regional bodies (Africa CDC, WHO, UNICEF, IFRC), academia, the UK Department of Health and Social Care (DHSC) and the Foreign Commonwealth & Development Office (FCDO). Sixty people registered for the event – an average of fifty people were present over the three days. Sectors represented included research, deployment, capacity strengthening and mental health and wellbeing.

Our intent was to carry out a structured, interactive and shared reflective learning exercise to understand the nature of our successes, challenges and what we could do better to work more effectively. There were 3 specific objectives:

1. **Review key learning from the last 18 months of UK-PHRST and partners' collaborative working – to include deployment, research and capacity strengthening and underpinning themes of mental health and partnership.**
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What happened during the event?

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The review was conducted as a highly participatory three-day event which occurred mostly as panel and group discussions to capture a rich range of views and practice. This was supplemented with Q & A sessions, plenary discussions and a gallery walk of workshopped-posters.

The account of the different session that occurred over the three-day event is detailed as follows.

Day 1

Setting the scene

Dr Ed Newman (Director of UK-PHRST) set the scene for the event by presenting an overview of the work of the UK-PHRST. In his words, the UK-PHRST had called the learning review because "we are committed to equitable partnerships and strive to ensure our work across all three pillars of our mandate is in response to needs identified by our partners and that workplans are co-created and co-delivered wherever possible." As an overview of the team's work Dr Newman summarised the UK-PHRST's journey since the previous learning review in 2022:

On deployments (response): 28 individuals were deployed to 15 countries/territories in that period covering eight health disciplines, five different disease outbreaks and humanitarian situations. 100% of partners identified tangible contributions made by UK-PHRST deployees; 60% stated that the deployments had fully contributed to strengthening their own health systems while 40% reported that there had been a partial contribution.

On research: since the last review 12 new research projects had been added while six had been completed or were nearing completion. There were 33 research outputs in that period including two peer reviewed publications. To raise the profile and encourage implementation of the study findings, 64% of the research studies had been considered by practice or policy-related stakeholders

locally, nationally, regionally or internationally through publications, workshops, policy briefs, blogs, launch/dissemination events and stakeholder meetings. Eighty-one per cent of partners assessed the UK-PHRST research partnerships as effective and 15% as fairly effective.[1]

On capacity strengthening: the capacity strengthening arm of the UK-PHRST has undergone a reformulation and expansion since the last review. Five theme areas of concentration constitute the core elements of the pillar's work – Community Protection, Emergency Coordination Leadership, One Health, Research Capacity Strengthening and Technical Activities, as well as advice and provision of subject matter expertise. The number of capacity strengthening activities grew from 22 to 54 over the two years since the previous review. Capacity strengthening partners found 100% the initiatives useful.[1]

On partnership as an underpinning value: 61% assessed the UK-PHRST as very effective in supporting partners to achieve their goals, 31% as fairly effective and 3% as not very effective.[1]

Official opening

Dr Kamene Kimenye (Director of Kenya-NPHI) opened the event and warmly welcomed members of the review to her country. She shared the 13 key public health issues she sees as vital to promoting health security. First was the need for equity in all partnerships and especially on the international scene, citing the International Health Regulations and the Pandemic Treaty. Second was the need to strengthen national public health institutes to be at the forefront of coordinating essential public health functions to improve outbreak management and strengthen the capacity of the public health workforce overall. Third was ensuring that there remains a multi-sectoral approach that collaborates with other stakeholders in the health security sector. Fourth was the need to promote national security and minimise national conflicts that impact a country's health security. Fifth, the need for local manufacturing and the innovative suggestion of pooled procurement by developing nations to share cost effective health products and technologies whilst encouraging economic growth.

Her next three issues focused on strengthening laboratory capacities, health intelligence and safe data sharing; investing in research and innovation nationally and promoting technological advancements in public health to enhance surveillance, and outbreak management. As a means to facilitate this she advocated, as the ninth issue, the adoption of models of outbreak management that reduce bureaucracy and promote efficient and timely responses to emergencies.

The last three public health issues discussed by Dr Kimenye were leveraging the private sector to invest in, promote healthy lifestyle and ensure the production of safe and quality food for the nation, thereby addressing the needs of both the aging population on the one hand, and a young, vibrant population on the other. Dr Kimenye ended with a call to re-focus efforts on the very real threat to global health – non-communicable diseases alongside the emerging threat of climate change – and to adopt a holistic approach to population health.

Thom Banks (UK-PHRST Programme Manager & Senior Management Team member) supported by Sarah Armstrong (UK-PHRST Training Manager) and Olive Leonard (UK-PHRST Social Equity & Human Rights Officer) provided the group with an update on the status of recommendations generated in the 2022 review. The 2022 learning review was held in Cape Town, and attracted 36 participants (10 country partners, two regional bodies, four universities and DHSC). Thirty-five recommendations were generated and 20 of these were adopted as priority areas of work. The significant progress achieved to date in their implementation was presented. Table 1 below captures core recommendations where progress has been recorded under the deployment, research and capacity strengthening pillars.

1. Nzegwu, F. (2024). 'Annual Partner Feedback (MEL) Report Year 8: 2023/2024'.

Table 1: Progress recorded on the recommendations of the 2022 Cape Town Learning Review

On deployments	Progress made
Lay the groundwork for effective deployment.	Standardised pre-deployment meetings with partners are done as good practice wherever possible for all UK-PHRST deployments.
Encourage greater clarity of assignment.	UK-PHRST collaborates on ToRs before deployment through discussion with GOARN and for bilateral ToRs/ deployments (e.g., Zambia).
	There is a learning objective in UK-PHRST's deployment training on ensuring ToR flexibility whilst recognising that we must remain within our remit.
Shift roles of deploying agency/deployee: Actively shift international support to a capacity strengthening role.	Exploring opportunities for capacity strengthening during deployment now included in all pre-deployment briefings and during pre-deployment training.
Assess deployment impact: Develop a framework to assess impact of deployments.	Impact study on international deployments is nearing completion and will lead to a proposed framework for evaluating deployments.
	Partner feedback collected after every deployment.
On Research	
Expand scope of research activities to include research or impact studies that focus on the post-deployment period, specifically on how to expand and strengthen our partnerships.	Impact of deployments study in partnership with Africa CDC includes consideration of strengthening partnerships post deployment, highlighting the need to need to establish a framework for post-deployment evaluations.
Establish guidelines for undertaking research: Co-develop and publish equitable partnership principles/guidance on partnering with UK-PHRST.	Equitable partnership principles included in research plan and included in annual reviews.
	All 12 new research projects were identified as priorities by partners and all proposals co-created and co-delivered with partners.
Identify and embed research opportunities within existing networks of expertise, organisations or systems to support the strengthening/growth of research systems in countries.	Re-established relationship/partnership with the global health network (TGHN).
	Strengthening project links/collaborations with MRC Units in both Uganda and The Gambia.
	Three projects being delivered with Africa CDC as partners.
	Cross border-research collaborations e.g., – investigating filovirus transmission (West Africa).
Equity of outputs: Ensure equitable co-authorship to facilitate ownership and use of findings.	Proportion of partners from Official Development Assistance (ODA)-eligible countries who are first or senior authors on peer-reviewed joint publications was 100% in the latest review. It continues to be monitored.

On deployments	Progress made
On Capacity Strengthening	
Aim to develop post-capacity strengthening activities/ projects to ensure that new capabilities are applied in partners' activities and sustained.	Capacity strengthening proposal template includes focus on long-term, sustainable engagement with activities co-developed and responsive to the evolving needs of our partners.
	We now have a focus on promoting long term partnerships and sustainable approaches during and after deployment.
Actively engage more local (national, regional) capacity: Utilise centres of excellence/expertise locally to deliver capacity strengthening and support activities – leveraging local resources.	All capacity strengthening activities are designed and delivered with national or regional partners – e.g., Africa Centres for Disease Control and Prevention (Africa CDC), World Health Organisation African Region (WHO AFRO) and Ministries of Health (MoHs).
	Where activities include training, in particular, we engage local expertise.
	Train the Trainer approaches are used wherever appropriate.

In addition to the core pillar recommendations, some notable achievements were shared under the crosscutting themes such as gender and human rights including the development of a women in leadership course and a review and training provided on the Gender in Outbreak Preparedness & Response (GENPAR) Toolkit; and in mental health where the UK-PHRST has incorporated in its approach, country and context-specific approaches in supporting this strand of work.

Panels

Three panel presentations followed the opening and scene-setting sessions – panels 1,3 and 4. Panel 2 was deferred to day 2. The panel discussions focused on the three pillars of UK-PHRST's work. Panel members presented their work with the UK-PHRST and described major areas of learning that had emerged for them/their team.

Panel 1 was on capacity strengthening in practice and considered whether and how capacity strengthening activities had been delivered with sustainable impact for outbreak preparedness and response. Panellists were Dr Charles Njuguna (Regional Advisor, Country Readiness Strengthening AFRO); Dr Amal Ali (Technical Advisor to the Director General, Ministry of Health Development, Somaliland), Ms Rachel James (Risk Communication and Community Engagement Coordinator, East and Southern Africa, IFRC), Dr Radjabu Bigirimana (Technical Officer & AVoHC Programme Lead, Africa CDC).

Dr Claire Bayntun (Head of Capacity Strengthening, UK-PHRST) kicked off the panel session with a short introduction to capacity strengthening at the UK-PHRST, its evolution and the progress made to date. She presented the values and approaches that underpin capacity strengthening as follows:

- Building strong, long-term partner relationships.
- Co-design and co-delivery.
- Ensuring all activities have sustainability and impact.
- Focus on peer learning – partner involvement in all activities.
- Reflecting global health direction and priorities.

Key areas of activity in 2024/25 occurred in the following areas: community protection, One Health, Emergency Coordination Leadership, Technical Assistance and Research Capacity Strengthening.

Specifically addressing capacity strengthening in deployment, Dr Bayntun described two key areas of work: 1. mentoring/on the job (e.g., data collection, analysis, use, visualisation, reporting and management; coding feedback data, social listening and interviewing; rapid qualitative assessments) and 2. sharing knowledge (e.g., community feedback mechanisms, infodemic management; data collection tools etc).

Dr Charles Njuguna presented the WHO AFRO regional strategy for health security and emergencies focusing on the need to build on a country's existing capacity and to link preparedness activities to outcomes. A key observed learning was the direct relationship that exists between the number of completed preparedness activities and detection, notification, and response times. He described the tabletop exercise on community readiness that was undertaken in Ghana alongside the UK-PHRST as an important and successful project on which the two organisations had collaborated. A concluding thought on improving how we measure our progress and impact was a move away from reporting output measures such as number of assessments, evaluations, reviews, towards more substantive outcomes like change in disease burden, cost estimates, outbreaks prevented, and timely responses.

Dr Amal Ali presented a short background history on Somaliland, including demographic and health information. She described the UK-PHRST bi-lateral deployment to Somaliland, a comprehensive epidemiological outbreak investigation on dengue fever which included an assessment of the dengue fever surveillance system, an outbreak response evaluation, assessment of technical capacity gaps in the outbreak response workforce and the identification of relevant research opportunities to strengthen dengue fever outbreak responses in Somaliland. She enumerated what went well in the exercise as follows: at pre-deployment a relatively rapid response, having a Somali-speaking epidemiologist and a clear terms of reference. During the deployment, several informal training exercises were conducted; on-the-ground support was executed as a collaborative effort, bringing together various stakeholders to discuss and address pertinent outbreaks-related issues. This inclusive approach led to identifying gaps and developing comprehensive plans to address these issues, ensuring a more effective outbreak response; and finally, an immediately granted extension which enabled the work to continue uninterrupted. In post

deployment the ministry met with the wider UK-PHRST team in London to discuss the deployment and potential post-deployment collaboration; post-deployment plans were co-developed and two epidemiologists assigned; and a post-deployment learning session that was held. Regarding what could be improved, greater levels of support were proposed in identifying resources needed to ensure the sustainability of in-country capacity strengthening efforts, in-country research productivity and by offering mentorship to the Ministry/Departmental leaders, focusing on strengthening women's leadership during crisis.

Ms Rachel James reflected on the cross border RCCE readiness training in April 2024 supported by UK-PHRST. The training was identified as a priority need for the East Africa region where outbreaks threaten multiple countries and sharing and utilisation of RCCE data across borders is paramount. UK-PHRST provided critical support function through additional funding and technical/multidisciplinary support via RCCE, capacity strengthening and equity and human rights experts. This was a multi-partner activity where key RCCE and PHE stakeholders from seven Ministries of Health were supported by Collective Service partners-IFRC, UNICEF and WHO-and Africa CDC to collaborate across response pillars and countries through the scenario-based training. It also entailed cross border commitments to strengthen collaboration and sustained advocacy for RCCE data utilisation. The use of the Rapid Qualitative Assessment (RQA) methodology utilised by the Collective Service and later UK-PHRST in Malawi's cholera response has been subsequently deployed in Lusaka. UK-PHRST and US CDC supported the Collective Service to train select MoHs and University of Zambia staff and worked with UNICEF and Zambia Red Cross to rapidly collect qualitative data with communities affected by cholera in four rounds across affected provinces. Results were shared with other response pillars supported by UK-PHRST and informed adaption of the response to address community concerns and reduced transmission and deaths. The importance of building national capacity to undertake Rapid Quality Assessments (RQAs) in emergencies was clear and the Collective Service has supported development of a training package being piloted in Zambia and Zimbabwe with UK-PHRST RCCE and Social Science technical experts, with plans for expanding and systematising these approaches in other countries in the region. Excellent teamwork in response to requests from country and regional partners in ESAR has enabled provision of targeted technical expertise and strengthening of RCCE and social science capacity in the region.

Dr Radjabu Bigirimana (Technical Officer & AVoHC Programme Lead, Africa CDC) began by highlighting areas where Africa CDC and the UK-PHRST have historically shared priorities focused on enabling coordinated efforts for an effective regional health emergency response. Together these two organisations continue to work collaboratively to strengthen robust emergency response and recovery capabilities to address public health emergencies and support partners in LMICs to prepare for, prevent, detect and respond rapidly to disease outbreaks. Examples of such areas of collaboration include AVoHC training curriculum development. An AVoHC training needs assessment (TNA) revealed key gaps and challenges for an effective deployment (including the fact that many deployees did not feel fully prepared to undertake a deployment at the point of embarking on one). This resulted in collaboration with the UK-PHRST in the design and development of AVoHC induction course to strengthen AVoHC members' capacity by equipping them with the necessary knowledge for effective deployment support. In research, Africa CDC's Emergency Preparedness Response knowledge management priorities align will the UK-PHRST research programme and targets generating data to enable evidence-based decisions for health emergency preparedness, response, recovery and health system strengthening. Other areas of ongoing work between the two organisations include the MEL Framework review, operational research framework development; an ongoing study on the impacts of international public health deployments on national capacities for outbreak management, AVoHC's Induction Course ToT, AVoHC's Induction Course Roll out and the Joint deployment Collaboration framework. Dr Radjabu concluded by stating that AVoHC/ Africa CDC and the UK-PHRST have a historical relationship that has generated collaboration, mutual learning and appreciation for the strengths that each organisation brings to the partnership.

Panel 3 reflected on UK-PHRST's research approach – in particular, how we work together in research partnerships and what methodologies we should use to ensure we achieve impactful research. Panellists were Dr George Githinji (Researcher, Kenya Medical Research Institute & co-PI RaVIG project), Professor Dimie Ogoina (Chief Medical Director of the Niger Delta University Teaching Hospital) and Dr Maria da Luz Lima (President of the National Institute of Public Health of Cape Verde).

Professor Gwenda Hughes (Deputy Director for Research, UK-PHRST) introduced the panel session with a short presentation on UK-PHRST's research strategy and its underpinning principles which included equity and transparency in partnership, co-identification and co-leading of research, strengthening collaboration with universities/ research institutes in countries of research; facilitating south-south/ cross border research collaboration, encouraging multidisciplinary research; strengthening community engagement and full participation in research, evaluating the impact of outbreak responses and strengthening our research capacity. She revealed that the 12 new research projects launched since the last review had been co-developed with partners and were either underway or completed. There were 11 new partnerships with partner (ODA-eligible) research institutes. Six of the 12 projects have community engagement as a core feature; seven of the 12 projects are multi-disciplinary; three of the 12 projects are south-south/cross border collaborations. There were also new areas of research such as implementation science, participatory research and One Health. Regarding the impact of our work, five of the 12 projects are evaluating public health interventions, surveillance or learning. There is also a monitoring requirement that new proposals identify pathways to impact including identifying milestones and steps to involve practice/policy-related stakeholders at project conception. Consequently, 11 of the 12 projects have had MoH, NPHI and/or Africa CDC engagement and involvement from their inception. At the last review only 33% of studies met this requirement compared with 64% currently. Areas of capacity strengthening in research were also identified and included supporting ODA early career researchers as well as the provision of training in:

- Implementation of new laboratory assays and tools.
- Laboratory methods.
- Field research (over 200 field researchers were trained in Mpox in Nigeria).
- Social science methods and qualitative data research capacity (Guinea).
- MHPSS interventions, outbreak response for MHPSS and sector experts (Lebanon).

Dr George Githinji presented the RaVIG project co-designed and implemented in collaboration with the UK-PHRST. Three objectives of the study were identified as follows: To explore the feasibility of establishing portable genomics sequencing into outbreak responses in collaboration with MoH and the country's outbreak response teams; Compare at least two selected outbreak responses utilising conventional outbreak response approaches with similar outbreaks separated in time or space; To understand the composition, origin, dissemination, and dynamics of selected viral disease outbreaks occurring during the study in coastal Kenya. The project has its origins in KEMRI identifying this need nationally. It has to date developed guidelines for rolling out field based whole genome sequencing to inform public health interventions for disease outbreaks response; it is undertaking research into the optimal design for mobile based genome sequencing; and is providing and co-developing support in the development of effective outbreak response strategies and emergency preparedness plans; and the formulation of policy decisions regarding control of and sustainable resource allocation for epidemic management.

Ongoing learning is occurring for the project and the team continues to work collaboratively to enable the following outcomes:

- Rapid on-site analysis.
- Rapid turn-around time/ decision making.
- Access to remote sites.
- Rapid identification of source and drivers of an outbreak.
- Integration with patient data.

Professor Dimie Ogoina's presentation centered on how to further our understanding and learning on research impact within and beyond the context of the UK-PHRST & NCDC Mpox project. The overall aim of this joint project was to use a comprehensive multi-disciplinary approach to establish the critical clinical and epidemiological characteristics of Mpox infection in Nigeria in order to strengthen detection, prevention, response and control in Nigeria, and inform practice in similar endemic settings.
In his presentation Professor Ogoina identified ten key areas of research impact against which he benchmarked the UK-PHRST/ Nigeria CDC study as follows:

	Impact criteria	Achieved?
1	Relevance	Yes
2	Interdisciplinary approach	Yes
3	Engagement and collaboration	Yes
4	Ethical considerations	Yes
5	Clear Communications	Partly achieved
6	Innovation	Partly
7	Replicability and Scalability	Pending
8	Practical applications	Pending
9	Policy impact	Pending
10	Long-term impact and sustainability	Pending

He outlined the main areas of learning from the project as 1. co-production (research priorities were local partner led, design and method were co-created as were research planning, training and shared leadership and decision making); 2. knowledge transfer and skills development; and 3. stakeholder engagement. He identified the following as things that could be done differently to further enhance the project:

- Research readiness assessment for partners.
- Planned, predictable and measured knowledge and skill transfer.
- Partnership commitment assessment.
- More long-term commitments for institutional research capacity strengthening.

Regarding things that the project could do more of he identified the following: research equality, mutual respect and stakeholder engagement. He concluded by acknowledging that the goal of sustainable and impactful research collaborations requires clear communication, trust, diversity, sharing of resources, feedback, engagement and continuous improvement; and could only occur in the event of collaborators embracing these values and implementing a learning strategy where these principles are consistently upheld and integrated into people's work.

Dr Maria da Luz Lima presented the Cabo Verde Event-Based Surveillance project – a partnership between Cabo Verde's national public health institute, University of Brasilia, and the UK-PHRST. The project's aim is to investigate whether an Event-Based Surveillance (EBS) system developed with and relying on the participation of community leaders is feasible and more effective at detecting infectious disease outbreaks than centralised Indicator-Based Surveillance (IBS) systems. To date key activities have been co-developed and implemented, including the development of the methodology for an EBS system focused on community leaders as well as the training of community leaders and local surveillance staff on the developed tools. Significant learning has occurred for stakeholders through the continuous evolution of the original draft of the methodology and in the overall planning process itself. The focus going forward is to continue to improve research collaboration across the countries involved in the study. Other key areas of learning have occurred through technological collaborations and in generating greater levels of quality in communication and planning.

Panel 4 on deployments was the last session of the day where panellists reflected on how best to make deployments more context specific to partner needs. Panellists were Professor Roma Chilengi (Director General, Zambia National Public Health Institute – ZNPHI), Dr Martins Livinus (Emergency Preparedness & Response Team Lead, WHO Country Office, Kenya), Ms Sara Hollis (Team Lead, Health Information & Risk Assessment) and Mr Achwanyo Kutjok (Health Advisor, British Embassy, Juba).

Dr Ed Newman launched the panel presentations with a short presentation of his own on the deployments sponsored by the UK-PHRST in the preceding 12 months. Fifteen members of UK-PHRST staff deployed to 6 different countries (Haiti, Kenya, Malawi, Sudan, Zambia, Zimbabwe) on cholera. Additional deployments occurred to Gaza, South Sudan and Somaliland in support of other outbreaks. In feedback surveys, the receiving country was asked the degree to which deployment objectives met – 76% reported that the objectives were fully met, and 24% partially met. Partners were asked the about whether the deployment contributed to improving the country's public health system. Sixty percent of partners agree that the deployment had fully contributed to improving the public health system and 40% partially. Asked about the usefulness of the deployments 89% reported them as useful and 11% as fairly useful. All countries of deployment identified tangible contributions made by the deploying team.

Professor Roma Chilengi attributed the successful management of disease outbreaks in Zambia in large part to partnership support. Specifically mentioned were UKHSA's partnership in supporting Zambia's agenda on safeguarding public health security and in the previous 18 months UK-PHRST engagement in the response to two major outbreaks – COVID-19 and Cholera. The nature of the technical assistance and support provided included surveillance, risk communication and community engagement, infection prevention and control and research – Rapid Qualitative Assessments. With respect to the outcomes of the partnership working, Professor Chilengi reported that some level of local capacity had been strengthened and local ownership of the process enhanced. The challenges he outlined related largely to financial sustainability and the short-term nature of training without planned and implemented ongoing training. Opportunities to address these challenges were identified during partnership discussions including joint planning for greater financial sustainability; integration and alignment of learned activities and strategies into national policies and systems and investing in local trainers and the strengthening of expertise locally. Specific areas that could be improved were listed as follows:

- The co-creation of programmes to tailor how support is best effected.
- Greater work and effort to understand contextual challenges and work through solutions.
- Employing a Training of Trainers Approach.
- Structured and long-term knowledge exchange and skills transfer.
- Policy guidance.

Dr Martins Livinus spoke about the benefits, areas of improvement, and lessons learned from the WHO Emergency Response Deployments and UK-PHRST's Kenya partnership. The benefits were described as increased technical support to country teams through capacity strengthening; provision of specialised expertise in various aspects of public health such as epidemiology, infectious diseases and disaster management etc.; linkages to institutions of higher learning for research, documentation and publications of country office activities; knowledge sharing and experiences from different contexts enhanced the emergency interventions; and collaboration and expanded network for other activities including resource mobilisation. He recommended the following as good practice to aspire towards:

- Integration into the team enabled dynamism, effectiveness, and efficiency in the overall emergency response.
- Enhanced partnerships with UKHSA/UK-PHRST and sister agencies led to exchange of ideas and best practices.
- Psychological support for deployed personnel improved stress management and emotional resilience.
- Flexibility and adapting strategies based on on-ground realities enabled the team to have timely interventions and use resources more efficiently.

Ms Sara Hollis opened her presentation with a brief background on GOARN. Established in 2000, GOARN is a global technical partnership coordinated by WHO consisting of 310 technical institutions and networks providing technical support for alert and outbreak response (including NPHIs and MoHs), coordination and rapid multidisciplinary technical support for outbreak response. Their provision of support transcends deployment to include alerts and risk assessments, capacity strengthening and training, rapid response capacities and operational research and tools for response. GOARN's deployment mechanism was also described – beginning with the identification of an event or operation, leading to an alert being raised, triggering a request for assistance by the national health authorities through WHO. A call by GOARN triggers its partner focal points to upload appropriate expert profiles for consideration. This is followed by the selection of appropriate experts who are contracted by WHO to deploy with GOARN for the mission. Some of the greatest challenges encountered were listed as coordination and collaboration with the range of actors – WHO country office, the local health authorities, other UN agencies, NGOs and community organisations; limited awareness of GOARN mechanisms; engagement/integration with national structures; resource constraints, short deployments lengths, limited diversity of offer (e.g., regarding relevant language, country, institution experience), shrinking funding, security concerns, risks to personnel, administrative hurdles and visa requirements and delays. Potential solutions were also outlined including:

- Sensitisation with national response actors, including with new tools (ERF, Orange Book).
- Exercising the "Alert" function within GOARN, moving upstream, e.g., ops calls, request for information on Signal, other forums.
- Expansion of who can request support, host GOARN expert, and process a GOARN deployment.
- Increased alignment across rapid response capacities (interoperability during deployment, joint technical working groups).
- Systematic pre-deployment and post-deployment briefings.
- Improved focal point engagement via new partner onboarding process.
- Where possible, advocating for slightly longer deployments (12 weeks minimum) or phased rotations to provide more stability and continuity.
- Twinning and capacity to strengthening to build a more diverse pool of deployable experts.
- Strategic grouping to engage partners with particular competencies such as language.
- Lightening HR pre-deployment processes.
- Diversifying funding sources.
- The launch of the GOARN Monitoring and Evaluation framework which will greatly improve how to identify gaps and track progress.

Mr Achwanyo Kutjok presented key lessons learned from the South Sudan/UK-PHRST deployment exercise. He began by discussing the background to the deployment, including the public health and socioeconomic context of South Sudan. The joint project with the UK-PHRST occurred following a declared yellow fever outbreak by the Ministry of Health in Western Equatoria State in South Sudan. A range of partners supported the Ministry of Health to respond to the outbreak. Two members of the UK-PHRST were engaged through GOARN to provide technical assistance for the yellow fever response. The UK-PHRST deployment was to review the yellow fever outbreak investigation and response to identify ways to strengthen future responses in South Sudan. The UK-PHRST had previously sent a deployment to South Sudan in 2023 in response to a suspected viral haemorrhagic fever (which turned out to be measles). Key lessons learned were enumerated as follows:

- The deployment was not as rapid as would have been desired. This was attributed to delays within WHO and the British Embassy in Juba due to internal processes e.g., deciding on the duty of care for team members given the security situation in the country.
- The UK-PHRST members were able to identify gaps, challenges and areas for improvement within a very short timeframe.
- The deployment strengthened FCDO personnel skills in outbreak management – the main learning here was that of learning how WHO and MoH work together (or don't) in response to outbreaks.
- UK-PHRST was viewed positively by the government of South Sudan and this has strengthened broader UK-government engagement on health.

Regarding what could have been done better the following issues were highlighted:

- The need to manage partners' expectations.
- Ensure adequate time for the deployment depending on the country context. Include some elements of flexibility within the Terms of Reference to allow for a change of focus where needed.
- Undertake greater levels of engagement with the local authorities (e.g., Ministries of Health) – engage sufficiently at post with Government of the Republic of South Sudan (GRSS) before and during the deployment to smooth the team's operations while in the field.
- Timely completion and sharing of the final report to be able to inform planning.
- Drafting of action plans for the implementation of recommendations during the deployment period where possible.
- Share findings more broadly to the region e.g., Africa Health Advisers forum.

My main takeaway of this learning review is to understand a lot about what the other partners are doing and the strategy that they're using to develop their capacity. And to see how the UK Rapid Support Team is developing a methodology to engage partners to increase the quality of their job …

Learning Review participant.

Day 2

In discussion on the makings of good partnership

Day 2 kicked off with **panel 5,** a discussion and reflections session on the makings of good partnership between Professor Gwenda Hughes and Dr Chinwe Ochu. They pair outlined the core elements of good partnership as being 1. strategic (i.e., carefully thought out, starting with correctly choosing who to partner with. In other words, values, goals and interests must align). This would include undertaking a stakeholder analysis to identify like-minded partners, having clear objectives and an end goal, clearly defining roles and responsibilities, having a clear plan from the start on how to achieve the desired goal and ensuring joint decision making is ongoing. 2. It must be mutually beneficial with equitable access to benefits from the partnership. 3. It must be equitable which implies transparent relationships, being honest about expectations with everyone working together towards those expectations. Dr Ochu and Professor Hughes discussed the barriers to good partnership including historical perceptions of inequity and bias, a lack of transparency, and non-inclusion of partners at the earliest stages of conceptualisation. To give context to their discussion they reflected on some of the issues that had strengthened the Mpox Nigeria CDC/UK-PHRST partnership listing the following eight as core to the partnership:

- The team had a common interest – same goals and objectives.
- They worked together as a team from the start beginning at protocol development.
- There was mutual benefit – each had something to offer which the other party desired.
- They assembled people with the required skills.
- Managing expectations and continuously reviewing whether or not the expectations were on track.
- Having early conversations to avert problems or change course as the needs dictated.
- Showing and maintaining a mutual respect alongside a flexibility to resolve problems.
- Understanding the political and cultural landscape so that levers of power can be drawn on as necessary to help unblock bottlenecks.

Speaking about what could be improved, they listed community participation as core – getting the community to identify what their priorities are even at the stage of protocol development; improving the bi-direction approach to learning and knowledge management; national partners investing in their own research and development to minimise dependency which negatively impacts equitable partnerships; learning to appreciate one another and what each person has to offer; and understanding how best to communicate research evidence to politicians. The session concluded with Dr Ochu likening a partnership to a musical symphony where each musician (team member) plays their unique instrument (based on skill) to create beautiful music or in this case, a well-oiled partnership.

Panel 2 from day 1 on embedding MHPSS into public health emergencies featured next. This session was co-led by **Dr Naeem Dalal** (Mental Health specialist, Zambia National Public Health Institute) and **Mr Dumsani Mamba** (Mental Health Technical Officer, Africa CDC). The team provided the meeting with an overview of what constitutes Mental Health and Psychosocial Support (MHPSS):

- Any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders. (IASC, 2007).
- MHPSS combines psychological (thoughts, feelings, behaviours) and social aspects (values, norms, significant others, life circumstances, culture) of the human experience.
- MHPSS interventions provide stability, minimise stress and strengthen constructive relationships within resources.

They also discussed the importance of MHPSS to deployments. Specifically, this included:

- Enhancing the impact of programming across sectors, thereby contributing to saving lives.
- Helping to strengthen health, social and education systems in the longer term.
- Bridging the gap between people, their families and service providers during emergency response.

At the individual level, MHPSS provides support for people's general psychosocial wellbeing; helps in dealing more effectively with personal challenges or practical problems; prevents mental health issues such as mood swings, anxiety, eating disorders, personality and psychotic disorders during and after the emergency. Key pillars

in which MHPSS needed to be embedded were identified as partner coordination, information and planning, health operations and technical expertise, finance and administration. The session concluded with a scenario exercise in which groups of participants reflected on the possible mental health challenges that could be encountered in a combined natural disaster (drought) and outbreak (cholera) situation such as Zambia was at the time of the event experiencing.

Group work sessions on capacity strengthening, deployments and research followed in which people were asked to reflect on priorities for improving the work of the pillar being discussed. On research, priorities were to focus on ways of improving impact in the next research plan; on deployment the focus was on enabling greater alignment of deployments objectives with partner needs; and on capacity strengthening priorities the focus was on improving the impact and sustainability of capacity strengthening activities in the next phase of UK-PHRST's work with partners.

Dr Jake Dunning (Senior Research Fellow, Pandemic Sciences Institute, University of Oxford) led the next session – a substantive plenary session to capture the rich insights and recommendations generated from these sessions. Final recommendations are reported at the end of this report.

The afternoon session featured three parallel sessions: Community-led Responses (panel 6); Global Health Architecture (panel 7) and Integrating the three pillars of UK-PHRST's work at country level (panel 8).

Panel 6 session was introduced and chaired by **Dr Nadine Beckmann** (Senior Social Scientist, UK-PHRST).

Panellists were Dr Gbenga Joseph (Deputy Director, Nigeria Centre for Disease Control), Dr Elizabeth Shayo (Principal Research Scientist, National Institute for Medical Research), Professor Jonas Brant (Professor of Public Health, Epidemiology & Health Surveillance, University of Brasilia) and Dr Anastasiia Atif (Social and Behaviour Change Emergency Specialist, UNICEF).

Dr Gbenga Joseph began the session with a brief introduction to what constitutes a community-led response. He explained that a community-led response involves enabling communities to design and execute strategies to take ownership of their health outcomes which are informed by their distinct perspectives via their organisations and networks. Community-led responses are underpinned by principles of empowerment, inclusivity, participation, transparency, and respect for local knowledge. Applying these principles ensures that responses are community-driven, embedded and therefore sustainable. In speaking about the Nigerian context, he assessed the current status of response structures as follows:

- Well established national and state structure-led response system.
- Weak community-based structure-led response system.
- Weak community-based surveillance system.

He concluded that the current community structure, backed by partner funds, requires transition to full community ownership with government support to ensure sustainability. Regarding the way forward to address this he suggested the following six strategies:

- Begin by engaging with community leaders and members to explain the objectives and importance of the community led response.
- Focus on training and empowering community members to take active roles in community led response.
- Work with local health authorities, NGOs, and other stakeholders to ensure comprehensive support and resource availability.
- Establish monitoring and evaluation mechanisms to track progress, gather feedback, and make necessary adjustments.
- Establish community health funds to support rapid deployment of response teams during emergencies.
- Involve community members in the development of local health rules and protocols.

Dr Elizabeth Shayo presented learning from the UK-PHRST and University of Tanzania's Rumours Study which was designed to understand how community knowledge can improve trust and engagement in infectious disease outbreaks. A salient feature of the discussion was that one-way risk communication is inadequate as it focuses on what communities don't know as opposed to drawing on the vast knowledge and clarity that communities have about their own priorities. Consequently, all public health related activity must involve *speaking in* communities and *learning with* communities and ensuring that they are central to any decision-making. A key finding of the study was that community health workers are critical to community engagement because they reach "beyond health facilities with a role in prevention, detection, and response to pandemics" and are trusted. Key findings indicate that documenting community views first was essential for designing a training that was responsive to community questions and concerns; non-scientists with any level of education can

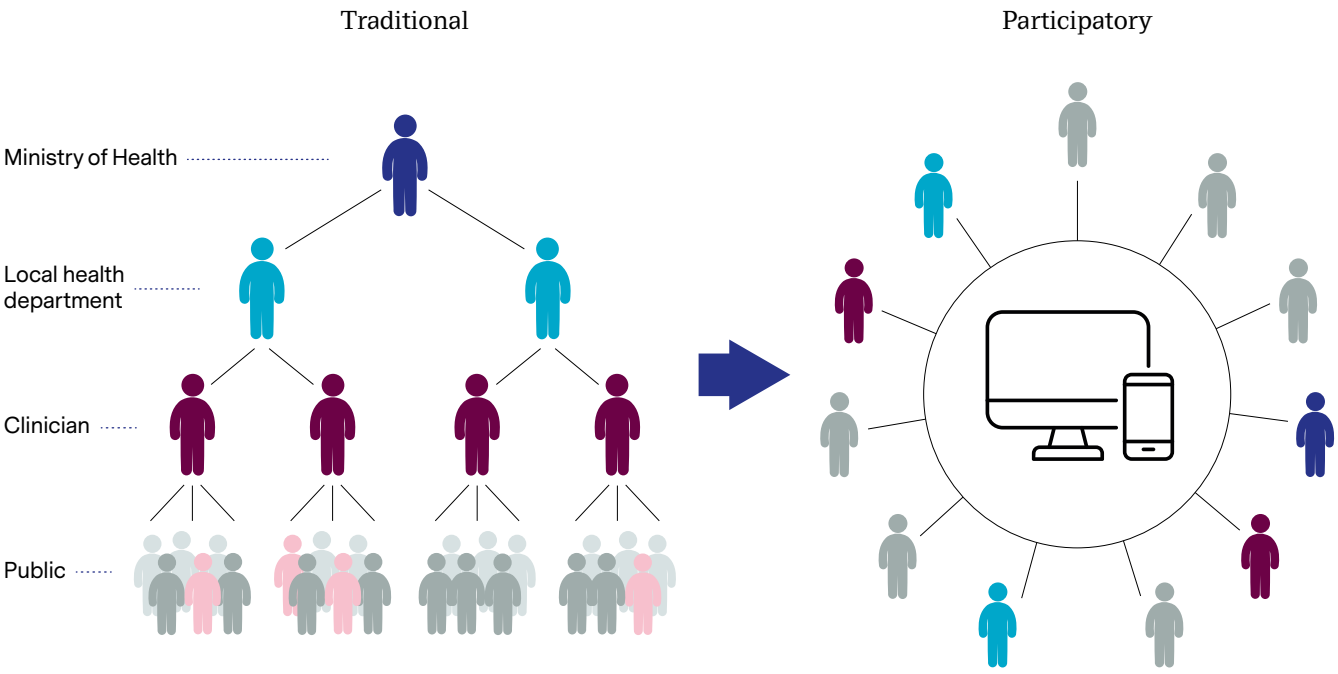
be engaged in technical discussions around vaccine development and deployment; community health workers (CHWs) and others embedded in the health system are good candidates for participating in research and engagement; This type of engagement, including the formative work, can be done quickly to inform clinical trials of new vaccines and outbreak response.

The study had four recommendations:

- The reflexive practice of *Kusikiliza Katia Ngazi Tatu* (listening on three levels) should be integrated into routine training for CHWs.
- Continuously updated and responsive training resources should be available to health workers and other key actors from whom Tanzanians may seek advice about vaccines.
- Local leaders, religious leaders, and influential people should be supported with training alongside health workers and officials to address the "mixed messaging" communities are experiencing that leads to a lack of confidence in vaccines.
- The systematic integration of social science into epidemic preparedness and response activities is critical to improve public health responses to disease outbreaks in Tanzania, achieve universal health care (UHC) and implement the Health Sector Strategic Plan (HSSP V).

Professor Jonas Brant defined a community-led response as consisting of actions and strategies that seek to improve the health and human rights of community members; it is specifically informed and implemented by and for communities in the form of community groups, organisations or the networks that represent them. The key characteristics of community-led action were identified as emphasising local knowledge, enabling local empowerment, ensuring sustainability of action, ensuring interventions are contextually relevant, driven by the community themselves, and locating the fulcrum of decision making in the community. Professor Brant illustrated community-led responses through 3 projects – a malaria project in the Dominican Republic, a COVID-19 and polio project in Sao Palo, Brazil and the US-based CORE Group Polio Project, describing the key characteristics of a community-led organisation, group or network. Professor Jonas then briefly discussed the joint Brazil/ Cabo Verde/UK-PHRST project on event-based surveillance (EBS) for the detection of early signs of infection. He defined surveillance as the systematic collection, analysis and interpretation of health data to monitor the progression of a health event. This activity is a huge challenge at the community level, hence the rationale for their joint study which seeks to examine traditional surveillance vs participatory surveillance. The difference between the two is captured in figure 1 below:

Figure 1: Comparison of traditional and participatory surveillance



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Developing and events-based surveillance system with the participation of local community leaders is the optimal approach for early detection of outbreaks and other public health events. This would allow for more sensitive and rapid detection, complementing official information, placing local leaders at the centre of the response and ensuring that communities and their leadership are recognised, all of which would ensure a more rapid response to the health event.

The session concluded with an outline of the key features of community ownership and leadership – in his words, the "true guardians of health", including accountability and transparency, an observance of equity and humans rights, adaptability and innovation, partnership and collaboration.

Dr Anastasiia Atif presented the final session of the panel. She shared learning obtained from community insights provided on their engagement in the cholera response that occurred in Zambia. The insights were converted to recommendations and actions developed to address them. The insights included the need for increased transport – one of the greatest challenges to quickly seeking care; and increase community members' knowledge of cholera prevention, which was mixed; this included correct messages, but often, the greatest emphasis was on a clean environment.

Based on the findings of the recent Rapid Qualitative Assessments (RQAs) supported by the UK-PHRST, UNICEF undertook a number of initiatives. A select listing of the activities is listed below:

- Convened two rounds of joint message review, harmonization, and validation sessions under the leadership of MoH and ZNPHI and engagement of partners (ZRCS, WHO, USAID, Federation of Sign Language Translators and Zambia Deaf Society).
- A co-creation workshop was conducted with community-based disability inclusion networks and organisations of persons with disabilities, and the adaptation of tailored materials is underway. Finalised materials include Oral Cholera Vaccine (OCV) poster, OCV and Oral rehydration Points (ORP) community-based volunteer job aids, cholera brochure and translated 3Cs (Clean, Cover, Contain) posters.
- Materials were distributed to various cholera hotspot health facilities and communities. Revised multi-media messages were disseminated promoting priority practices of water safety, hand washing, and early care seeking through 15 national TV and community/FM radio stations selected based on wider reach and estimated listenership of over 10 million nationally.
- Findings were presented to IPC WASH pillar, and combined findings and recommendations with the WHO IPC assessments were raised to MoH IPC leadership.
- Case Management team at WHO using the data to raise concerns to the Head Doctors at the CTCs about issues of care/patient monitoring.

Like the speakers before her Dr Atif finished the session by emphasising the key role of religious leaders in emergencies and the opportunities for engagement with communities including the early involvement of religious leaders, government recognition of them and their important roles, undertaking a pre-epidemic training programme for religious leaders, equipping religious leaders effectively and intersecting with religious values and national desired outcomes.

Conclusions & recommendations from Panel 6

Dr Beckmann then led a lively conversation in which key questions were posed and discussed and recommendations generated:

How do we define community and how do we ensure that community leaders do truly represent their communities?

Sometimes they are a leader but don't recognise they are leader. Understanding what the expectations are for being a leader. Vice versa people who say they are leaders but are not; rather they are representing themselves. It's about having a network, being engaged with need of communities – recognising leaders who advocate for this.

Some countries have more formal systems such as the traditional leaders in Nigeria. It's also about identifying key institutions in the community and identifying

their leaders. We use those platforms/institutions to identify people for the response. There are vulnerable groups inside communities, and these are not usually part of the leadership. Challenge in being aware of power dynamics within the community.

How do we overcome these issues?

We need to make a conscious effort to represent groups that are in vulnerable situations. E.g., mapping of community members and all nuances of the community. Real leaders should also be trying to represent these other groups.

Do literacy levels effect community led response?

Using simple solutions led by the community is effective. Communities understand the best way to disseminate messages, and if the community is not literate, this will be reflective in the type of methods used for the response.

Are traditional leaders/alternative medicine leaders included in the response, and what happens when their views/practices differ from "the official" response?

We engage with them, get them on side where possible and use them as a trusted resource.

It's a two-way process – we should work with doctors and nurses in hospital too to try and get them to work with traditional healers, acknowledging the important access and role they play in the community, and noting they may be the easiest access the community have to a health professional. Medical care and spiritual belief can and should exist together.

How do we ensure sustainability and continued engagement of community actors?

Something that can be considered alongside the UK-PHRST's work is the training of trainers for example.

Social responsibility, using the strategic actions and structures within the community.

Create a communication strategy, prepare in advance for emergencies – prevention as well as response. Respond to messages/create a community feedback loop so people know their reporting is being used.

People have to recognise and see that it is beneficial for their community. Making sure our work has a visible impact and benefit. Political commitment and fair allocation of resources needs to be seen. We need to both work at community level but also using advocacy to translate findings into actions.

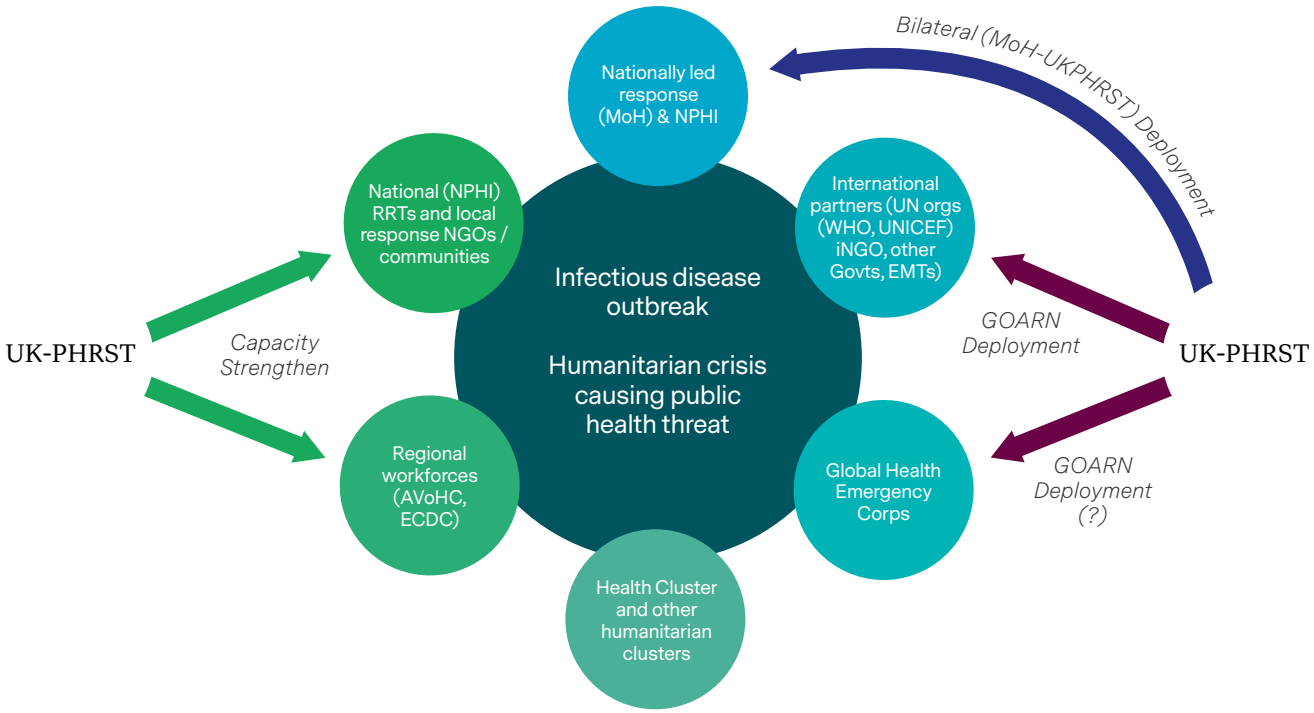
Recommendations from Panel 6:

1. **Ensure early engagement and continued engagement with communities – ideally pre-emergencies.**
2. **Listen to concerns of community and continue to engage in the dialogue.**
3. **Undertake intersectional engagement and community mapping – identifying diverse leaders within the community and supporting them to lead. Sometimes they may think they are not leaders/not recognise their own leadership but have standing and influence – require support, encourage and build their skills.**
4. **Create products (tool kits etc.) in different languages including language that is well understood, accessible and tailored to the audience.**
5. **Respect community's cultural activities and stop regarding culture as a barrier and find ways to work within it rather than against it.**
6. **Always provide the community with feedback to build trust.**
7. **Continue to bring community leaders "into the room"/allow them to represent their communities at high level meetings, particularly when feeding into policies and guidelines.**

Panel 7

Dr Newman introduced the session with an overview of the global health architecture illustrated below.

Figure 2: Global Health Architecture



He then posed the following questions:

- Where should UK-PHRST strategically place itself in the new world order of Global Health response?
- Is our multinational membership of GOARN and therefore, maybe, Global Health Emergency Corps (GHEC), enough?
- How do we support the operationalisation of NPHI emergency workforce as a regional capacity?
- How do we help our partners have a loud voice on the global stage during this period of change?

The four panellists were Professor Roma Chilengi, Dr Kamene Kimenye, Dr Radjabu Bigirimana and Dr April Baller (IPC & WASH Team Lead, Country Readiness Strengthening Department, WHO Health emergencies programme, Geneva).

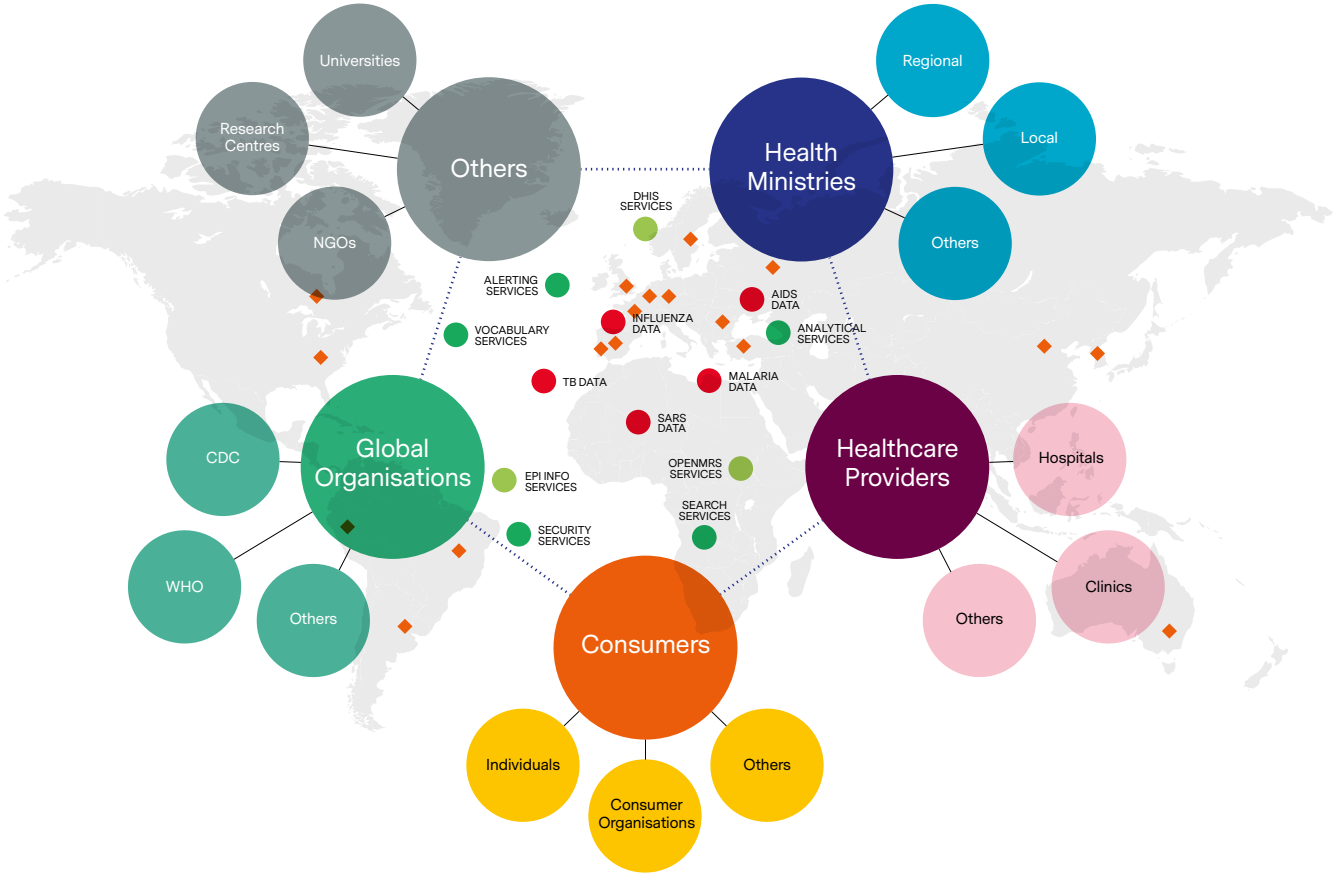
Professor Roma Chilengi acknowledged the fact that major progress in public health in the last century had been achieved across the world. However there remained major areas of need, notably, an upward trend in inequalities in economic status and health and a world system that perpetuates a dependency of the "have nots on the haves". He suggested that the role of the UN and other global agencies within a continuously changing global system may need re-examining. He highlighted three key areas of concern: 1. Governance: There were concerns regarding the strings tied to aid on the global scene. Additionally, there is limited

support to Africa-specific concerns until reverberations are felt beyond the continent. He pointed out the establishment of Africa CDC was a bonus to the continent and an opportunity to improve Africa's space in the Global Health Architecture through an African-led initiative. 2. Political implications: The role of international diplomacy in forging health agreements and partnerships remains critical, and political will, leadership and credibility are critical drivers for embracing, supporting and implementing global health initiatives. Professor Chilengi spoke about the need to balance national and regional sovereignty in addressing transnational health threats; and to leverage on good, tried and tested global practices and strategies. 3. Technical implications: there is an unequal landscape of technical capacities and opportunities across the global south. He explained that the way forward required the development of a deliberate agenda and implementation plan for research and development for neglected tropical diseases, emerging infectious diseases and other health priorities; and establishing collaborative forums/platforms for sharing good practice, data and research findings. He concluded that this means that the global south needs to find its economic emancipation to drive a health agenda that can be meaningful both to its citizens as well as to the global health architecture.

Dr Kamene Kimenye presented an illustration of the multiple connections within the global health architecture framework (Figure 3).

She focused on some key dilemmas facing global health architecture: 1. Individual rights vs the collective good: examples provided included quarantine & isolation, mandatory

Figure 3: Complexity of connections within the Global Health Architecture



Architecture in this context refers to all of the systems and capacities, including mechanisms for financing and governance, at national, regional, and global levels that are crucial to the world's collective ability to prepare for and respond to health emergencies.

vaccination, equity, access and allocation of resources. 2. Privacy vs public health surveillance: some examples were health data and data security, digital contact tracing. 3. Moral distress of healthcare workers. This included their risk of personal safety alongside their duty to serve. 4. Public health communication including transparency vs public panic, cultural sensitivity, data sharing vs country sovereignty. Dr Kimenye further elaborated on the linkage between health and security presenting five potential scenarios.

Scenario 1: Health sector receives assistance from the security sector in responding to health needs that do not constitute a security threat or risk e.g., humanitarian emergency settings.

Scenario 2: Security sector is mobilised and deployed to address a health problem that is also deemed to be a security threat e.g., Ebola Virus Epidemic, COVID-19.

Scenario 3: Overlap in which the security threat is the source of a health threat rather than vice versa e.g., the intentional release of biological and chemical agents and bioterrorism.

Scenario 4: Increased engagement between health and security actors when the health sector is under attack and has to rely on security sector actors for protection e.g., response in bandit zones.

Scenario 5: Security sector actors mobilise the health sector to perform a security function in a situation where there is no health threat e.g., surveillance or intelligence gathering activities, sometimes in violation of ethical, legal and normative standards concerning confidentiality, trust, impartiality and neutrality.

Dr Kimenye suggested nine areas of strengthening for the future included strengthening global health governance; addressing issues of equity and access including to technological advancements; addressing issues of climate change and health security; strengthening of national health systems; integrating interdisciplinary approaches; promoting ethical and equitable policies; having predictable and sustainable finance, ensuring the centrality of the community engagement and participation and leveraging on the increasing youthful population to advocate for health security.

Dr Radjabu Bigirimana in his presentation focused on a "bottom-up" approach to ensuring an effective global health architecture. Since health emergencies begin and end in communities, a systemic approach is required to achieve health protection. This begins with a resilient national and local public health service tightly integrated with primary health care; and empowered communities supported by a regional and global network of health emergency preparedness and response systems and partners. This, in turn, is enabled by a strong and coordinated health emergency workforce at all levels. For a strong health emergency workforce to become a reality, three core elements were identified: 1. Empowered and supported national leaders to build and deploy the capabilities needed to stop health emergencies is essential for an effective response. 2. Better connected leaders across borders to ensure a coordinated response and 3. Robust regional and global platforms to prepare for and respond to health emergencies. Health emergency response systems need to be interconnected, vertically across global, regional, national and local levels and horizontally within each level. AVoHC as a strong regional health emergency workforce is committed to contributing to coordinated regional and global efforts for an effective regional emergency response. For the future, and working in collaboration with the UK-PHRST, AVoHC is exploring undertaking collective engagements with the RST to improve on response interventions to contain health emergencies. This includes improved programme operations, capacity strengthening of competency based curriculum and training materials including MHPSS, RCCE, etc., joint emergency responses through joint deployments and operational research to obtain reliable, real-time findings to inform decision-making.

Dr April Baller explained that WHO is learning the lessons from COVID-19 to strengthen Health Emergency Prevention, Preparedness, Response & Resilience (HEPR). A new definition of pandemic emergency has been developed as part of amendments to International Health Regulations (IHR) at the 75th WHA, June 2024. Each and all of the following six criteria must be met for an "event" (which, according to the IHR, means a manifestation of disease or an occurrence that creates a potential for disease) to be determined a "Pandemic Emergency". It must:

1. Be a public health emergency of international concern (PHEIC).
2. Be of communicable disease nature.
3. Have or be at risk of having wide demographical.
4. Exceed, or is at high risk of exceeding, the capacity of health systems.
5. Cause, or is at high risk of causing, substantial social and/or economic disruption etc.

6. Require rapid, equitable and enhanced coordinated international action.

Dr Baller explained that WHO has established a process to draft and negotiate a new convention, agreement, or other international instrument. Expected areas for action or gaps to be addressed (if agreement can be reached) are as follows:

- Global preparedness and response arrangements – including at the human-animal interface – to help anticipate and prevent future pandemics and address them more effectively when they do arise.
- Sustained, predictable funding for health emergency preparedness and response, including from domestic budgets to support preparedness measures and help ensure that the world is prepared and can respond to the emergence of dangerous pathogens.
- Governance and oversight mechanisms to increase trust, ensure accountability and foster transparency.

WHO is working on the core capabilities needed to protect health and ensure full integrated into multi-sectoral and health systems. Additionally, WHO is adapting and aligning the core capabilities needed to protect health to specific threats and settings in order to manage all-hazards. It is, overall, working to strengthen the global architecture for health emergencies to enable safe and scalable care. The current status of the GHEC development/ implementation includes:

- Establishing the GHEC secretariat at WHO Headquarters and the maintenance of a global GHEC working group that includes 7 global health emergency networks and 6 WHO regional emergency leaders.
- Strategic alignment and collaboration at global level and incorporation of GHEC into future WHO budgets through the Fourteenth General Programme of Work (GPW 14) process.
- Supporting language included with broad endorsement in the draft article 7 of the Pandemic Accord.
- Initiation of an interim GHEC design/steering group with country and network leaders.
- Launch of a globally inclusive process to establish benchmarks for national rapid response capacities.

The anticipated impacts include: 1. On the emergency workforce (countries strengthen their workforce to detect and contain emergency health threats; capacity strengthening is implemented based on international guidance, standards and benchmarks; health emergencies are managed closest to where they begin). 2. Surge capacities (countries scale up response with their own deployable surge capacities and expertise; countries can access trusted existing networks for interoperable surge capacities when required; no country or district is overwhelmed by emerging health threats. 3. Connected leaders (leaders have trusted networks to collaborate on regional and global responses to transnational threats, enabling a coordinated global solidarity when needed, and ensuring that the pandemic is stopped).

Conclusions and recommendations of Panel 7

A discussion session followed the panel presentations:

There was a broad consensus that where Global Health Security (GHS) fits in a country's health configuration depends on the health structure in the country, however, all modalities should be considered regarding where best to place and operationalise it. Pertinent questions include what does it look like? what is already in place in the country? Is there a public health institute? Is there funding set aside? These types of questions will all feed into the specific GHS. A couple of questions shaped the conversation:

Is there a role for UK-PHRST in relation to its partners in this arena?

What is the role of UK-PHRST? Is it to ensure that public health institutes have a greater voice?; to assess the level of stakeholders in Africa in the global health area and assess how to give strength to their voice? Global Health is about noise, after all. If, in Africa, Africans can't package their collective voice in a way that create better noise that relates to Africa, then how can the UK-PHRST themselves amplify that?

How do we seriously address the inequities and inequalities?

A strategy is needed to advocate that a problem here can be a problem elsewhere. For example, Australia has a Global Health Ambassador. Recognising that this is a broad issue, with high stakes, they give importance/gravitas to this issue. Is this something that can be replicated elsewhere?

There is a lack of investment noted as well. Pharmaceuticals and therapies drive profits but "Big Pharmaceutical" companies don't invest. For example, there are no therapies for Yellow Fever, but conservative management is promoted. There is therefore a need to look inward, to invest within when it comes to the negotiating table.

Improving the efficiency of partnerships, increasing transparency and proper coordination, identifying opportunities, and reducing duplication are all skills that are needed. One way to see a benefit is to look for opportunities Africans themselves can leverage on to improve Global Health.

Ultimately health and security are interlinked. Everyone should be engaged to promote health, whether in schools, hotels, churches, prisons, etc. Everyone should understand what the key health issues that impact them are and everyone should be engaged in protecting their communities.

Recommendations from Panel 7:

1. **In partnership with UK-PHRST there is need to look at various areas and frameworks to determine where to best focus effort. Examples of areas include HEPR; community protection; community readiness.**

2. **Amplify the national and regional "voice". This can be enabled through:**

   - **National Public Health Institutes (NPHIs) – although a fairly new establishment in many countries, must access opportunities to engage in the discussions and negotiations.**

   - **Educating national governments and colleagues to understand that the global health scene is a vast interdepartmental negotiating body and that public health professionals, academics, related disciplines/ perspectives and communities can and should feed into the government perspective and shape the messaging.**

   - **Engaging in-country with technocrats in MoHs before messages are drafted, passed or circulated widely is therefore crucial.**

Panel 8 on integrating the three pillars of UK-PHRST's work at country level was the last panel of the day and event. The panel was chaired by Dr Claire Bayntun. Three panellists reflected on the desirability and feasibility of this at country level. Panellists were Dr Kola Jinadu (Consultant and Technical Officer, WHO); Dr Abdul Sesay (Head of Genomics Strategic Core Platform MRC Unit The Gambia at LSHTM); and Dr Abiodun Egwuenu (ISID Emerging Leader in International Infectious Diseases & Epidemiologist at NCDC).

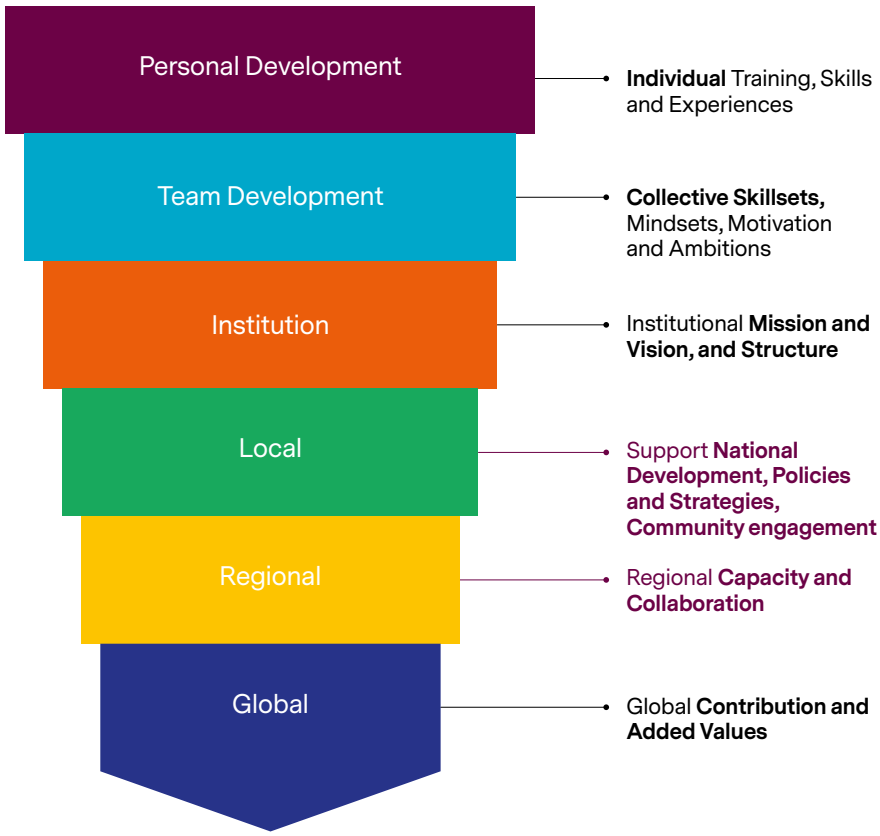
Dr Jinadu presented the table below as the key considerations for integrating the three pillars of the UK-PHRST's work at country level. He suggested that several areas of UK-PHRST's work already appear to incorporate elements of the three pillars, such as UK-PHRST's work on integrating research into capacity strengthening practice and vice versa; incorporating capacity building expertise into deployments and leveraging operational research to inform decision making and to inform deployments and approaches to deployments. He concluded with the observation that a collective, integrated and sustained effort to prepare, detect and respond to major health risks is at the core of successfully managing an outbreak; and the UK-PHRST needs to consolidate this clearly visible trend in its work.

Figure 4: Key considerations in integrating capacity building, deployment and research at country-level

Capacity building	Deployment	Research
1. Prioritize in-country capacity building	1. Leveraging existing capacities in preparedness to improve response – Risk Calendar	1. Alignment with national, regional and global HEPR strategies
2. Employ core elements of capacity development strategy	2. Linkage with existing pool across all levels for sustainability	2. Incorporating Desk Reviews into Research
3. Identify and fill gaps in highly specialized areas	3. Leveraging preparedness capacities to bolster response – Risk Calendar	3. Community of Practice
4. Continuous needs assessment	4. Participation of experts in the AARs and SIMEX	**4. Capacity building in Research**
5. Mindful of attrition	**5. Capacity building of experts in highly specialized areas**	**5. Leveraging operation research to inform decision making in Deployment and Capacity Building**
6. Maintain roster of international and in-country experts	**6. Integrating Research into RST deployment (Pre & Post)**	
7. Leveraging profiles of pool on the roster	**7. Standardize SOPs & Joint Deployment**	
8. Participation of experts in the After Action Reviews (AAR) and Simulation Exercise (SimEx)		
9. Integrating Research into Capacity building package		
10. Joint Research		

Dr Abdul Sesay likened the integrated delivery approach proposed through the work of the UK-PHRST to a journey much like his own genomics journey at MRCG at LSHTM which began as a genomics facility in 2017 and is now recognised as a centre of excellence in 2024. The Medical Research Council Unit (The Gambia) at LSHTM analyses sequenced genomes, equips researchers to use data to help find the causes of disease and, by implication, disease outbreaks and undertakes extensive capacity strengthening to train scientists across the continent. A pictorial representation of the journey of the centre, particularly, its "top-down" approach is presented in Figure 5. It began with training at the individual/ personal level (skills and experiences were developed) moving up to the team level (collective skillsets, mindsets, motivation and ambitions were strengthened here); then to the institution (where an alignment with mission, vision, and structure occurred); then to support for national/ local development (impacting policies, strategies and community engagement) to the regional (here capacity and collaboration merged) and finally to the global (where contribution and added values occurred).

Figure 5: Personal preparedness: A top down approach



The Centre's capacity strengthening model combines training and support (comprise of hand-on laboratory training, on-site and at MRCG, bioinformatics training at MRCG and access to high performance computing) with coaching and mentoring (networking, regular on-line training, advice on training courses, grants and fellowship) and Monitoring, Evaluation, and Learning (site visits, support/training on accreditation/certification, external quality program, learning and accountability). This has evolved into a global partnership with 13 international partners out of which has developed several research studies, capacity strengthening activities and application of research findings in outbreak situations – a clear example of the benefits, the sustainability and impacts of an integrated approach of the kind advocated for the UK-PHRST.

Dr Abiodun Egwuenu had as the central theme of her presentation the need to do away with "silo" thinking and replace this with a "thinking together" strategy. She started her session by enumerating important benefits of having an integrated approach to the UK-PHRST's work at country level. This approach she viewed as enabling the following:

- A shared, collaborative and implementation agenda (e.g., merging empirical findings in partner countries with new analytical frameworks and decision-making tools from UK partners).
- A holistic approach to public health challenges.

- Enhanced training opportunities.
- Strengthened local health system.
- Improved research outcomes.
- Real-time data from deployments.
- Practical insights for capacity strengthening (e.g., experience in responding to health emergencies in different settings).

Dr Egwuenu pointed out the need to be aware of the tension that exists between collaborative advantage (the synergy that can be created through joint working) and collaborative inertia (the tendency for collaborative activities to be frustratingly slow to produce output or uncomfortably, at times, conflict ridden).

Three key challenges to integrating the three pillars were identified as 1. relating to human resource (e.g., Nigeria's ongoing brain drain/ the retention of qualified staff; the ongoing training/retraining of its staff). 2. Funding (funding for health remains below agreed targets. Nigeria is yet to achieve 15% of annual expenditure on health as agreed at the Abuja declaration, 2001) 3. Materials (infrastructure for public health and health as a whole is still suboptimal/inadequate despite significant progress made to date). Dr Egwuenu's presentation then elaborated on how to address these challenges. UK-PHRST was urged to give consideration to:

- Ensuring the deployment ToRs are jointly developed and have post-deployment sustainability actions clearly identified.
- Holding discussions with NPHIs and MoHs to identify areas of research post-deployments; include the ministries of agriculture and environment to strengthen partnerships in response and research.
- Undertaking online course training as part of pre-deployment.
- Identifying how to measure knowledge transfer. Bridging the "know-do" gap and having this reflected in Monitoring & Evaluation.
- Supporting national partners to reach their politicians if requested by generating outputs that are easily understood and align with national concerns.
- Leveraging local centers of excellence for research.
- Joint mapping of financial resources not only of stakeholders.
- Developing a research sustainability plan which includes transitioning of research to routine work as part of the plan (including existing funds).
- Discussing emergency "funds" as part of post-deployment even if no action gets taken, this important conversation would have been started.

- Encouraging countries to prioritise Joint External Evaluation (JEE) and work towards improving capacities including funding.
- Along with AVoHC, UK-PHRST, IHR, WHO, GOARN undertake joint mapping infrastructure to support outbreak response and research.
- Leverage key systems such as FETP (this is critical resource for Training of Trainers, RQAs), Public Health Emergency Management programme (EOC managers important for outbreak response training).
- Community engagement structures (link communities to reporting systems e.g., SITAware in Nigeria).

Conclusions and recommendations of Panel 8

A discussion session followed the presentations centering on the following three core questions:

How do we effect integration?

In routine discussions with national institutions the need for greater levels of integration should be highlighted. Having a framework will facilitate this. For example, Somaliland deployment is an example of the 3 pillars being integrated illustrating opportunities to build in capacity strengthening work in a sustainable partnership way.

There's a need for greater focus on research in an outbreak situation where deployment and capacity strengthening are often thought to align more naturally. For example, when MSF deploys they always do recovery surveillance. Need to engage people to ensure research has prominence during a response.

Why do we need these three pillars integrated?

In a deployment there are opportunities for research even from an examination of the data generated. This could become a launch pad for further useful research with longer term implications for outbreak management.

Similarly, capacity strengthening should be part of each deployment. In deploying there is often a knowledge gap. If capacity is not strengthened deployees will inevitably return to address a similar future outbreak. There is a need to think outside the box about how capacity strengthening can continue outside deployment.

How do we integrate?

Capacity strengthening is the base of everything – with that the country can grow its skill and consolidate learning and achievement.

There is a need to think in an integrated manner with sustainability of the activity as the ultimate goal. By making sustainability the goal and undertaking mappings of the partner landscape to identify and tap into existing resource, we can change the way we work.

Communities of practice can facilitate integration enabling people to build on relationships formed, for example, during deployment. There are existing bodies that can be expanded, for example, technical working groups, networks created post-deployments or post-research and professional groups are resources to tap into.

Systematically learning about what works in this arena is also crucial. For example, can we learn about what has worked in Somaliland and RCCE deployments that have led to ongoing and expanded areas of support?

Recommendations from panel 8:

1. **UK-PHRST should recognise that we are conceptually integrated. We need a mindset change to work as "one team" and to consider as natural the integration of other pillars of our work with sustainability as the ultimate goal.**
2. **Trial this out – look for additional funding or resource available for small pieces of work rapid, responsive, integrated work– e.g., vaccination effectiveness study in Kenya.**
3. **Partners also need to take an integrated viewpoint when engaging with the UK-PHRST identifying opportunities for integrating other areas of work into the primary area of engagement.**

It has been really good … UK Rapid Support Team is a partner. They are not sitting at the table telling us or leading us in the things that we need to do. They sit together in a reasonable manner and listen to our priorities to help strengthen capacities and produce a lot of [results].

Learning Review participant.

Day 3

Day 3 was devoted to pulling together the final set of recommendations. A summary of discussions in the five thematic areas considered on the previous day – capacity strengthening, deployment, research, partnership working and mental health and wellbeing – was shared with the meeting in a plenary session. A detailed discussion ensued from which a set of final set of recommendations was generated. A gallery walk was then undertaken by all workshop delegates to prioritise the recommendations. Six recommendations were ultimately adopted as the key priorities to incorporate into the work of the UK-PHRST.

The day and event concluded with a conversation about the future and focus of the UK-PHRST and partners' work. The three panellists were Dr Ed Newman, Dr Kamene Kimenye and Dr Charles Njuguna. In their discussion the following 11 key themes were highlighted as core to our collective efforts to continue to build on our partnership and our joint commitment to work towards a world where global health security threats are minimised.

1. **Sustainability is key and should be starting point of developing collaborative activities.**
2. **Our work starts in communities and ends in communities. So prioritising community protection through their engagement and participation is critical to our approach.**
3. **Partnership is vital in a changing global health architecture landscape. This includes relationships of UK-PHRST with its national/regional partners; as well as UK-PHRST's potential role of coordinating partners during emergencies.**
4. **There is a need to tell UK-PHRST & Partners' story – how we work together and why it works quite well. Document and share this good practice.**
5. **Governments must lead and own the process – the role of the UK-PHRST is to support them in this endeavour.**
6. **National partners must engage stakeholders in their own countries to broaden skills and other resources available to input into a project; as well as facilitate buy-in. UK-PHRST should endeavour to work across institutions in-country.**
7. **Post deployment contact and continued mutual work is essential.**
8. **Engagement with parliamentarians by national partners is essential. UK-PHRST can support this process as advocates.**
9. **Joint priorities must be aligned.**
10. **Understanding the contexts and environments in which UK-PHRST works.**
11. **Inclusion of mental health and wellbeing in emergency care and capacity strengthening should be fundamental to all our work.**

Learning is not attained by chance, it must be sought for with ardour and attended to with diligence.

Abigail Adams, 1780.

Appendices

Appendix 1: Full set of generated recommendations (per pillar & cross-cutting)

Below are the 20 recommendations generated during the Learning Review in Nairobi, Kenya.

Capacity strengthening

1. Map partners and resources in the outbreaks management space: this is to understand and identify where UK-PHRST can add value and contribute strategically, recognising UK-PHRST's strengths and remits.
2. Support outbreak response systems strengthening with partner organisations by co-assessing and responding to identified need where UK-PHRST can add value.
3. Explore ways/mechanisms to manage and share knowledge with and between partners
4. Continue to ensure government or national partner institutions have ownership and leadership in capacity strengthening activities to enable long-term sustainability.
5. Strategically ensure that capacity strengthening activities are embedded throughout the UK-PHRST's other pillar activities to maximise impact and sustainability.
6. Identify specific priority areas of MHPSS that can be integrated into capacity strengthening activities more broadly.

Deployment

1. Proactively engage partner countries pre-deployment to the country to understand the context and expectations of the assignment. (e.g., work with a checklist of key information to understand/ask to ensure that country specific technical/social and political contexts are understood).
2. Define clear expectations in ToRs and create process/ opportunities for its periodic review and adaptation during the deployment.
3. Incorporate capacity strengthening opportunities into ToR.
4. Ensure training for deployees incorporates training on diplomacy/cultural humility to enable even more nuanced and effective responses.
5. Increase length of deployment to up to 12 weeks, where appropriate.
6. Support sustainability of gains made during deployment through engaging with and supporting the development of recovery plans and by participating in interaction reviews (IARs) and after action reviews (AARs); and sharing learning more widely.
7. Ensure that exit planning includes long-term actions wherever possible, including remote support as required.

Research

1. Create and/or adapt generic research protocols for use during outbreaks: This implies having an agenda/routine processes/ sets of tools available to identify research opportunities, plan, budget for and implement research (including obtaining ethical approval ahead of time) such that undertaking research is always in a "ready to go" state.
2. Undertake research readiness assessment: before embarking on a research partnership undertake an assessment with partners to understand not only needs but also the partner research landscape of collective available skills and gaps to ensure effective and sustainable research outcomes.
3. Continue to implement impact assessment of research undertaken.
4. Promote and support research capacity strengthening – prior and during research activity.
5. Ensure community engagement and full participation in all studies, including providing feedback to the community and ensuring true partnership not tokenism.
6. Explore how best to communicate research evidence to governments, especially within the context of national research priorities and plans.
7. Participate in early action reviews, interaction reviews, after action reviews – all opportunities for research priorities to be discussed and identified.

Appendix 2: Priority Recommendations & the UK-PHRST Management Response

Below are the 13 priority recommendations adopted by the Learning Review by pillar/thematic area alongside UK-PHRST's management response.

UK-PHRST pillar/work area	Management response
Capacity strengthening	
1. Map partners and resources in the space to understand where UK-PHRST can add value and support, recognising UK-PHRST's strengths and remits.	The UK-PHRST regularly conducts partner mapping within our operational sphere. We will continue to do this to ensure we avoid any duplication of activities. For all new activities we embark on, under RST's remit of building capability and capacity for outbreak response, we will systematically identify, review and engage with relevant local expertise/ institutions where appropriate.
2. Continue to ensure government or national partner institutions have ownership and leadership in capacity strengthening activities.	Where the activity is UK-PHRST led, we will continue to ensure that direct government/national partner engagement and collaboration occurs. Where we are partnered with other international organisations in delivering an activity, we will influence and advocate for national ownership and leadership as appropriate.
3. Support outbreak response systems strengthening with partner organisations by co-assessing and responding to identified need where UK-PHRST can add value.	The UK-PHRST's remit centres on response and readiness to respond. We will continue to support outbreak response national infrastructure strengthening where these activities clearly fall within our remit with a view to ensuring that we are working sustainably; and signpost appropriately where the activities fall outside our remit to other partners more able to conduct preparedness and health systems strengthening activities.
Deployment	
1. Proactively engage partner countries pre-deployment to the country to understand the context and expectations of the assignment. (e.g., work with a checklist of key information to understand/ask to ensure that country specific technical/social and political contexts are understood).	In addition to early engagement with partners pre-deployment, the UK-PHRST will develop a checklist of pre-deployment activities to ensure that the deployment context is understood and that expectations of the UK-PHRST and our partners are fully aligned.
2. Incorporate capacity strengthening opportunities into ToR.	Where the UK-PHRST works bi-laterally with partners, we will include a commitment in our ToR to engage with partners to identify capacity strengthening and other opportunities to ensure we work in a sustainable manner. We are limited in the degree to which we can modify ToRs agreed in advance between the requesting partner and a third-party multinational facilitator. In these situations we will advocate for clarifying and if needed modifying ToRs during pre-deployment briefings with the requesting partner.

UK-PHRST pillar/work area	Management response
3. Support sustainability of gains made during deployment through engaging with and supporting development of recovery plans and by participating in interaction reviews (IARs) and after action reviews (AARs).	During pre-deployment engagement with partners, the UK-PHRST will request to be involved/invited to inter and after action reviews, to identify and respond to areas of need that fall within our remit and where we can strengthen capacity post-deployments in a sustainable manner. Similarly while on deployment we continually build relationships with national partners and look to co-assess and co-identify areas where we can provide additional support after the deployment to improve future readiniess to respond.
Research	
1. Promote and support research capacity strengthening – prior to and during research activity.	Supporting research capacity strengthening is a priority for the UK-PHRST and a central feature of our research plan. We will continue to ensure this occurs in the development of all new research projects with our partners. We will work closely with our partners and use insights from deployments to identify and prioritise gaps in research capacity that we will address in our strategic research planning.
2. Create and/or adapt generic research protocols for use during outbreaks: This implies having an agenda/routine processes/sets of tools available to identify research opportunities, plan, budget for and implement research (including obtaining ethical approval ahead of time) such that undertaking research is always in a "ready to go" state.	The UK-PHRST will work to create a library of off-the shelf research protocols, in collaboration with research partners.
3. Ensure community engagement and full participation in all studies, including providing feedback to the community and ensuring true partnership not tokenism.	The UK-PHRST will include community engagement and participation, as appropriate to the research study, in research proposals at the development stage and require researchers to identify how this is being addressed at project implementation. We will ensure project leads work closely with UK-PHRST and partner experts in anthropology and in risk communication and community engagement to develop approaches for meaningful community participation throughout the project, ensuring that key research findings and their potential impact on public health or health policy are shared with affected communities once the project concludes. This will be monitored as a research output.
4. Explore how best to communicate research evidence to governments, especially within the context of national research priorities and plans.	The UK-PHRST research proposal template will require study leads partners to identify how they will, and monitor how they do, engage with and communicate research findings to national governments throughout the research study. This will include, for example, developing policy briefs and holding workshops with policy leads to share research findings and latest evidence highlighting the implications these have for best practice in outbreak management and response, and making recommendations for updating national guidelines and policies, as appropriate.

UK-PHRST pillar/work area	Management response
Cross-cutting	
1. Advocate for and build awareness of MHPSS and the need to integrate it into all relevant areas of the work of UK-PHRST and partners.	The UK-PHRST currently includes MHPSS training in its core deployment training course, mandatory for all new UK-PHRST deployable members. We will continue to advocate and build awareness for its inclusion in our work with partners where appropriate.
2. Integrate community engagement and participation into UK-PHRST policies and approaches, working with communities in meaningful and respectful ways that builds and maintain trust.	The UK-PHRST will continue to promote and advocate for community engagement and participation in our ways of working with partners. UK-PHRST provides specialist support for community engagement through RCCE and Social Sciences expertise during outbreak response, which in turn also advocates for community engagement and further partner involvement by demonstrating the benifits of such engagment to the overal response.
3. Leverage on UK-PHRST and influence on the global stage to advocate for partner perspectives and strengthen partner capacity to advocate on behalf of themselves.	The UK-PHRST will continue to speak at appropriate forums on the global stage to advocate for greater levels of inclusion of partner perspectives. Additionally, the Health Diplomacy training provided by UK-PHRST is designed to support partner self-advocacy.

Appendix 3: Programme for the Nairobi Learning Review

Day 1 – 25th June 2024		
Time	**Agenda Item**	**Who?**
09.00 – 09.10	Welcome & Purpose of the day.	Dr Edmund Newman
09.10 - 10.00	Opening address.	Dr Kamene Kimenye
10.00 - 10.15	Comfort break.	All
10.15 - 10.30	Icebreaker.	Dr Femi Nzegwu
10.30 - 10.50	Setting the scene: our collective work over the last 18 months.	Dr Edmund Newman
10.50 - 11.10	Implementing the 2022 recommendations: progress to date.	Mr Thom Banks
11.10 - 12.00	**CAPACITY STRENGTHENING** **Panel (40 Minutes).** Evolving Capacity Strengthening: the journey so far (10 minutes). **Panel 1 – Capacity Strengthening in practice.** Panellists' presentations reflect on whether and how capacity strengthening activities have been delivered with sustainable impact for outbreak preparedness and response – what works & what needs improving? Some areas to consider: Reflecting on our work over the past 18 months, please describe the major areas of learning related to the panel topic that have emerged for you and your team; and which have influenced how you deliver your activities. In what ways have these areas of learning helped advance your practice and that of your team? How sustainable do you think it is? Looking back on these areas of learning what, if anything, would you/could you and/or the UK-PHRST have done differently/better and why? What should we be doing more of?	Dr Claire Bayntun **Panellists:** Dr Charles Njuguna Dr Amal Ali Ms Rachel James Dr Radjabu Bigirimana
12.00 - 12.15	Q&A/Plenary (15 minutes).	**Chair:** Dr Benjamin Djoudalbaye

Day 1 – 25th June 2024		
Time	**Agenda Item**	**Who?**
12.15 - 12.45	**Panel (30 Minutes).** **Panel 2 – Embedding mental health and wellbeing in public health emergencies: case studies.**	**Panellists:** Dr Charles Njuguna Dr Amal Ali Ms Rachel James Dr Radjabu Bigirimana
12.45 - 13.00	Q&A/Plenary (15 minutes).	Dr Joseph Akoi-Bore
13.00 - 14.00	Lunch.	All
14.00 - 14.50	**RESEARCH** **Panel (30 Minutes).** Our research approach – what progress have we made and what can we do better? (20 minutes). Professor Gwenda Hughes **Panel 3 – Improving the impact of our research.** Panellists' presentations reflect on how we work and should work as partners and what methodologies we use to ensure we achieve our joint aims of impactful research. Some areas to consider: – Reflecting on our work over the past 18 months, please describe the major areas of learning related to the panel topic that have emerged for you and your team; and which have influenced how you deliver your activities. – In what ways have these areas of learning helped advance your practice and that of your team? How sustainable do you think it is? – Looking back on these areas of learning what, if anything, would you/could you and/or the UK-PHRST have done differently/better and why? What should we be doing more of?	**Panellists:** Dr George Githinji Professor Dimie Ogoina Dr Maria da Luz Lima Mendonça
14.50 - 15.05	Q&A/Plenary (15 minutes).	Dr Farhana Haque

Day 1 – 25th June 2024		
Time	**Agenda Item**	**Who?**
15.05 - 15.55	**DEPLOYMENT** **Panel (40 Minutes).** Expanding/evolving our deployment approach (10 minutes). **Panel 4 – Deployment: becoming more context specific to partner needs.** Panellists' presentations reflect on the degree to which deployments align well with partner needs, how this is happening and the impact on the quality of deployment outcomes. Some areas to consider: – Reflecting on our work over the past 18 months, please describe the major areas of learning related to the panel topic that have emerged for you and your team; and which have influenced how you deliver your activities. – In what ways have these areas of learning helped advance your practice and that of your team? How sustainable do you think it is? – Looking back on these areas of learning what, if anything, would you/could you and/or the UK-PHRST have done differently/better and why? What should we be doing more of?	Dr Ed Newman **Panellists:** Professor Roma Chilengi Dr Martins Livinus Ms Sara Hollis Mr Achwanyo Kutjok
16.00 - 16.15	Comfort break.	All
16.15 - 16.30	Q&A/Plenary (15 minutes).	**Chair:** Dr Victor DelRioVilas
16.30	Wrap up day 1.	
18.30	All invited to networking & socials at Mercure Hotel, Room TBC. Sign up for parallel sessions on day 2.	

Day 2 – 26th June 2024		
Time	**Agenda Item**	**Who?**
09.00 - 09.15	Morning reflections on the learning from Day 1. Any light bulb moments? Programme for the day.	All Dr Femi Nzegwu Mr Thom Banks
09.15 - 10.00	**(Discussants: 30 minutes).** **Q&A/Plenary (15 minutes).** **Panel 5 – The value of partnerships: personal reflections.** – What makes a good partnership? Discussants explore approaches for reaching a common understanding and developing mutual goals.	**Discussants:** Dr Chinwe Ochu Professor Gwenda Hughes
10.00 - 10.15	Tea break.	All
10.15 - 11.00	Parallel Group work sessions on Capacity Strengthening, Research and Deployment. **RESEARCH (Room TBC)** **Group work (45 minutes).** Group discusses: Priorities for improving impact in the next research plan. – Do the key areas of learning discussed by the panel resonate with the group? Are there identifiable gaps? – Give two recommendations on how this area of work could be made more effective/impactful and sustainable?	Self-selection
	DEPLOYMENT (Room TBC) **Group work (45 minutes).** Group discusses: Priorities for enabling greater alignment of deployments with partner needs in the next phase UK-PHRST's work with partners. – Do the key areas of learning discussed by the panel resonate with the group? Are there identifiable gaps? – Give two recommendations on how this area of work could be made more effective/impactful and sustainable and align better with partners' needs?	Self-selection

Day 2 – 26th June 2024		
Time	**Agenda Item**	**Who?**
	CAPACITY STRENGTHENING (Room TBC) **Group work (45 minutes).** Group discusses: Priorities for improving capacity strengthening in the next phase UK-PHRST's work with partners. – Do the key areas of learning discussed by the panel resonate with the group? Are there identifiable gaps? – Give two recommendations on how this area of work could be made more effective/impactful and sustainable?	Self-selection
11.00 - 12.30	Group presentations and plenary discussion on capacity strengthening, deployment and research – full session (including opportunities for strengthening mental health & wellbeing).	**Chair:** Dr Jake Dunning
12.30 - 13.30	Lunch.	All
13.30 - 14.20	Parallel panels on Community-led response, Global Health Architecture and Integrating the three pillars of UK-PHRST's work at country level.	Self-selection
	Panel (40 Minutes). **Q&A (10 minutes).** **Panel 6 – Community led response.** (Community-led responses are actions and strategies that seek to improve the health and human rights of their constituencies, that are specifically informed and implemented by and for communities themselves and the organisations, groups and networks that represent them.)	**Chair:** Dr Nadine Beckmann **Panellists:** Dr Gbenga Joseph Mr Siddartha Shrestha Dr Elizabeth Shayo Professor Jonas Brant
	Panel (40 Minutes). **Q&A (10 minutes).** **Panel 7 – Global Health Architecture.** (Broadly, the world's endeavour to organise itself in health-related matters that go beyond individual state boundaries. In short, it pertains to issues of global health governance with political, financial, technical and operational implications.)	**Chair:** Dr Ed Newman **Panellists:** Dr Maureen Kamene Kimenye Dr Radjabu Bigirimana Dr April Baller Professor Roma Chilengi

Day 2 – 26th June 2024		
Time	**Agenda Item**	**Who?**
	Panel (40 Minutes). **Q&A (10 minutes).** **Panel 8 – Integrating the three pillars of UK-PHRST's work at country level.** (Is it desirable or feasible to seek to integrate UK-PHRST's work (in capacity strengthening, deployment and research) at country level enabling one area of work to move seamlessly into another; and if so how might this be encouraged or effected?) Panellists reflect on whether this is desirable, to what extent it is feasible and, if so, how this might be effected.	**Chair:** Dr Claire Bayntun **Panellists:** Dr. Kola Jinadu Dr Abdul Sesay Dr Caroline Mwangi Dr Abiodun Egwuenu
14.20 - 15.50	**Group work presentation & plenary discussion (90 minutes).** From our discussions and reflection over the two days, what are our key actionable recommendations on improved practice for: capacity strengthening, deployment, research, partnership working, mental health & wellbeing in public health emergencies? Provide two recommendations per theme area per group.	**Chair:** Dr Femi Nzegwu All
15.50 - 16.45	Extended Tea Break: Exploring collaborative opportunities with pillar leads.	Dr Ed Newman Ms Eno Umoh Professor Gwenda Hughes Dr Claire Bayntun
16.45	Wrap up day 2.	

Day 3 – 27th June 2024		
Time	**Agenda Item**	**Who?**
09.00 - 09.15	Morning reflections on the learning from Day 2. Any light bulb moments? Programme for the day.	All Dr Femi Nzegwu Mr Thom Banks
09.15 - 09.35	The WHO Regional Emergency Preparedness Response Hub for Eastern and Southern Africa, and its role in strengthening national capacities to prepare for, detect and respond to shocks.	Dr Sabeeha Quereshi
09.35 - 10.30	Presentation & plenary discussion on key recommendations – reaching a consensus: – Capacity strengthening – Deployment – Research – Partnership working – Mental health and wellbeing	Dr Femi Nzegwu
10.30 - 10.45	Tea break.	All
10.45 - 12.00	Discussion on key recommendations – reaching a consensus continued.	Dr Femi Nzegwu
12.00 - 13.00	Lunch.	All
13.00 - 13.30	Selection of priority areas/recommendations to advance: Gallery walk (30 minutes).	All
13.30 - 14.00	In conversation about the future of our work (30 minutes). "Looking to the future, where should we focus our efforts, what should we do differently?"	**Discussants:** Dr Ed Newman Dr Benjamin Djoudalbaye Dr Kamene Kimenye
14.00 - 14.30	**Final plenary (40 minutes).** Presentation of agreed priority recommendations. – Final reflections on the event and next steps.	Dr Femi Nzegwu Dr Ed Newman
14.30 - 15.00	Close of the event.	Dr Ed Newman

Appendix 4: Attendees at the Nairobi Learning Review

Below are the 20 recommendations generated during the Learning Review in Nairobi, Kenya.

Attendee	Position
Dr Cathy Abbo	Associate Professor, Department of Psychiatry, School of Medicine, College of Health Sciences, Makerere University, Uganda
Dr Adeyinka Jeremy Adedeji	Researcher, National Veterinary Research Institute (NVRI), Vom, Nigeria
Ms Lisa Aissaoui	Project Coordinator, UK-PHRST
Dr Amal Ali	Technical Advisor to the Director General, MoH, Somaliland
Ms Sarah Armstrong	Training Manager, UK-PHRST
Dr April Baller	Infection Prevention and Control (IPC) & WASH Team Lead, Health Emergencies Programme, WHO
Mr Thom Banks	Senior Programme Manager, UK-PHRST
Dr Claire Bayntun	Head of Capacity Strengthening, UK-PHRST
Dr Nadine Beckman	Senior Social Scientist, UK-PHRST
Dr Radjabu Bigirimana	Technical Officer & AVoHC Programme Lead, Africa CDC
Dr Joseph Akoi-Bore	Director, Centre of Research & Biomedical Analysis (CRAM), Macenta, Guinea
Professor Jonas Brant	Professor, University of Brasilia, Brazil
Professor Roma Chilengi	Director General, Zambia National Public Health Institute (ZNPHI)
Dr Naeem Dalal	Non-Communicable Diseases, Injuries and Mental Health Specialist, Zambia National Public Health Institute (ZNPHI)
Dr Victor DelRioVilas	Senior Epidemiologist, UK-PHRST

Attendee	Position
Dr Jake Dunning	Senior Research Fellow, Pandemic Sciences Institute, University of Oxford
Dr Abiodun Egwuenu	PhD Scholar, Charité Universïtatmedizin/Humboldt University" and "ISID Emerging Leader in International Infectious Diseases"
Ms Ellie Fairfoot	Capacity Strengthening Officer, UK-PHRST
Ms Sabrina Gehrlein	Community Engagement & Accountability delegate, International Federation of the Red Cross and Red Crescent, Nairobi
Dr George Githinji	Scientist, KEMI-Wellcome Trust Research Programme, Kilifi, Kenya
Dr Argata Guracha Guyo	WHO Emergency Preparedness & Response (EPR) Team Lead, Ghana
Dr Farhana Haque	Implementation Science Lead, UK-PHRST
Dr Mohamed Abdi Hergeye	Director General, Ministry of Health Development (MoHD), Somaliland
Mr Ignatius-Roy Hillcoat-Nalletamby	Communications Officer, UK-PHRST
Ms Sara Hollis	Team Lead, Health Information and Risk Assessment, WHO Regional Emergency Hub, Nairobi
Professor Gwenda Hughes	Deputy Director Research, UK-PHRST
Ms Rachel James	Interagency RCCE Coordinator with the Collective Service, Unicef ESAR
Dr Arisekola Ademola Jinadu	Consultant & Technical officer, WHO ESAR
Dr Gbenga Joseph	Head of department, Health Emergency Preparedness and Response, Nigeria CDC
Dr Kamene Kimenye	Director General, Kenya NPHI
Mr Achwanyo Kutjok	Health Adviser, British Embassy Juba, South Sudan
Ms Cristina Leggio	Senior Microbiologist/Microbiology lead, UK-PHRST

Attendee	Position
Ms Olive Leonard	Social Equity & Human Rights officer
Dr Maria da Luz Lima	President, National Institute for Public Health, Cape Verde
Dr Martins Chibueze Livinus	Emergency Preparedness & Response Team Lead, WHO Kenya CO
Mr Dumansi Njobo Mamba	Mental Health Technical Officer, Africa CDC
Dr Ed Newman	Director, UK-PHRST
Mr William Nicolas	Project Manager, UK-PHRST
Dr Charles Kuria Njuguna	Regional Adviser Country Readiness Strengthening, WHO AFRO
Dr Femi Nzegwu	MEL Lead, UK-PHRST
Dr Chinwe Ochu	Director, Planning, Research & Statistics, Nigeria CDC
Professor Dimie Ogoina	Professor of Medicine & Infectious Diseases, Niger Delta University, Bayelsa, Nigeria
Dr Abdul Sesay	Head of Genomics Strategic Core Platform, MRC Unit The Gambia at LSHTM
Dr Elizabeth Shayo	Principal Research Scientist, National Institute for Medical Research, Tanzania
Ms Helen Tomkys	Head of Global Health Security Preparedness, International Directorate, Department of Health & Social Care, UK
Mr Anthony Twyman	Senior Infection Prevention and Control Specialist, UK-PHRST
Ms Eno Umoh	Operations & Deployment Manager, UK-PHRST
Dr Biksegn Yirdaw	Assistant Professor, Public Mental Health, LSHTM, UK

UK Public Health Rapid Support Team (UK-PHRST) and Partners Learning Review

Post Review Reflections & Actions
Nairobi 2024

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