Mid-term Evaluation of the EU Support to the United Nations One UN Response Plan to Covid 19 in Nigeria

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ABBREVIATIONS

AfDB	African Development Bank
AU	African Union
AUDA	African Union Development Agency
BF	Basket Fund
BMGF	Bill & Melinda Gates Foundation
COVID-19	Coronavirus disease (COVID-19)
DAC	Development Assistance Committee
DG- INTPA	European Commission Directorate – International Partnerships
EU	European Union
EUD	European Union Delegations
ET	Evaluation Team
EUTF	EU Emergency Trust Fund for Africa
FCDO	Foreign, Commonwealth & Development Office
FMoH	Federal Ministry of Health
GAVI	Vaccine Alliance
GIZ	Gesellschaft fuer Internationale Zusammenarbeit
GON	Government of Nigeria
HSS	Health System Strengthening
HLPD AU-EU	High Level Policy Dialogue
ILO	International Labour Organization
IR	Inception Report
MoH	Ministry of Health
MS	Member State of the European Union
MSPRP	Multi-sectoral Pandemic Response Plan
MTE	Mid-term evaluation
OECD/DAC	Development Assistance Committee of the Organization for Economic Cooperation and Development
PHC	Primary Health Care
PI	Partnership Instrument
PTF	Petroleum Trust Fund
PUNO	Participating United Nations Organisations
EM	Evaluation Matrix
NACA	National Action against Aids
NASSCO	National Social Safety Net Coordinating Office
NCDC	Nigeria Centre for Disease Control
NPHCDA	National Primary Health Care Development Agency
NEMA	National Emergency Management Agency
RCO	Resident Coordinator's Office
R&D	Research & Development
RRT	Rapid Response Team
SDG	Sustainable Development Goals
SPRP	Strategic Preparedness and Response Plan
ToR	Terms of Reference
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United National Development Programme
UNIDO	United Nations Industrial Development Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN-Women	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organisation

Table of contents:

1. INTRODUCTION TO THE MID-TERM EVALUATION

1.1. OVERVIEW

The outbreak of COVID-19 further highlighted to both the public and private sectors the importance of a good health system. This is in view of the subsequent socio-economic blockade that has taken place in Nigeria. With an average life expectancy of 53.95 years, which is below the sub-Saharan average of 56 years, the World Health Organisation (WHO) ranks Nigeria 163 out of 191 in health system quality, making it one of the fifth worst health systems in the world.

Nigeria faces a number of major health care challenges. These include inadequate funding, poor management and human resources, insufficient drugs, lack of sufficient staff, poor treatment of patients and infrastructure, and poor hygiene. With insufficient financing and human resource shortages being the biggest challenges in the health sector, private sector support has highlighted the importance of private public partnership in both financing and human resource management.

Financing stands out as the main problem, as the national budget allocation for health in recent years has been consistently below the 15% recommended in the 2001 African Union 'Abuja Declaration'. In the federal budget estimates for 2020, the allocation for the provision of primary health care and capital expenditure has decreased compared to the 2019 budget. This is because Nigeria has an annual population growth of 3%, and therefore requires a growing health budget, not a declining budget. N46 billion was allocated for capital expenditure, compared to N47 billion in 2019, representing a reduction of 2.13%. Similarly, the Basic Health Care Provision Fund (BHCPF) decreased by 13.12% from N51.22 billion in 2019 to N44.50 billion in 2020.

The foundation of any good health system is Primary Health Care (PHC). Nigeria has 30,000 PHC facilities in the 774 local governments of the country. Many of these PHCs are in a state of neglect, with only 20% of them in working order, thus limiting access to health care for the population and putting pressure on secondary and tertiary health care institutions.

With an out-of-pocket expenditure rate of 75 per cent and health insurance coverage of 4 per cent, the National Health Act (NHA) of 2014 that led to the creation of the Basic Health Care Provision Fund (BHCPF) aimed at removing financial barriers to accessing primary health care, particularly for the poor and vulnerable, along with the Primary Health Care Under One Roof (PHCUOR), has not yielded the desired results, six years later.

In such a context of structural issues, Nigeria could become the next COVID-19 disaster after India. Experts fear that Nigeria, being the most populous nation in Africa, which has several similarities with India, including climate, poor access to coronavirus vaccines, high population density, huge deficiencies in the health sector and a worsening security crisis across the country, could become the next COVID-19 hotspot. A whole-of-society approach will be needed to limit the spread of Covid-19 and to cushion the potentially devastating impact it could have on vulnerable people and economies. In terms of prevention, Nigeria recently launched the National Social Behaviour Change Campaign as part of efforts to prevent and contain the spread of the COVID-19 pandemic. The campaign labelled H.A.N.D.S is a joint collaboration between the federal government and the United Nations in Nigeria with funding from the current EU programme to be evaluated. The goal of the four-month campaign is to increase the number of Nigerians who believe in and practice preventive behaviours for COVID-19, communicating the main message that "The power to stop COVID-19 is in our H.A.N.D.S".

The United Nations system in Nigeria, in collaboration with the government, in March 2020, due to the rapidly spreading health crisis, launched the **COVID 19 Basket Fund** with the aim of complementing ongoing efforts to mobilize resources in support of the national multi-sectoral response plan to the COVID-19 pandemic, developed by the Presidential Task Force on COVID-19.

The Basket Fund serves as a unique funding and investment platform for various stakeholders (UN and other multilateral bodies, bilateral, private sector, foundations, philanthropists, among others) to channel their financial support to ensure an efficient, effective and impactful response to the

coronavirus pandemic. The COVID-19 Basket Fund is managed through the United Nations system in Nigeria, through a project management board that includes representatives of the Presidential Task Force on the COVID-19 response, relevant government agencies, contributing donors and the United Nations system.

The intervention is based on a three-level strategy:

- At federal level: Provision of support to the Ministry of Health and their agencies and departments including the NCDC and NPHCDA, in charge of the health-related response and the National Emergency Management Agency (NEMA) to other sector responses including on social protection.

- State level: promoting the leadership of Governors and systems supporting the COVID-19 response including state level task forces and state commissioners, contributing to strengthening design and implementation of State level energy preparedness and response plans linked to the Federal plan and eventually supporting the design and deployment of localised recovery plans.

- the Local Government Areas (LGAs): supporting the LGAs in their role in terms of ensuring dissemination of messages, identifying and addressing local level needs and vulnerable persons as well as issues relating to social cohesion. Hence, the Basket Fund supports LGAs to implement these initiatives.

- Linking the basket fund to:

- social protection policies

- pro-poor policies and human rights approach

The BF has been a multi sectoral intervention. It spreads amongst six outputs/results and is linked to the wider UN COVID-19 Strategic Preparedness and Response Plan (SPRP). This fund includes support to structures within the Ministry of Health (MoH) such as the National Centre for Disease Control (NCDC) and the National Primary Health Care Development Agency (NPHCDA).

This report provides the findings of the "Mid-term Evaluation of European Union (EU) support to the United Nations One United Nations (UN) Response Plan to COVID-19 in Nigeria".

The main objectives of this evaluation are to provide an overall independent assessment of the past performance of the EU Support to the United Nations 'One UN Response Plan to COVID-19 in Nigeria', paying particular attention to its intermediate results measured against its expected objectives, and the reasons underpinning such results, key lessons learned, conclusions and related recommendations in order to improve current and future interventions.

According to the ToR, the focus of the evaluation is on the assessment of the achievements, the quality and the results of the interventions.

This evaluation will provide an understanding of the cause-and-effect links among inputs, activities, and outputs, outcomes and impacts.

The evaluation pays particular attention to the results measured as follows:

1. Result 1: Improved rapid procurement of disease commodity packages for surveillance, prevention and control, and clinical management.
2. Result 2: Complementary On-going Risk Communication Strategies for sustained community engagement and cooperation are supported.
3. Result 3: Development of tailored and decentralized response strategies at state-level aligned to the coordinated framework at the Federal level is supported.
4. Result 4: Access to essential health services are maintained through socio-economic analytics, and pro-active early recovery and social protection activities, targeting vulnerable groups.
5. Result 5: Capacities for R&D and Modelling are strengthened.

6. Result 6: Coordination of partnerships and mobilisation of resources for collective response are improved.

This evaluation will specifically serve to:

7. Understand the performance of the Intervention, how quickly UNDP, leading the One UN Basket Fund has put the programme into action.
8. Evaluating the quality of results achieved by implementing UN agencies, its enabling factors and those hampering a proper delivery of results in order to adjust its design or implementing modalities.
9. Analysing the contribution of the various projects to the achievement of objectives and results of the overall programme.
10. Elaborate some recommendations to strengthen the coordination and synergies among the various projects and with stakeholders.
11. Establishing linkages between this programme and the contributions of other development partners and flag the possible discrepancies/lack of synergies.
12. Identifying the features of the programme that could be replicated and scaled up;
13. Analysing the sustainability of the actions and recommendations for the exit strategy.

The Evaluation Team assigned for this assignment consists of 3 experts[1]:

- Dr. Eric Donelli, Health, WaSH and Nutrition Expert
- Mr. Alain Peyré, Business and Value Chain Development Expert
- Mr. Olugbenga Akinyemi Akinbiyi, Infectious Disease Expert

The backstopping team, whose aim is to facilitate the experts' work consists of:

- Ms. Silvia Finizio, Project Director
- Ms. Clara Beffa, Senior Project Manager
- Mr. Andrea Bellini, Quality Supervisor

This Mid Term Evaluation (MTE) began in December 2021 with a preparatory phase (inception and desk phase) which resulted in a review of the available documentation, the formulation of the Evaluation Matrix (EM) and an Inception Report (IR). A virtual kick-off meeting was held on the 10th of December with the participation of the major stakeholders involved in the response. This meeting provided the opportunity to discuss and to reach a consensus on the EM and IR contents. This was agreed in January 2022.

The field phase commenced on Monday 31st of January 2022 with a briefing at the EUD followed with meetings with the Nigerian counterpart and UN agencies. The Evaluation Team (ET) was then able to visit[2] six states (Sokoto, Kano, Lagos, Anambra, Edo and Adamawa) for in depth consultation with the main implementing partners. Back in Abuja the ET completed stakeholder's interviews and finally a de-briefing meeting was held on February 11th of 2022 at the UN house under the leadership of UNDP and EU and with the presence of BF partners through a virtual connection.

[1] The experts' short bios are presented in annex 3.

[2] The choice of regions for the field visit of this MTE was based on geographical coverage and to have a mix of urban and rural areas.

To facilitate readers comprehension of the content, the major findings are presented following the six pillars/expected results of the BF. More in-depth analysis is presented in the main report using the selected traditional Development Assistance Committee (DAC) evaluation criteria as follows:

- relevance
- coherence
- effectiveness
- efficiency
- impact
- sustainability
- and EU specific evaluation criterion, which is the EU added value.

2. ANSWERED QUESTIONS AND FINDINGS

2.1. RELEVANCE

This chapter describes the extent to which the intervention objectives and design responded to needs/priorities and how the BF design and objectives contributed to the needs of Nigeria for controlling the COVID-19 pandemic[3] (**EQ 1.1**).

The BF has been planned and remains an emergency intervention aimed at supporting the National COVID-19 plans (MSPRP). The project was conceived based on previous Participating UN Organisations (PUNO) experience and knowledge[4] and therefore consistent with international practices and regional programmes. Initially based on a UNDP concept note, the BF project document was prepared and developed in close consultation with WHO, MoH, PTF, NCDC, NPHCDA. Based on the programme Log frame, with results and activities implemented, the overall concept and approach of this BF is appropriate in relation to the prevention, treatment and follow up of the COVID-19 response. However, the design could have been realistic to avoid ascribing the project with some results that were/are not relevant and feasible in an emergency context such as results O3 and O5.

The ET in-country interviews, at the Federal and State level, brought a foregone conclusion on the relevance of the BF with Government and the main Donors Health Strategies. This is detailed under the sub question “to what extent were the national authorities involved in the design?” below.

In conclusion, the BF design was relevant to the needs of the GON and PUNOs portfolios.

Nevertheless, this high relevance rating in contributing to the action goal and the design pertinence in respect with international practices and regional programmes had few weaknesses in its formulation and design, such as:

- Some outcomes of the design, while relevant, were weak contributors to the Goal (O3, O5). The ET believes that the purpose of these outcomes was relevant, but their formulation was not smart.
- Outcome 3 was relevant yet without sub-objectives it could have provided results that was marginally useful for the States. This finding is supported by State level feedback, stating that 1) in a context of a rapidly changing situation, it was not possible to establish full-fledged strategies and 2) support to strengthen local response - which consisted much of operational training for the Health System pillars - appeared lightly coordinated and insufficient in some cases, and 3) the main success factor at State level has probably been the strong leadership of Governors and the State Ministry of Health, which guaranteed swift adaptive response and strong commitment from all stakeholders, even in the absence of specific strategies.

[3] Also, to the sub questions presented in the Evaluation Matrix

[4] Other BF in the health sector have been developed in Tanzania and Zimbabwe.

- Outcome 5 relevance was assessed as low, because emergency situations are not the best time to carry out RD and Modelling activities. A significant period may have been needed to produce reliable R&D results. Moreover, the focus on capacity building would also suggest that national (or local) on-going teams or on-going research projects could have been supported. However, specific themes or initiatives were not identified at the design stage.
- The budget allocation may have been inadequate to scale up some actions (e.g., O4). Socio-economic support packages were relevant to maintain access to health services and increase resilience, but most replies gathered in the six States reflected that coverage would have been higher with more resources. The budget and resources allocated for a support to MSME sector, are not commensurate with the size of the needs or with other parallel efforts carried out by GON or even by private sector.
- As the Log-Frame was not revised or updated during the implementation period of the BF, no provision for flexibility was foreseen in the BF design. State level stakeholders in Edo, Anambra and Adamawa expressed that in some cases, when State Government was not facing difficulties in specific areas, a mechanism for 'fast solutions or reorientation of the results activities would have been useful to maintain speedy implementation.
- The BF log frame objectives and indicators were poorly formulated. The logical framework was not finalized to allow proper monitoring. Without clearly formulated objectives (and sub-outcomes) and with no SMART indicators, the implementing partners faced significant difficulties in establishing strong links between the individual projects' outputs (PUNO concept notes) and the BF project document outcomes. Therefore, the relevance of the PUNO proposal is not consistent with the BF purpose. For the same reasons, monitoring was often reduced to the accumulation of the Concept Note results; however rarely conveying a global impression on progress and global effectiveness. Although an emergency initiative, the BF would have deserved a much better objectives definition, more sensitive indicators, and a pre-set system to link systematically individual PUNOs results to the main BF log-frame (this is also relevant for the effectiveness criteria).
- Due to the emergency and short preparation time, the consequences of the BF on Government of Nigeria commitments have not been fully considered. One example is found in how the Government would ensure balanced coverage of the six outputs in all States, since PUNO were not present and/or working in all Nigeria's States. Another example relates to supplementing timely procurement support by addressing the needs for infrastructure/hardware repair (oxygen generators to be fixed, missing cold storages, etc)
- Possible pandemic evolution scenarios were not envisioned in the BF design (e.g., vaccines). Since February 2022, the pandemic dynamics has changed and hence, the BF relevance needs to be reassessed.

The relevant sub questions proposed in the Evaluation Questions Matrix are the following:

1 - Sub-question: How was the project concept developed and adopted?

The BF has been planned and remains an emergency intervention aimed at supporting the National COVID-19 plans (MSPRP). The project was conceived based on previous PUNO experience and knowledge and therefore consistent with international practices and regional programmes. Initially based on a UNDP concept note, the BF project document was prepared and developed in close consultation with the WHO, MoH, PTF, NCDC, and NPHCDA.

2 - Sub-question: Was this design pertinent in respect with international practices and regional programmes?

The ET considers that the design of the BF is pertinent. The design of the BF is based upon six main results; (see above) each result has been complemented with a set of specific activities for

the implementation phase and in line with the prevention, treatment and follow up aspects of the Covid 19 response. It was also made based upon previous UN health emergency interventions.

3 - Sub-question: Would an alternative concept or design have been preferable? If so, which one?

In such an emergency context, alternative design would have been difficult to be conceived, however, the design could have been more realistic to avoid ascribing the project with some results that were/are not relevant and feasible in an emergency context such as results O3 and O5.

4 - Sub-question: To what extent were the national authorities involved in the design?

The BF project document was prepared and developed in close consultation with WHO, MoH, PTF, NCDC, and NPHCDA. The ET in-country interviews at the Federal and State level brought a foregone conclusion on the relevance of the BF with Government and main Donors Health Strategies. Nevertheless, interviews with some GON members emphasized the desire for a stronger involvement of local authorities in the concept and design of the action plan. Below the State level, local stakeholders were also in agreement that the BF design and implementation was and has remained relevant to the local needs. All stakeholders demonstrate commitment to the objectives of the action plan and a common feature was/is the appreciation of the deployment of GoN actions and support at State/local levels as embedded in project design.

5 - Sub-question: How were the needs of the country identified and reflected?

Many of the primary effects of the COVID-19 crisis on Nigeria have been economic, rather than health related. The socio-economic aspect is not the objective of this MTE therefore the ET focused on the health aspects and support provided by the BF.

The country's health needs were identified based on the WHO international standards to cope with the COVID-19 pandemic based on its three control aspects: prevention, treatment and follow up. In the Nigerian context the preventive aspect has been the main approach and provision of vaccines were not included in the first phase of the BF.

Prevention has been the core approach of the BF, as treatment against the virus is still unavailable. Preventive measures of the BF included physical or social distancing, quarantining, and ventilation of indoor spaces, covering coughs and sneezes, hand washing, and keeping unwashed hands away from the face. The use of **face masks** or coverings has been recommended in public settings to minimise the risk of transmissions. **Social distancing** methods to prevent the spread of COVID-19 include quarantines; **travel restrictions**; and the **closing** of schools, workplaces, stadiums, theatres, or shopping centres. Individuals may apply social distancing methods by staying at home, limiting travel, avoiding crowded areas, using no-contact greetings, and physically distancing themselves from others. Tests provided by BF included rapid antigen test and in more advanced health services PCR[5]. However, the ET was not in the position to assess the quantity of the products provided.

6 - Sub-question: How was the GON commitment embedded in the design?

[5] Current tests involve collecting nose and throat swabs from patients with suspected COVID-19. If the virus is present in the cells collected from these patients, viral genes can be detected using a technique called polymerase chain reaction (PCR). This selectively amplifies a sequence of DNA, in this case from a SARS-CoV-2 gene. This offers a highly specific way of detecting the presence of the virus, even from a very small sample. PCR-based tests are being used to varying degrees by countries across the world to identify patients with active infection.

The GON commitment was clearly embedded in the BF design through all the six BF expected results. The GON[6] support has been paramount in the BF implementation.

During this pandemic, the overall national response has been coordinated and directed by the Presidential Task Force (PTF) with a direct reporting line to the President. The Federal Ministry of Health (MOH), the NCDC in particular, took the lead for the health-related response while the Ministry of Humanitarian Affairs, Disaster Management & Social Development (MHADMSD) and National Emergency Management Agency (NEMA) provided leadership to other sectorial and social protection responses. Strong restrictive measures have been taken by the Federal Government on movement and gathering of people – including closing of bars, shops, places of worship and airports confining most civil servants and employees to working from home and calling on the population to respect social distancing guidelines.

State Governors have imposed measures and restrictions in their own respective States. The ET assessed a different degree of execution of those measures in between states; additionally, the division of labour between the three layers of government (Federal, State and local) complicates the efficiency and cost-effectiveness of BF. Interviews with some GON members emphasized the desire of a stronger involvement of the local authorities in the concept and design of the action plan.

7 - Sub-question: Did all stakeholders demonstrate commitment to the objectives?

The ET could assess a high level of commitment of all stakeholders in supporting the BF, their contribution of course varies according to their capacity and mandate as implementing partners or donor. The One UN COVID-19 response BF, managed by UNDP has a wide range of stakeholder involved. The direct beneficiaries of the action are the Federal Ministry of Health (MOH), the Nigeria Centre for Disease Control (NCDC), the Presidential Task Force (PTF) on COVID-19 and the Ministry of Humanitarian Affairs, Disaster Management & Social Development (MHADMSD). The final beneficiaries of this action are the populations living in the 6 geopolitical regions of Nigeria. Additionally Contributing development and private sector partners beside European Union (EU) have been the UN agencies (FAO, ILO, IOM, UNAIDS, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNWOMEN, WHO and WFP; the private sector Dangote and AP Maersk; the Government of Switzerland; Bill & Melinda Gates Foundation; MacArthur Foundation and Government of Norway.

8 - Sub-questions: What mechanism was foreseen to guarantee GON action at state/local levels, and how was this embedded in the project design?

The project had embedded in its design a strong component in order to support the mechanism of GoN actions at state and local level.

Output 3, “Development of tailored and decentralized response strategies at state-level aligned to the coordinated framework at the Federal level is supported” was specifically designed for this purpose. This output supported the development of state level plans aligned to the national COVID-19 multisectoral pandemic response plan. Key Activities: 3.1 Provide technical supports to States and Local Governments to develop COVID-19 contingency and response plans tailored to the local context and aligned to the broader Federal level plan; 3.2 Provide integrated support packages to the implementation of State and Local Government contingency and response plans. This action had the highest financial contribution between the BF expected results as shown below.

[6] National COVID19 Multi-Sectoral Pandemic Response Plan; Presidential Task Force on COVID19 Response - March 2020

Result 3: Decentralized response strategies	27,130,617	37%

9 - Sub-question: Were all the outputs relevant to the MSPRP purpose?

Among the BF six expected outputs the ET consider Result 5: Capacities for R&D and modelling the less relevant in an emergency setting also considering the little budget allocation (75,000 US$) which amount to only 0.1% of the BF overall budget.

10 - Sub-question: Should additional outputs have been included in this project? Which ones?

The BF could have considered since the beginning of the action as an additional output the vaccines procurement which has now in the latest phase taken on board.

11 - Sub-question: Was the balance of funds allocated between funds adequate?

As per table below the total budget was allocated in between the six BF expected results. At the time of the MTE the total expenditure has been of 73,133,599 US$[7]. For the ET the budget allocated to result 5 and the high allocation for result 3 remains questionable in an emergency setting considering the fact that response strategies are already well known for infection diseases (e.g. Cholera).

Results	Actual Expenditures	% of total spent
Result 1: Procurement of disease commodity packages	26,497,678	36%
Result 2: Communication Strategies for community	7,325,762	10%
Result 3: Decentralized response strategies	27,130,617	37%
Result 4: Access to essential health services	11,787,041	16%
Result 5: Capacities for R&D and modelling	75,000	0.1%
Result 6: Coordination of partnerships	50,000	0.1%
Monitoring & Evaluation	267,500	0.4%

Budget allocation may have been inadequate to scale up some actions (e.g. O4).

12 - Sub-question: How well the BF worked in respect of the socioeconomic and medical pillars of the assignment?

Socio-economic support packages were relevant to maintain access to health services and increase resilience, but most replies gathered in the six States reflected that coverage would have been higher with more financial resources. The budget and resources allocated for a support to MSME sector are not commensurate with the size of the needs or with other parallel efforts carried out by Government or even by private sector.

This sub-question aims at addressing relevance from an ex-post perspective. More details on this are presented in the chapter related to effectiveness. At this level, the sub question asked to officials and CSO representatives yielded similar feedback in most states (except Lagos): the principle of socioeconomic package was relevant, but impact was limited as the CSO partners of the PUNO faced budget limitation to cover more beneficiaries. Officials and PUNO representative indicated

[7] For more budget details please refer to the efficiency chapter 2.4

that the socio-economic and medical package were both relevant in principle and in implementation. The replies from Lagos state were less positive as a whole.

2.2. COHERENCE

This chapter presents the ET findings in relation to the compatibility of the intervention with other interventions (EU, UN and GON and other institutions) in the country health sector in responding to the **EQ: Have the BF design and implementation strategy created synergies with a) Government programs and policies, and b) with DP programmes[8]?**

The BF coherence has been described as "**Strong *and needed"*** by all interviewed stakeholders because the BF intervention modality and strategy were and are aligned with the GON, UN and EU Emergency Trust Fund for Africa (EUTF) strategy in Nigeria and with other EU and policies and Member State actions. As highlighted by the reports and by the interviewees, the intervention had a powerful catalytic effect with a strong positive reinforcement/synergy in all involved health organisations (Hospitals, health centres, laboratories etc.) and has influenced the partner's policy and interventions of course in relation to the Covid-19 epidemic, with reference to health and hygiene procedures. Examples of this influence include the Norway Embassy considering to pursue support to Health sector within this BF and in a parallel toit; and increased engagement of local authorities with CSO to better canvass the remote areas and linked marginalized persons into the official health system.

The ET opinion is that the BF design and objectives were coherent with on-going EU initiative (NE Nigeria, HSS, RCDSC and ECHO), and fully coherent with MoH portfolio and Presidential Task Force roadmap. The BF objectives were fully coherent with WHO, and UNICEF mandate. However, the coherence is weaker in relation to other PUNOs' portfolios and mandate: this is due to the fact that PUNO's mandate does not target specifically health-related matters such as COVID-19. This assessment is based on the document review, confirmed by interviews of the main stakeholders (health system implementers, state authorities, task force, and Development Partners).

Coherence was then assessed in relation with the implementation modality[9]. Replies among Development Partners and among PUNO indicated that the implementation model has generated difficulties, but not to the level where program would be slowed down. Other consideration linked to the country context, allows confirming that in the context of Nigeria, indirect management was the only practically feasible option. An alternative option would have consisted in a project approach through partnership/sub agreements with multiple partners. However, the preparation of this modality approach is likely to have taken significant lead time, and the implementation work flows might have been slower, too.

Coherence was also assessed in term of geographical coverage[10]. With a PUNO-driven implementation, not all BF outcomes were implemented in all States. No provision was made in the BF design, to monitor inputs and outputs in each State, and possibly to balance the support offered. The partial coverage of the BF may have led to unequal response capacity across all States, introducing in such case 'weak' points in the national shield and hindering the overall control of the pandemic. The above design weaknesses were mitigated during implementation, through the

[8] **Sub-Questions: (i)** What positive reinforcement/ synergy did the BF create for your organization? (ii) Would you say that the BF activities implementation was consistent (since 2020)? (iii) How was your involvement in activities coordination or in the institutional management of the BF activities?

[9] This is also relevant for the BF relevance

[10] This is also relevant for the BF relevance

supervisory support at Federal level and through the Board monitoring and screening of the BF efforts.

The coherence sub-questions proposed in the Evaluation Matrix are the following:

1 - Sub-question: How do you rate the coherence of the BF concept within your organisation?

The ET stakeholder's interviews revealed a high rate of consensus among them on the coherence of the BF concept and approach. However, the ET experience raised the following questions: was this EUD additional support (action) really needed? (An additional intervention and support through a BF for Covid-19) considering the nature of the epidemic in Nigeria and the many on-going actions on Health System Strengthening (low number of cases, low number of deaths etc.) Is COVID-19 a real health priority in the country? Many stakeholders interviewed including the ET have a doubt if we do consider the real country health priorities.

2 - Sub-question: Are the BF modality and strategy aligned with the EUTF strategy in Nigeria and the Sahel and with other EU policies and Member State actions?

The BF modality and strategy is aligned with the EUTFs objectives "strengthening resilience of communities, especially the most vulnerable, as well as refugees and Internally Displaced Persons" and on supporting "improved governance".

Directly responding to the EUTF goals, the overall objective of the EU Support to the United Nations Development Programme (UNDP) 'One UN Response Plan to COVID-19 in Nigeria' has been to ensure optimum care of the confirmed COVID-19 cases and contain further spread of the outbreak in Nigeria. The comparative advantage of funds allocated through the EUTF has been the possibility to promptly contribute financially to effectively kick-start the UNDP 'One UN Response Plan for COVID-19 in Nigeria' as well as to create the political space necessary in order to have better alignment and cohesion among EU and other international stakeholders in Nigeria.

BF complementary actions and synergies with other on-going EU projects: The EU has several other initiatives which can directly strengthen the support to the UNDP 'One UN Response Plan for COVID-19 in Nigeria'. The BF has built on the achievements of and seeks complementarity with on-going programmes. The EU has provided around EUR 250 million in support to Nigeria's health sector under the 9th, 10th and 11th European Development Funds (EDF) over the last decade. The emphasis has been on support to immunisation for communicable diseases (polio in particular) and to improve maternal and children's health and nutrition. The current Maternal and Children's Health & Nutrition (MCHNP) programme is implemented by UNICEF for an amount of EUR 48 million in three States (Kebbi, Bauchi, Adamawa). The World Health Organisation (WHO) is implementing a EUR 21 million programme that focusses on the strengthening of health systems in two States (Sokoto and Anambra) and polio eradication. The EU has also provided considerable support to the WASH sector to ensure communities and health facilities have access to running water as well as set up communities to foster hand hygiene and better environmental sanitation with reduction of open defecation. As from 2019, the EU implements in conflict affected Yobe State in North-East Nigeria an innovative programme (EUR 30 million) that not only supports affected and vulnerable communities to meet basic needs through providing cash transfers but is building state capacity to implement the National Social Protection Policy, including a specific nutrition sensitive social safety net programme in response to malnutrition. Furthermore, in Anambra State, the EU's health systems strengthening programme, implemented by the WHO, is developing a pilot to link cash transfers to the extreme poor to a health insurance system.

GON is not eligible for budget support. However, the EU Delegation has identified a few possibilities within existing programmes for small-scale support to NCDC in response to the COVID-19 pandemic (EUR 300,000 on the West-Africa Regional Indicative Programme (RIP) support to the Regional Centre for Disease Surveillance & Control (RCDSC); EUR 200,000 for solar panels on the Nigeria Energy Support Programme).

ECHO is providing support to the crisis response through a programme with UNICEF (EUR 1,2 million) mainly aimed at the purchase of medical supplies. In line with the EU Social Protection Guidance Package across the Humanitarian-Development Nexus (SPaN), the EU promoted linkages and synergies between the humanitarian and the early recovery response to the COVID-19 crisis, ensuring consistency and alignment of cash transfers and working towards the contribution of humanitarian actors towards the national social protection system. At the regional level, support is provided through the 11th EDF RIP, to the Regional Centre for Disease Surveillance & Control (EUR 5 million), an action implemented by the Gesellschaft fur Internationale Zusammenarbeit (GIZ) and co-funded by the German Government.

At global level, the EU has made available significant funding to WHO for combatting the COVID-19 outbreak. Also, the World Bank (WB) and the International Monetary Fund (IMF) were quick to announce global support for combatting the COVID-19 crisis and restoring stability in its aftermath.

3 - Sub-question: Has the intervention influenced the partners' policy and interventions?

Rather than influenced, it would be better and more appropriate to use the word ***strengthened*** as the intervention was embedded in already defined health policies and strategies. Additionally, considering the emergency nature of the intervention and its limited implementation time, the intake was marginal.

4 - Sub-question: What positive reinforcement/synergy did the BF create?

The BF had and still has a very strong positive reinforcement and synergy effect on the stakeholders involved. These can be summarised as follow: coordination, ownership, information sharing, involvement of the private sector, involvement of national institution at central and peripheral level and alignment with health national policies and strategies. The BF clearly had a catalyser effect on the health system strengthening.

5 - Sub-question: Was the BF activities implementation consistent since 2020?

The BFs six outputs and their related implemented activities remain consistent and did not change during the intervention duration. The ET has no knowledge of any logical Frame revision, made by UNDP.

6 - Sub-question: How was the involvement in coordination activities or in the institutional management of the BF activities?

The coordination aspects of the overall BF intervention had/has three main entities involved: (i) the GON; (ii) the PUNO and (iii) the EUD. As previous health crisis has underscored; the importance of an efficient coordination between the stakeholders involved is paramount for a successful operation through a strong national ownership, alignment to government plans and working through

national institutions. The BF had this approach and the interviews with stakeholders and documents, reports review revealed a satisfactory coordination between them.

GON has a National COVID-19 Multi-Sectoral Pandemic Response Plan led by the Presidential Taskforce which has been adopted and serves as a blueprint for a whole-of-Government response. The UN and international community worked closely with the Presidential Taskforce and coordinate their responses accordingly although a better coordination between the UN agencies involved revealed some weakness in between them in terms of coordination and information sharing as they tend to work in silos.

The EU had an on-going coordination with other donors and stakeholders. The EU had an active participant of the Health Development Partners (HDP) working group and is in continuous and on-going coordination with EU Member States, key partners and like-minded countries – monitoring closely the situation and taking proactive steps. Key participants in the group are not only the main donors (DFID, Canada, USA and the EU), UNFPA and the WHO but as well key Foundations as Dangote and the Bill & Melinda Gates Foundation.

2.3. EFFECTIVENESS

The assessment of effectiveness is based on two main aspects: (i) the level of achievement of the outputs targets based on information derived from reports and data gathered during interviews and on NCDC website; and (ii) the overall perception of stakeholders assessed through their replies to sub-questions.

We provide below the answers to the EQs.

Evaluation Question 3.1 In which way and to what extent was the rapid implementation of Nigeria's National COVID-19 Multi-Sectoral Pandemic Response Plan strengthened (national and overall)?

The BF projects greatly strengthened the pandemic response plan, through tangible and significant contributions:

1. To pillars I-Epidemiology and Surveillance, IV-Infection Prevention and Control, V-Case Management, through outputs 1 and 3;
2. To pillars II-Laboratories, IV-Infection Prevention and Control, and VII-Security, Logistics and Mass Care through outputs 1 and 4;
3. To pillar VI-Risk Communications and Community Engagement through output 2.
4. The BF had also indirect contribution, via the BF Board to pillars VIII-Coordination and Resource Mobilisation and X-PTF Coordination Activities.

Overall, the effect of the BF was the strengthening of the State Health Systems in terms of infrastructure and of staff capability. BF impact was also noted in terms of enhanced coordination and collaboration between several agencies and groups at State level, and improved joint work between Government agencies and between Development Partners.

The outreach to and support for the vulnerable and marginalized was sizeable and resulted in preserving livelihoods, maintaining access to health services, and finally in higher resilience for these groups. The BF support to the productive sector was less significant compared to other initiatives from GON or the private sector.

Evaluation Question 3.2. How was the performance of procurement of disease commodity packages?

5. Globally the procurement of disease commodity packages has been very effective, as demonstrated by the tally of deliveries, and the statements of beneficiaries in the visited States.

6. Procurement was timely thanks to advanced action of UNDP, and to the effective management of PUNOs to procure the commodities. Minor difficulties were reported in the early stage (Q2-Q3 2020) for logistics, validity dates..., but the subsequent deliveries were better organized.

7. Unmet needs were reported in some areas of the visited States, but overall, these gaps seem not to have been overly detrimental to the COVID-19 response at State level; respondents only indicated that more coverage would have been better with more packages.

8. There seems to have been slight mismatch between the needs and the supplies in Lagos State, but in the other States visited by the ET, stakeholders indicated the coverage of their needs was satisfactory both in quantity and quality of the purchased commodities.

Evaluation Question 3.3. Did the risk communication strategy succeed in engaging communities, and in modifying the beliefs and behaviours in ways favourable to the pandemic control in Nigeria?

9. All communication channels and means have been used, and there has been a huge mobilization and effort to convey risk management messages. While some lack of coordination was felt despite the existence of integrated strategic communication plans, the messages have reached the finer levels of the territory, at time at the cost of significant voluntary efforts from the CSO involved.

10. The ET, in the six States visited, gathered anecdotal evidence of a significant and positive impact of the messages on the population's beliefs and attitudes. Change also occurred in the discourse and response of traditional leaders, although with resistance in some States. These changes have not been measured as such by the project, for want of indicators of outcome for the activity 'communication'. Several statements on this topic were made often spontaneously, both by stakeholders and civil society representatives, which constitute a body of indirect evidence establishing the impact of the communication activities.

11. In the emergency context, it is well understandable that no tools have been used for measuring how effective the messages had been in shaping mindsets. At the end of this implementation period, the stakeholders have no certainty of which channels have been the best to modify behaviours; hence, no possibility to extract lessons learnt for the future. Case in point, messages have not yet extinguished the hesitancy for vaccination among Nigerians - neither in other countries.

12. Despite the positive effect of output 2, after two years under the COVID-19 pandemic, fake information and conspiracy theories are still spreading on social media, all with a negative impact on behaviour change.

Evaluation Question 3.4. Were the state-level strategies developed and what has been the rate of their implementation?

13. The purpose of the output was appropriate, but the formulation was not accurate. This wording is a summary of two activities in the original concept paper: 1) support developing State and local level strategies, and 2) support their implementation.

14. As discussed in the inception report, there was no point, and probably no possibility to developing overarching 'State level' strategies in the context of a rapidly evolving pandemic. Instead, the States have adapted their responses based on a daily monitoring and crisis management routines, and on information generated at Federal level (NCDC). This adaptation and modulation of the response was supported by the BF, through operational

support to several pillars of the health systems in the States. The National Guidance was thus implemented and/or adapted at State level under the form local rules and procedures, and ad hoc arrangements suitable to local circumstances.

15. In that context, WHO and UNDP mobilized resources under Output 3 to build capacity, enhance coordination, and strengthen State response in the areas of case management, tracing, surveillance.

16. While the operational approach for this objective was sound, these activities and their results were not well described beforehand, and not well documented. Replies to interview questions demonstrate the positive impact on the key functions of States Health System; however, the ET was unable to establish the detail of how support had been provided, through which channels and to which beneficiaries. An input/output table would have been useful to track the different sub-activities under this output.

Evaluation Question 3.5. To what extent was access to essential health services maintained for vulnerable groups?

17. Based on the implementation progress reports, and on direct interactions with a few beneficiaries and with the CSO associated to this activity, the ET believe the objective has been achieved; and that effectiveness was high for this outcome.

18. The ET noted direct positive effect on the resilience of vulnerable groups, as well as positive side effects for the women (livelihoods or micro-business sustained, enhanced opportunities to voice GBV or other health issues, inclusion in the social networks and/or banking system...)

19. However, the stakeholders' replies also reflected some limitations to this activity:

    1. Not all States have been receiving support packages: there might have been disparities in BF support across the States served. However, since the distribution of resource was decided upon by the Federal Government in consultation with NCDC and PTF, it is probably safe to infer that coverage was appropriate to the national and Sates situation.

    2. Different situations were noted between rural and urban settings as well as the beginning of the pandemic in 2020 and now, where access to health services is back to usual levels.

    3. Differences were also noted in the needs of target groups and the coverage between the early stages and present phase of the pandemic, reflecting the adaptative nature of the BF support.

    4. Some CSO representatives (Anambra) have suggested a better inclusion in State COVID-19 response and more broadly in the State Health System; this would relate both to an active role in implementing the BF activities[11], and in enhanced voice and supportive role in State response system.

20. The support packages for MSMEs were effective in supporting response capacity (production of PPE by MSME, some of these women-led); however, the sub-project is much smaller than other support packages[12] mobilized by the GON (see in Annexes Communications from Min. of Industry or the private sector). While past support was relevant and useful, the BF might explore more sizeable/synergistic and more effective ways to support the productive sector, possibly through partnerships with the private sector members of the BF.

[11] It was explained that the exclusion of CSO from proposal submissions and implementation was to avoid delays, as the CSO will need to go through HACT assessments. This would become less relevant at present when emergency subsides.
[12] See Link on National COVID-19 response including stimulus packages- accessed on 02 Feb 2022

<u>Evaluation Question 3.6.</u> Has the coordination of partnerships and the mobilization of resources generated a stronger collective response?

21. The stakeholder's replies to the sub-question were overwhelmingly positive and have left no doubt the BF provided a platform for positive coordination between GON and development partners, and between Development partners themselves.

22. At State level as well, findings demonstrate an improved coordination and enhanced commitment: although not directly caused by the BF, this was a consequence of the mobilization generated by and around the BF support.

23. A few instances were reported, of resources insufficiently forthcoming from the BF to enable full coordination locally (logistics to attend meetings, means of communication), or to facilitate the coordination between State and Federal level Institutions.

24. The ET believes that coordination of partnerships and the mobilization of resources generated a stronger collective response; more so through resource mobilization, which made possible useful controls of the pandemics locally, than through coordination, which had a positive effect at State level, but perhaps less so at Federal level.

The overall assessment of effectiveness could be summarized along the following lines:

25. A large majority of replies, over 75%, are positive in regard with the effective achievement of outcome and outputs. The evaluation matrix had proposed that thresholds of 40% and 60% positive replies for outcome and output, respectively, would determine success. The rate of positive responses is calculated ex-post based on responses to interviews, assessing the views expressed by each participant in central and State level as either positive or rather positive, or negative, or rather negative.

26. Triangulation was carried out and there is a convergence of views between replies from civil society representatives, from Government officials, and from Development partners, although the later had a broader appreciation of this effect (based on the feedback received in Board meetings).

27. The result monitoring tables (see findings in the sub-question sections above) provide evidence of successful achievement, with the understanding that output 5 and 6 became less relevant to the BF during implementation.

The replies to sub-questions were obtained both through individual face-to-face interviews with key respondents in Abuja (representatives of the Federal Government and of Development partners), and in the six states, through focus group discussions that gathered senior officials from Ministry of Health, manager-level officials involved in primary health centres, representatives of local authorities, and representatives of the civil society organizations. The composition of these groups is provided in Annexes.

A summary of replies to sub-questions and findings is presented below, for the sub questions of the evaluation matrix; this section is followed by replies to the Evaluation Questions 3.1) to 3.6) and by a summative assessment.

<u>1 - Sub Question: Did the implementation strategy prove appropriate/ effective? How much so?</u>

This sub-question aimed at getting the stakeholders' assessment of the project delivery model.

Overall, a large majority of responses (86%) show the project modality was effective. The list of surveyed people can be found in the annexe 6.

1. Federal Government representatives appreciated the effectiveness of collaboration with Government system (response plan) and recognized the BF was able to mobilize significant resources in relative short time; they also noted the effectiveness in resources generation, quick disbursement, and accountability.
2. State-level officials indicated very good effectiveness of the implementation modality, due to close cooperation with PUNOs that complemented well the Government support, and for reaching out to the most affected among the population. This was nuanced by a few comments indicating the model would have been better if proposals could be developed at State level, or at least with better interaction between technical teams of State and Federal levels (also noted by PUNO state-level staff).
3. Development partners (other contributors to the BF) were all in agreement the BF implementation strategy was effective; however, a few replies noted the relative weakness of the log frame (indicators) and in progress reporting, adding BF may have been stronger with proper program planning and management.
4. UNDP and PUNO stakeholders also found the modality effective as it provided opportunity for within-UN cooperation; some stakeholders also noted the effectiveness of the BF governance system (Board and Technical Committee). In this stakeholder's group, a few replies mentioned the initial difficulty in reaching financial agreements (UNDP with PUNOs), which has increased lead time, and insufficient support and coordination by UNDP for preparing the concept notes to be submitted to the Board.
5. Representatives of the CSOs were less concerned, as they were not directly involved in the implementation model; nevertheless, their replies reflected the wish that the implementation should have better coordinated with the State actors (also noted by some LLG representatives).

2 - Sub-Question: Was the implementation methods for (your) respective activities appropriate?

This sub question aimed at highlighting the merits and demerits of the implementation procedures, for each stakeholder group.

On average, most responses (85%) indicated that the implementation modality was appropriate for the objectives and activities pursued by stakeholders. The negative replies are linked to difficulties in preparing concept notes and lack of possibility of direct access by CSO to the BF support.

6. Among the Government officials, replies noted the BF comparative advantage to make things work and to add scale to Nigeria response (in particular for Output 1). In Edo State, the MoH representative stressed the BF effectiveness for building capacities (risk management, information, contact tracing) and for providing health volunteers with step-by-step protocols that strengthened surveillance work. Other positive replies confirmed the effectiveness of the BF, because the project organization and implementation model associated Govt channels with CSO.
7. Stakeholders in the PUNOs group highlighted the effectiveness of BF for giving access and openness to rural communities when carrying out the risk communication activities; they also noted RCCE helped to reach out to the hard-to-reach groups, as well as gather information and feedback from audience. These

respondents indicated for example that the extra effort in communication about COVID-19, enabled Health officials and CSO operators to identify and/or engage more with marginalized groups, as compared to the situation before the BF. Most PUNO found the implementation was effective/ appropriate to their own modalities, although each PUNO remained responsible for their own financial management (transaction time). One reply in the PUNO group alluded to difficulties in concept notes preparation; however, adding the onus was on the PUNOs to adapt their ways of preparing proposals. This reply also highlighted that since Government stakeholders were not always able to express timely their needs, in some cases the proposals might have reflected more 'standard' contents, which made these 'acceptable' for the BF Board.

8. In the CSO group, one reply was negative on the basis that the BF goals and objectives were not reflecting enough the potential role of CSO in the pandemic response; adding that despite strong involvement of CSO in fighting COVID-19, very little support had been provisioned for CSO.

9. For the Development Partners, replies were all positive. The implementation model through proposals was seen as optimal in the pandemic's context (short time to respond, absence of credible alternative models). Other replies noted the effectiveness of the Board and the technical Committee, and the effectiveness of UNDP as BF manager, despite some weaknesses in reporting and proposal preparation support.

3 - Sub-Question: Is the expected outcome (likely to be) achieved?

The stakeholders' replies are a qualitative judgement, not always fully informed since not all of them had a complete vision of the BF progress and results; nevertheless, the replies reflect their global perception of the achievements to date. All replies were positive, whether they relate to contributing to national plan, successfully tackling the pandemics, reaching more vulnerable persons, or resulting in an improved situation in States (COVID prevalence, other diseases). CSO noted the wide outreach to vulnerable and marginalized, resulting in higher resilience. Replies indicated that achievement of outcome also consisted of much better coordination and collaboration between several agencies and groups at State level. One reply in the Development partner group noted that besides achieving its outcome, the BF had triggered better joint work with Government and between Donors.

Outcome	Targets (Project Document)	Achievement as of July 2021
50% rate of success in implementation of the national pandemic response plan (aggregated rate of success for each of the 10 functional areas.	50%	+76%

4 - Sub-Question: Could the same outcome be achieved in a better way?

This sub-question yielded only a few replies, as the overall perception on effectiveness was positive. Three replies were reinforcing the assessment that the implementation modality had been

appropriate, and no alternative strategy would have been justified. It was deemed better to implement activities, even if there was some imprecision in preparation, rather than to wait and have better defined modality and/or projects. By contrast replies highlighted that:

1. All in all, there could have been better interaction within the UN family and between the UN agencies and Government agencies.
2. On procurement, some packages procured unilaterally by UNDP for quick delivery. At this time there was no representation/inclusion in the global procurement systems, which may have decreased Nigeria position for future supplies[13]; conversely global procurement systems proved also to have limitations in terms of availability of certain supplies (tests).

5 - Sub-Question: Are the respective outputs (1-6) achieved?

The question was aimed at gathering stakeholders' inputs for the Evaluation Questions a) to e) (see below).

Overall, 24 replies out of 26 (92%) indicate that the outputs where achieved; negative replies relate to output 5.

There is noticeable variance between targets and achievements; however, the ET was not able to determine in detail the underlying reasons for these, because the progress report does not elaborate on this aspect. Overachievement may be a result from the synergies created by the project at State level. Underachievement, for example in output 4.4 and 4.5, could be due to insufficient resources allocated by the PUNOs to CSO partners for them to reach out the beneficiaries, or other logistics challenges; otherwise, it could be generated by the lag in reporting (4 to 6 months) meaning that at the date of the MTE, data available were not the actual results as of mid-run of the project.

1. For Output 1

1. Several respondents highlighted that procurement was done in a strategic way, and offered good guarantees for avoiding waste or misuse of resources
2. All the replies indicated that disease commodity packages were procured mostly timely, in adequate quantity and of good quality.
3. Disease commodity packages included: oxygen concentrator, laboratory commodities, PPES, flip chart, dignity kit, RH kits 1 and 3, condoms and IEC materials, face mask, PPE, hand washing materials, branded T-shirts, hand sanitizers, bundles of wrappers, bundles of slippers, dignitary kits, bucket, mat, blanket, hijabs, pomade, whistle, delivery kit, CBT, Ventilators, ambulance, and basket support for setting up of sample testing site.
4. The Evaluation team was able to consult the four progress reports provided[14]. No accurate tally or description of inputs delivery was found in these reports, nor in their

[13] This would relate to the need for Countries to position themselves early in the procurement rounds of the Global Fund (Nigeria C19 RM was effective in June 2021- Window 4 for a total of USD133,589,650)

[14] Request for any and all source of information was made to UNDP and EUD, during inception phase and during the field interviews with the UNDP team. However, no additional documents were shared; therefore, the Evaluators have worked based on the information

Annexes. Therefore, the ET sough additional sources on the internet, in particular on the site of the European Union. The two sources were found consistent, and the ET could summarize the achievements as follows:

Output 1	Targets (Project Document)	Achievement as of July 2021
1.1 Number of testing kits dispatched	Year 1: 150,000 Year 2: 100,000	823,910
1.2 Number of laboratories with testing capabilities	Year 1: 15 in 12 states Year 2: 50 in all states	141 [2,618,773 tests performed]
1.3 Number of PPEs dispatched	Year 1: 15 million Year 2: 10 million	11.27 million[15]
1.4 Number of COVID-19 healthcare facilities with triage and treatment capacity	Year 1: +20 Year 2: +50	235 across nine states (Kaduna, Kano, Gombe, Sokoto, Borno, Akwa Ibom, Enugu, Lagos and Ogun) and the FCT
1.5 Percentage of acute health care facilities with isolation capacity	Year 1: +8 Year 2: +16	15

2. *For Output 2*

1. With all replies being positive, all stakeholders agreed that the risk management communication has had a huge effect on the population. The project for output 2 was fully completed by 2021, with a comprehensive use and coverage of combined medias. However, a few replies point at difficulties on the risk communication, such as 1) absence of a master plan could have created heterogeneity and lack of coordination across states (stated by NCDC); 2) absence of tools to evaluate the actual changes in beliefs and attitudes (stated by PUNOs).
2. The replies from representatives of the CSOs and PUNOs at State level, stated that the communication effort through a wide range of media had a massive impact, and resonated with other health messages. Most respondents in this group highlighted that the BF support had enhanced communication, and that the coordination with and involvement of Government agencies helped reinforce the messages.
3. Anecdotal evidence was collected by CSO and Government officials alike, confirming actual changes in practices (e.g., use of masks) and changes in attitudes (e.g., traditional leaders communicating more frequently and acting against GBV); in some cases (Anambra State) assessments were carried out, confirming that message had effect (e.g., in Anambra the vaccine response was slightly better than other states). Several replies indicated the communication strategy in the State was upcoming or on-going (Gov, CSO, PUNO).

available. An up-to-date on-line repository of validated reports and other technical documents might be a good solution to satisfy information-sharing/ aid transparency purposes.

[15] See list in annexes

Output 2	Targets (Project Document)	Achievement as of July 2021
2.1 Number of integrated communication strategies strengthened	Year 1: 2 Year 2: 2	6
2.2 Number of public awareness campaigns on preventive measures and recovery interventions supported	Year 1: 50 Year 2: 120	281
2.3 Number of individuals reached with risk communication and public engagement messaging	Year 1: 80 million Year 2: 110 million	208 million (25% in vulnerable groups)

3. *For Output 3*

The nature of the output and related indicator was inadequately described in the log frame. The provision of integrated support packages (activity 3.2) in the project document was no further defined, while it could obviously be arranged along the main pillars of the response plan/ and or health system. Replies to this sub-question provided evidence that significant support had been channelled to the key pillars of the State Health System, with a positive appreciation overall (75% of replies positive).

1. During interviews, the UNDP, and PUNOs indicated they had provided support to these strategies and plans both at Federal and State level, consisting in resources for logistics and coordination resources, technical assistance, and training on specific response procedures. The progress reports provide sufficient details on the support provided mostly training (including GBSV) and assistance in setting procedures. Reports yet provide limited explanation or details on how this was planned, what has been done (number of training sessions) and by whom (trainers): the activity appears to have been implemented within the framework of the national response plan and based on needs expressed in the States. More detail might have been useful since the activity scope was consequent, with training of some 5,293 health care workers in case management, IPC training for 55,000 health care workers and community volunteers, and intensive care specialist training for 93 health professionals plus 12 master trainers.

2. All stakeholders indicated that no strategy as such had been developed at State or Local level; however, WHO reported that Response plans had been set both at state and local level. This might appear as a contradiction when in fact it is not since the facts are reported differently by different respondents. It's the ET understanding that this apparent contradiction stems from a difference of perspective between the persons who prepared the project (mostly at Federal level) and the people who implemented it (mostly at State level). Where the logframe and project document state 'local response strategies', when it came to implementation, State level actors were in no position to actually develop strategies; instead, they were urgently unrolling the emergency function to fight the pandemic, with an adaptation of the central level response strategic roadmap. Over the implementation phase, the BF has thus significantly supported the deployment of local responses, yet this deployment was not formalized into 'State-level strategies'. This explains why the stakeholders' replies remain largely positive on the achievement of this output. Several

replies demonstrated the BF had supported the implementation of response to COVID-19 in line with Federal Government guidance, but with adaptations fitting the particular situation in the State.

3. On the PUNO side, WHO indicated their focus was at Federal level (review of response strategies, national monitoring), and this support helped adjust specific response at States level. The WHO responses (Federal and States) reflected strong results, with the training of a critical mass of health community workers, and with enhanced capacities for case management, surveillance & tracing, lab staffs, etc. The Government officials replies (from Government, EOC, PHC) confirmed that the BF provided resources to strengthen surveillance and tracking of cases, as well as for logistics (attendance to meetings); and this contributed to adapt the local response. In Edo State, the Ministry of Health appreciated the BF contributed additional resources for strengthening the EOC, which was a very light unit at the beginning of the pandemic.

4. Other replies from staffs in the State Health System (respondents from PHC, LLG, CSO) stated that the BF support was instrumental to maintain essential health services locally.

Output 3	Targets (Project Document)	Achievement as of July 2021
3.1 Number of States that develop and are implementing contingency, response, and recovery plans	Year 1: 10 Year 2: 36	32
3.2 Number of Local Governments that develop and are implementing contingency, response and recovery plans	Year 1: 25 Year 2: 50	27

4. *For output 4*

This output is largely considered as successfully achieved, as attested by 90% of positive replies and with two less positive comments.

1. In respect with the strengthening of the Health System during the pandemic:

2. Government officials' replies stated that access to health services was restored after an initial drop (second half of 2020). Respondents in this group (EOC, LLG, PHC) indicated very good achievements, with the delivery of PPE and tools, and LGA level training contributing to restore services quickly. Similar feedback was gathered from WHO representatives as they were closely associated with these efforts.

3. Similarly, the donation of commodities such as PPE to the community helped to protect the community members, the text for life initiative assisted the community accessing health services more easily.

2. In respect with socio-economic support packages

1. Replies indicated that target groups, in particular women (women-led households, women-led businesses) had a wide range of uses of the support provided (cash, food, small equipment...); access to health was not a priority as such. (PUNOs, CSO)

2. Respondents from the CSO stated the positive achievements under this output, explaining that cash transfer has reached the disabled, the elderly, and persons with chronic diseases.

3. UNIDO stated that after a slow start and careful preparation (mapping and selection), support was delivered in mid-2021, and additional equipment will be delivered in 2022.

3. *Two replies stated concerns on the achievement of Output 4*

1. One from one PUNO staff, considering that socio-economic packages were small in proportion of other support provided by Government.

2. One from a Development Partner noting that more accurate information on progress would have been useful.

Output 4	Targets (Project Document)	Achievement as of July 2021
4.1 Number of health care facilities providing health services (particularly reproductive and maternal health care and routine immunization) in line with the revised/new health investment framework	Year 1: 15 Year 2: 30	15
4.2[16] Number of households reached with cash transfers during the period (disaggregated by gender, women headed HH and age)	Year 1: 20,000 Year 2: 50,000	32,000
4.3 Number of peacebuilding and conflict transformation initiatives addressing post COVID-19 residual and emerging risks	Year 1: 4 Year 2: 8	not implemented/monitored
4.4 Number of vulnerable provided with livelihood opportunities in conflict affected and humanitarian contexts (disaggregated by sex/gender and age)	Year 1: 5,000 Year 2: 20,000	14,428
4.5 Number of people educated on SGBV prevention.	Year 1: 300,000 Year 2: 450,000	225,000 (>90% women)

[16] Indicators 4.2 - 4.5 were referenced 5.2 to 5.5 in the project document.

4. *For Output 5*

During the field mission, it was confirmed during the interviews with UNDP team and with the representatives of UNICEF and of WHO that Output 5 had been de facto 'dropped' from the implementation, and that the funds disbursed under this output had been wrongly inputted. UNDP and WHO representatives stated that a few research[17] reports had been produced (see Annex), and that support from an epidemiologist modeller from the UK had been availed. Nevertheless, it was also indicated these activities had not been funded under the BF.

1. The replies of official of the Health System (State level) indicated that some R&D took place locally within the hospitals' teams[18]. No resources from the BF were ever received for this RD work; recently a few proposals were submitted, which yielded no response (Edo, Anambra).
2. The replies from representatives of PUNOs and Development partners also reflected those difficulties for inter-agency coordination resulted in BF negligible investment in research, development, and modelling for COVID-19 response; this could be a missed opportunity for gathering local evidence towards strategic decision making.

Output 5	Targets (Project Document)	Achievement as of Sept. 2021
5.1 Number of gender-sensitive research and modelling activities conducted, and their results translated into policy action during and after the crisis	Year 1: 15 10 translated Year 2: 30 20 translated	Year 1: 4 Year 2: 2

Finally, this output was meant to strengthen the capacities of Nigeria, and in this respect the capacity building and its results were not well documented at national level, and absent at State level. Meanwhile, interviews revealed that research works has been initiated or are in the pipelines in some Sates (Edo, Anambra, Sokoto), and according to local feedback, some requests for support have not been entertained.

5. *For Output 6*

1. At State level, the respondents' replies were all in agreement, that the BF had been successful in establishing very strong collaboration and dynamics, as well as in breaking barriers and getting diverse agencies working better together (replies from PHC, LLG).
2. Among the Development Partners, there was also consensus about the effective coordination established by the BF Board and Technical Committee, both at the level of operational management and at the level of political relationships between Donors and with Government, the later yet subject to improvement.

[17] Some stakeholders appeared to confuse research (finding new solutions) with routine surveys (describing current solutions).
[18] There were about 20 publications (by ISTH) on the COVID-19, of which 3 formal studies (Edo State)

Output 6	Targets (Project Document)	Achievement as of Sept. 2021
6.1 Number of presidential taskforce's intersectoral coordination fora conducted per quarter (aggregated annually)	Year 1: 45 Year 2: 60	Year 1: 40 Year 2:
6.2 The COVID-19 Basket Fund management arrangements in place	Year 1: 1 Year 2: 1	Year 1: 1 Year 2: 1
6.3 Amount of financial resource committed by donors in support to COVID-19 in Nigeria through the one UN basket	Year 1: 100 million Year 2: 150 million	Year 1: 74 million Year 2: 93 million

6 - Sub-Question: How would you rate the fairness of the distribution of effects? were effects equally felt across different groups?

Overall, the ET opinion's is that the distribution of effects seems to have been fair over the project coverage areas and among the different groups; although for latter may have suffered of some weakness in some locations, due to the local implementation constraints. At State level, the ET received positive feedback from stakeholders. About the appreciation of a fair distribution at whole project level, few replies were collected for this sub-question, because each individual stakeholder may not have sufficient broad information on this matter; in addition, no information on distribution of effect was found in the project preparation documents.

1. *In terms of geographic coverage,* the UNDP and PUNO explained that seven priority States were selected by the Board, based on NCDC recommendations. The WHO yet worked in all states, while UNICEF country programme was focused (based on resources) to 19 States, with offices in 9 States. Their strategy was to develop successful models in specific state, which could demonstrate usefulness and be replicated in other States.
2. *In terms of balancing outreach to vulnerable groups,* the representative of CSO indicated some difficulties in reaching out extensively beneficiaries, due to limitation in resources. Other constraints reported included the gaps between the social registers at national and State levels: it was however confirmed that vulnerable persons were selected from SOCU's lists, which have been fully aligned with those of the National Social Safety Net Coordinating Office (NASSCO).

7 - Sub Question: Has the intervention created any unintended positive or negative effects?

There is a strong presumption that the intervention has had only positive effects, as reflected by the stakeholders' replies. There was no mention of any unintended negative effect in the interviews or in the project reports. Four positive side-effects were mentioned by interviewees:

1. MSDGI officials reported that support under Output 4 has strengthened NASSCO capacities, resulting in better linkages with States and increased inclusiveness of the vulnerable.
2. Two CSO representatives mentioned that by contributing to the PUNOs activities (Output 2, 4), their organization had gained visibility and recognition by the State Ministries, which possibly would create additional avenues for the project's outreach.
3. MoH officials (Anambra State) have noticed that with the elevated COVID-19 related efforts, other diseases were better accounted for, as a result social inequalities in access to health were

decreasing and gaps was literally being closed. This statement is drawn from the statements of the respondents who indicate a trend that they noticed, as a consequence quantitative data are not available.

4. The project caused an estimate of 8,000 women[19] to open a bank account, thus being banked for the first time in their life. About According to some stakeholders (CSO, UN Women, MSDGI), this positive side-effect would go a long way in protecting women income and allowing them to make their own choices on managing money.

Findings demonstrate the substantial contribution of the BF to strengthening the health system at Federal, State, and local levels, and supporting the rapid implementation of the national SPRP, directly for its pillars I, II, IV, V, VI, VII, and indirectly for pillars VIII and X (detailed in Question 3.1 above, p. 19). Based on this analysis, the ET consider that the BF effectiveness was VERY GOOD.

2.4. EFFICIENCY

The assessment of efficiency refers to the extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way.

Evaluation question 4.1: Has the BF implementation mechanism allowed the fastest delivery of solutions possible?

Based on the testimonies of all stakeholders, and on the findings derived from interviews, it can't be concluded that the BF implementation mechanism allowed the fastest delivery of solutions possible. The involvement of UNDP and some PUNO (WHO and UNICEF) were crucial in expediting procurement of disease commodity packages in early stage of the programme. This is less obvious for the other outputs, for which delivery might have been faster under alternative modalities. However, counterfactual evidence is lacking to demonstrate such faster options.

Evaluation question 4.2: Has the BF used resources with the best value for money (VfM)?

The overall answer to this Evaluation Question is that in the pandemic context, the BF has been reasonably efficient in maintaining value for money in delivering resources and solutions.

The ET has not used a quantitative approach to calculate VfM (nor proposed it in the methodology) because there is factual/quantified reference allowing to compare the VfM of this particular intervention to other modes, which would have been implemented and evaluated at the same period. Moreover the ET noticed that VfM was not defined in the background documents and not even in the UNDP initial proposal. The initial UNDP document mentions a very general definition of VfM as an operating principle of UN projects. The ET has not found any further development on the subject. The VfM assessment is therefore made on qualitative terms.

Taken globally, the BF's VfM would probably compare well with other implementation modalities (project-based delivery through direct subcontract with PUNOs, for example); finding a) highlight some issues with the current model; however, transaction costs and inconvenience are found in any modality. Breaking down the analysis, the ET considers that VfM was high for outputs 1 and 2 (findings b and c), and moderate for output 4 (finding e). For output 3, (finding d), additional details on the use of funds would be required to establish a proper assessment of the value for money.

Therefore, the ET considers that the VfM of the BF program, in a pandemic context, was GOOD.

We provide below the answers to the sub questions related to efficiency.

<u>1 - Sub-questions: Are the inputs/ resources provided by the various stakeholders adequate for achieving the planned results? Have the disease commodity packages been delivered timely?</u>

1. The replies to these sub-questions were largely positive (90%)

[19] Based on the last progress report's figures for cash transfers by UNDP and UNWomen (section 5.1 Gender, p. 37 of 58)

2. Stakeholders in the PUNOs group indicated UNDP's role in first round/ advanced procurement using links with UN China, which allowed probably one of the fastest COVID-19 related procurement cycles on the Continent. Subsequent procurement rounds through WHO and UNICEF were also timely and efficient, to the extent allowed by the logistics constraints generated by the pandemics.
3. It was also noted that funding was received timely from BF through UNDP. One reply however stressed for some PUNOs, there had been a mismatch between PUNOs funding expectations and UNDP allocations, because PUNO were not consulted in the BF design.
4. The replies from Government Health system officials reflect overall satisfaction on the timeliness of supplies (Output 1). The centralized delivery of the procured material was efficient and timely despite initial delay due to lock down of national airports. A few tests were wasted in early stages (one batch was received near the use-before date) but after the first wave stock management was improved and the turnaround time for testing was reduced. On the quantities of supplies, all respondents in this group stated that in general quantities were sufficient, although there was room to do more if more tests and supplies had been provided. Only a few replies noted that quantities had not been sufficient, for lab supplies (PCR testing instrument in Edo state), and for the supply of medical oxygen in emergency units (lacking in rural units).
5. For the stakeholders associated with Output 2 and Output 4 (PUNO staff and CSO), replies indicated resources were timely and adequate; most CSO agreed that funds disbursement was timely and allowed smooth implementation of support. although some CSO (Edo, Kano and Adamawa state) indicated they had faced constraints[20] to identify and reach out to adequately the vulnerable groups, those outside urban areas. Some respondents pointed out delays in implementing output 4 since data from national register needed reconciliation with SOCU and verification (ascertaining no one left behind). A PUNO representative indicated that disbursement of funds had gone well overall. However, they encountered a slow start, due to a) initial difficulty for PUNOs to adjust to working in common: planning, reporting, decision making, and b) delays incurred by the need to adapt the cash transfer delivery strategy: it has proven difficult to work with direct transfer through local agent and local banks had to be used, with additional time to comply with their financial management procedures[21]. Besides, one reply mentioned that information on fund allocations for non-government stakeholders[22] was scarce.
6. Representative from the Development Partners stated their view that in a pandemic context, the BF had been efficient in delivering support. Several respondents appreciated the leverage of a joint contribution, and the economies of scale in respect with transaction costs. The DP provided funds to the BF in a progressive manner, most of without earmarking. The early availability of EU funds, and the flexibility of Donors in the use of funds, has contributed well the effectiveness of the BF mechanism. While the BF administration might not have traced in detail funds from their origin to final use, this wouldn't have constrained the effectiveness in anyway.

2 - Sub-question: Is spending in line with the timeline and budget?

1. The sub-question was mostly asked to PUNOs and Development partners. All replies were positive. A few respondents noted the release of funds was not initially swift (due to new administrative procedures to be complied with). Respondents also confirmed that BF budget lines were fully spent for Output 1 and Outputs 2 by mid- and end of 2021, respectively.
2. It was mentioned that BF funds were used for socio-economic studies (Output 4) to support rapid response to COVID-19; at present additional support could be needed to get additional and finer data.

[20] The constraints were incurred by the need to follow specific operating procedures (health precautions), and insufficient funding to ensure exhaustive canvassing

[21] The combination of initial lead time, slow identification based on state registers, and change in modalities for cash transfer has caused significant delays as reported by the monitoring visit to Lagos state (June 2021)

[22] The reply is reported although there might have been a confusion with another support Government program, since the BF was not involving directly CSOs

3. Interviews reflected a slow spending on the MSME sub-activity for output 4 in 2021: this was caused by a late start, the need for initial mapping and screening of beneficiaries, and the provision so far of mostly training and assistance service. With investment support to MSME, this budget line would be completely utilized in 2022.
4. The BF spent 37% of its budget on output 3. Although support was sizeable in scope and depth, the expenditures seem not commensurate to the outputs. A more detailed narrative would be required to explain how capacity building activities could amount so high in the budget. By comparison, expenditures are fully documented/ justified for output one (34% of budget).
5. The timeline of disbursement and spending was fast after a latency phase of 6 months. The total cumulative expenditures reached US$ 33,304,554 in end of year 1, and US$ 40,100,200 by end July 2021, which shows a consumption rate of 57% and 77% respectively.

   The following tables reflects the utilization of funds by output and by PUNO, against the total spent. The expenditure is not remotely related to the budget that was presented both in the 'One UN response to COVID-19' project concept and in the financing agreement (amounting to some US$ 93.5 million): since both the description of outputs and the respective amounts have been sharply modified, comparison between budget and actual expenditure would have little meaning if any.

Output	Actual Expenditures	% of total spent
Output 1	26,497,678	36%
Output 2	7,325,762	10%
Output 3	27,130,617	37%
Output 4	11,787,041	16%
Output 5*	75,000	0.1%
Output 6*	50,000	0.1%
M&E	267,500	0.4%
Total	73,133,599	

*: See footnote

PUNOs	Funding	% of total
UNDP - Medical Procurement	16,497,678	23%
WHO and UNICEF - Procurement	10,000,000	14%
UNFPA CSO Engagement	1,501,724	2%
UNICEF and WHO - Case Management	2,347,691	3%
UNAIDS, UNFPA, UNICEF, UN Women, and WHO - Risk Communication	8,205,054	11%
UNAIDS, UNDP, UNICEF, and WHO Surveillance	5,055,547	7%
WHO and UNDP CART	10,024,391	14%
UNIDO, WHO, UN Women and ILO MSME	3,000,000	4%
UNDP MPI	1,513,650	2%
UNICEF and WHO Vaccine Roll-out (disbursement in progress)	14,595,364	20%
Monitoring, Evaluation, Audit and Reporting (UNDP managed)	267,500	0%
R&D*	75,000	0%
Coordination of partnerships*	50,000	0%
TOTAL ALLOCATED TO PUNOs	73,133,599	

*: See footnote [23]

The findings related to Efficiency include:

1. Most stakeholders among PUNO, Government agencies, and CSO agree that the implementation of the BF through proposals was appropriate. Nevertheless, this modality has incurred difficulties in terms of financial negotiations, operational procedures between UNDP and PUNO and between PUNOs, and in terms of the design, preparation, and management of projects proposals. In the latter area, UNDP management services were not fully efficient for revising the log frame and activities, for assisting PUNO produce strong proposals aligned with BF framework, and for reporting progress. The aforementioned difficulties have delayed until Q3 2020 the actual implementation of all outputs, except output 1 that consisted uniquely of procurement services.
2. The procurement of disease commodity packages has been very fast and their delivery timely. The quantities provided were appropriate to the needs although not totally sufficient, at the possible exception of supplies in the Lagos State. It may be argued that PUNO-based procurement has decreased Nigeria leverage by the international platforms (GAVI and Global Alliance). Each approach has merits and demerits, and it would take high-level discussion to come to a definitive conclusion on such question.
3. The delivery of communication services was fast and efficient in its strategy (integrated plans) scope, and outreach. Nevertheless, a lack of coordination and alignment between national and State level objectives may have decreased the global impact of the messages.
4. The delivery of support to the implementation of responses plans at State and local level was timely and efficient; however, in the absence of a detailed documentation on the nature and unit cost of services by the UNDP and PUNO, the total amount spent could seem disproportionate.
5. The delivery of support for maintaining access to health services was efficient in reaching out the targeted beneficiaries, but the delivery of cash transfers for vulnerable groups has been delayed by initial administrative procedures, the need to verify social/poverty registrars, and the need to reconcile financial procedures between PUNO and financial institutions. Delivery finally picked up in the second half of 2021. As the BF cash transfer support was additional to other Government and private sector support package, it the targeted groups seem not having been impacted by the delays in output 4.
6. Output 5 has become unused, and expenditures would be expelled and reallocated under other outputs. A few studies have been completed by the WHO and UNICEF and claimed under output 5. However, the capacity building dimension, which was underpinning the activity in the log frame, seem to have been totally overlooked. Other research work, initiated at State level, didn't receive support from the PTF or the BF. Altogether the output appears lowly efficient, without judging of the intrinsic value of the studies performed.
7. Similarly output 6 has been dropped. Most activities proposed in the implementation plan were actually taking place outside of UNDP control; hence an impossibility to actually deliver services to support these.

2.5. EUD ADDED VALUE

The EU added value of the intervention assesses the extent to which the action brings additional benefits to what would have resulted from Member States' interventions only.

EU ADDED-VALUE - In which way have EU funding for BF, or other programmes and resources, generated increments in outcome and outputs, which would not have been secured otherwise?

[23] According to an oral comment from UNDP, the expenditures for output 5 and 6 would be expelled since these two outputs have been dropped.

1 - Sub-question: What specific benefits has the Government got from EU involvement in the BF, as compared to separate interventions amounting to the same funding?

1. This question was proposed to the Development Partners. Replies were positive; centring on the fact the EU was instrumental in fostering a strong coordination among the partners, which make the project to function well. It was also mentioned that EU presence had certainly had a positive effect in deciding other partners to step in or to increase their contribution.
2. Some replies pointed to the EU's positive role in keeping the Board focus on results/progress. In addition, the EU added value was mentioned in terms of leveraging development partners' engagement and political dialogue with Government
3. One respondent in the Government indicated the EU presence had enhanced coherence with the principles of the Paris declaration on Aid effectiveness: strengthening consistency and complementarity of the BF with the government driven BPHCPF.

Sub-question: Would EU added-value aspects be possibly replicated in new projects (incremental portfolio?)

This question has not been proposed, given the little feedback gathered on EU value-added.

2 - Sub-question: Has the BF support been benefitting the EU image in the country/region?

1. EU was mentioned by several CSO and LGA representatives during the site visits. As well, MSDGI and CSO, as well as LGA and EOC were fully aware of the EU role in the BF, and appreciated the support provided towards women and vulnerable groups.
2. Implementation reports indicated that communication and visibility had been organized through a communication strategic plan in line with UN guidelines; however, such plan was not reference in the reports or availed to the ET. Nevertheless, UNDP reports further state that dispositions for ensuring visibility of the BF partners where systematically used in all material and supports used in communication event; and this is exemplified by a few pictures of events in the yearly and quarterly reports.

Other elements for analysing the EU added value could be found in the past and ongoing involvement of the EU for the Health sector in Nigeria. The EU support to the health sector was continued through the pandemic. At the global level, the EU has funded the Spotlight initiative, a UN Multiagency programme playing a key role in GBV prevention and response during the COVID-19 crisis. In Nigeria, the EU has provided funding for two thematic programmes implemented by UNICEF and the WHO. The EU is an active participant of the Health Development Partners (HDP) working group[24] and is in continuous and ongoing coordination with EU Member States, key partners and like-minded countries –monitoring closely the situation and taking proactive steps. These past experiences have provided the EU with first hand understanding on implementing health programmes in the Nigerian and regional context, thus adding significant value to the contribution to the BF, in terms of operational capacity and leadership.

The above analysis sums up into the following findings in respect with EU added value:

1. Most stakeholder rate positively the role and added value of the EU in the BF.
2. The size of the EU contribution has determined adhesion and contribution of other partners.
3. The EUD has demonstrated strong technical capacity and leadership to steer the programme; and this has led to an overall enhanced Donor dialogue for the health sector.

24 Key participants in the group are not only the main donors (DFID, Canada, USA and the EU), UNFPA and WHO but as well key Foundations as Dangote and the Bill & Melinda Gates Foundation.

4. The EU contribution has enhanced the environment for political dialogue between the Government and other Development Partners (including potentially EU Member States).
5. The EU visibility may have remained relatively low since no systematic communication strategy was adopted by implementing partners. Nevertheless, the role and contribution of EU was recognized in the visited States, where stakeholders such as PHC officials and CSO spontaneously mentioned their gratitude to the EU for the support provided.

Based on the above findings, the ET considers the EU Added Value was good in this action.

2.6. CROSS-CUTTING ISSUES

This chapter present the findings related to the EU Cross-cutting issues in responding to the following main evaluation question[25]: **How did the BF performed in achieving results linked to gender, rapid recovery and resilience of vulnerable groups, environmental impact, and good governance?**

The ET assessed that the EU cross-cutting topics have been considered and strongly embodied in the overall objective of this action as well in its framework dimension.

Gender

Although the action is addressed to the overall Nigerian population in coping with the Covid pandemic and improving access to quality of basic health services, the majority of the population seeking health services are women and children. Additionally, this intervention reinforces synergies with past EU-supported projects and on-going UN agencies as WHO, UNICEF, UNFPA in the field of prevention and treatment of health communicable and non-communicable diseases.

As a health project, the BF targeted as beneficiaries the entire population; we can however estimate that about 60% of those have been women and children. Interviews with medical staff, CSO and beneficiaries enabled concluding that the BF had a clear direct contribution in empowering women (and vulnerable groups) through better awareness (O2), enhanced resilience and access to health services (O4), increased visibility and inclusion, and improved voicing (O4).

The BF support has triggered positive changes in the population perception of the disease and in the approach to personal hygiene of issues related to gender (and vulnerable groups), in respect with: (i) outreach by health services, (ii) discourse and action of community leaders, (iii) dialogue and relationship with authorities. The socio-economic support (cash transfer) has been also crucial to increase the visibility (national register) and inclusion of women and vulnerable groups.

The evidence for the above is presented in PUNOs reports analysed by the ET during desk phase and was confirmed during the interviews in the state. Regrettably the limited extent of the M&E performed did not allow to gather evidence of these indirect changes.

Resilience of vulnerable groups

The strong achievements in Outcomes 1 and 2 prognosticate well for the stabilization of the pandemics into a 'post-emergency' mode, and for lowered risks levels of future contamination. Meanwhile, achievements in outcome 4 have enhanced resilience of, and empowered women and vulnerable groups. Outcomes 3 and 5 might contribute less significantly, while remaining positive in absolute terms.

The BF has triggered improvements of the health system in general, with specific increments at States level regarding prevention, control, and treatment of persons affected by the COVID-19 (PHC). Additionally, gains were also recorded and related to the improvement and awareness of basic hygiene measures by the entire population: State health officials reported that because of the

[25] **Sub-Questions:** (i) Has the BF reached out and sufficiently included [this specific] group in design and implementation; (ii) How much would you say the BF increased the resilience of [this specific] group; (iii) What environmental aspects could be of concern in the BF project? How has this been accounted/mitigated during the project cycle; (iv) How was the coordination state – provinces and UN agencies ensured; (v) How this intervention could have been more flexible in accordance with the pandemic or context changes.

elevated level of services in detection, monitoring and tracing, other communicable diseases as cholera, typhoid and other water related diseases decreased and were better detected and treated. This would help maintaining population health and contribute to fast recovery. The BF activities have resulted generally in positive behavioural change in respect with personal, family, and social hygiene, thus contributing to better resilience.

An unintended positive effect was the stronger coordination and high commitment of stakeholder noted at State level; this has in many instances compensated for insufficient resources and other constraints. By contrast, support packages for MSMEs may not be of sufficient scale, compared to the sector size and the scale of other initiatives[26], to have a sizeable contribution to the BF impact. In conclusion the ET opinion, the BF is likely to achieve the desired impact.

Environment

Regarding environment the BF support has generated a considerable amount of waste (disposable masks, swabs and syringes, reagents, and tests…) This issue had not been foreseen, and no provision was made to address or mitigate it. This resulted from the crisis; and in general, such issue has not been adequately dealt with in any country. Further consideration might be given on ways to mitigate environmental impact (reduce-reuse-recycle).

Governance

The Government of Nigeria implication in the overall the BF implementation was and is strong. The BF set up is likely to have resulted in elevated levels of scrutiny and accountability. Stakeholders testified on collateral positive effects on breaking 'administrative barriers' at state level. The emergency context created room for collaboration and cross-agency support, which would not have taken place under separate single-agency support projects.

The weak project formulation capacity of the UN system led the BF to rely heavily on the work of technical committee to review and or finalize the project proposals (concept notes) into a format allowing the Board to make funding decisions.

1. This situation might have resulted in overlap - the more so as some TC members were also sitting ex-officio at the Board.
2. Clarification was made that when members involved in TC work are sitting at Board meetings, they have an observer status and/or don't take part in voting decisions.
3. Nevertheless, this would reflect a situation where the technical committee has a de-facto power to orientate or influence decisions of the Board
4. Notwithstanding the previous clarification, the ET still believes that (i) the role of TC should be better described and set further apart from the BF functioning, and (ii) better project planning (BF log frame) and sub-projects preparation procedures (UNDP role) would result in stronger project proposals, better monitoring, and finally would enable the Board to work more efficiently.

2.7. SUSTAINABILITY

This chapter provides evidence to which extent the benefits of the intervention continue or are likely to continue in responding to the following **EQ: How far overall will the Government of Nigeria be able to continue maintaining health and cushioning the negative impact of the pandemic after BF support ends?** Or in other words will the financial and human resource sustainability of the action be maintained by the GoN at the end of BF (December 2022)?

The outputs and outcomes of the intervention have been satisfactory attained to a different extend and degree[27]: out of 6 results, 3 were ranked as good, 2 as medium and only 1 was not achieved.

[26] One stakeholder replies to a sub-question included the wording 'it was a drop in the Ocean'; a realistic judgment if a harsh one.
[27] Please refer to results grade of efficiency and effectiveness

Therefore, according to the ET's judgement, the sustainability of this action should not be too problematic.

1 - Sub question: Is access to the benefits generated by the intervention affordable for target groups over the long term?

Arrangements to guarantee the sustainability of the results brought by the intervention will mainly consist in the financial support of services provided by the health facilities and laboratories in providing testing, treatment, and vaccines and of the maintenance of the overall equipment's provided for these procedures, as well as the human resources needed to support and manage these gains and innovations.

2 - Sub- question: Are key stakeholders attaining the necessary capacities (incl. institutional, human and financial) to ensure the continued flow of benefits/services?

In terms of human capacity, the MoH and the hospitals' network have the technical capacities to ensure the continued flow of benefits provided by the intervention. Consistent steps have been taken by the relevant authorities for the testing and disease treatment capacity to remain at increased level and to be able to continue activity in autonomy.

Additional measures and strategies should however be explored, adopted, and deployed for and from State/local to increase financial availability for the health sector in involving the local private sector and the communities. In this regard, it looks like the private sector has not been sufficiently engaged with a view to contributing to the sustainability of the intervention.

At this stage is still not clear if the GoN will allocate additional resources/ funding to maintain the increased level of activities although the access to the benefits generated by the intervention is affordable for target groups over the long term.

3 - Sub question: How was/were the benefit of the action in the health sector beside the Covid-19?

It is also significant to recall the positive benefits of the action in the health sector beside the COVID-19 such as: (i) increased awareness and understanding of the general population on basic hygiene measures with the reduction of water borne diseases (ii) an increased importance in the access to essential health services, particularly reproductive and maternal health care; (iii) early recovery and social protection activities, targeting vulnerable groups contributed to maintaining access to health services and cushioning the negative impact of the pandemic, particularly for women headed households;

The BF has created synergy and increased fund raising (Euros 73.6 million as of end 2021 and additional commitment for 2022). This may indicate partners see the BF as a useful platform for further action, depending on tuning the model to the new pandemic context.

Replies to sub-questions at State-level revealed that more or better capacity development and handholding could have been availed and resulted in more sustainable Health System in States.

At the beginning of 2022, a different perspective is surfacing on the COVID-19 pandemics. The emergency phase is hopefully behind us and, while risk levels remain high, controls mechanisms would allow a progressive 'return to the normal'.

With these changes in context and priorities, the purpose and focus of the BF should be reassessed. Different approaches may be considered to match the newly defined goals. Finally, the feedback from State-level stakeholders tends to indicate that the success of COVID-19 response was due to the synergy between Federal and local leadership and the BF support. The elevated risk level and the ensuing sense of urgency have determined the best efforts from stakeholders at all levels. Will these levels of commitment be sustained when the sense of urgency recedes, and with what impact on the implementation of an extended Basket fund?

The ET wishes to qualify the overall rating, as the emergency context makes it arduous to assess sustainability. Obviously, with the curtailing of the pandemic, rating the sustainability of the BF as a support of COVID-19 response has little meaning. In the ET opinion, the BF is sustainable if it remains focused on the COVID-19 response, because its implementation mode and activity delivery mechanisms were dictated by the need to act fast and manage mostly procurement. The changed circumstances may require considering different priorities and better implementation modalities. The BF legacy could be better sustained with a broader purpose, and with a shift from input/delivery-driven approach to a more planned/monitored/ outcome-driven one.
The sub question to different stakeholders seek to check whether they will be able to maintain the level of activity/performance that was raise during the BF project; AND whether GoN would commit to an elevated level of budget/resources.

The evaluation questions planned by the ET during the evaluation preparation also included a set of sub questions to check the level of capacity and confidence of stakeholders involved in operations, as well as aspect pertaining to institutional strengthening (senior officials). Some of them revealed not be appropriate or pertinent for and in the BF context. Below some quick answers to those questions.

4 - Sub question: Did the BF project lead to updating policies? Are beneficiaries satisfied by the policy outcomes?
5 - What steps have been taken for the testing and disease treatment capacity remain at increased level?
Policy and strategies remain the same except for vaccines procurement in the latest phase of the action (2022). No treatment is so far available for the infection complications besides support in emergency unit (ventilation, intubation in support of the interstitial pneumonia).

6 - Sub question: Have RD and modelling capacity been enhanced so as to be able to continue activity in autonomy?
As underlined in other chapters of this report the less efficient and effective expected results of the BF has been Output 5. The ET could not find any evidence of Capacities for R&D and modelling implemented during the project.

7 - What measure(s) have been adopted for State/local strategies to be further deployed?
Further measures to be adopted by the national COVID-19 response including BF if continue and in its final stage are detailed in the Recommendation section of this report and in the **Nigeria COVID-19 Summit 2021 (December) Pushing Through the Last Mile to End the Pandemic and Build Back Better.**

8 - Sub question: Has the private sector been sufficiently involved with a view to contributing to the sustainability of the intervention?
On the local private sector front only Dangote Foundation was reacting in supporting the epidemic. Dangote and the Managing Directors of Access Bank Group, Zenith Bank, Guaranty Trust Bank, MTN, ITB and others are spearheading a coalition of private sector organisations to support governments' on-going efforts. For sure other options and contributors could be deployed and explored.

9 - Sub question: Does the BF project increase resilience to shocks, by addressing root causes of specific dimensions of fragility? How has socioeconomic analytics and pro-active early recovery and social protection activities, targeting vulnerable groups contributed to maintaining access to health services and cushioning the negative impact of the pandemic, particularly for women headed households?"
The BF paid particular attention to the most excluded or marginalized within communities, including elderly, internally displaced people, returnees, refugees, war widows, orphans, minority ethnic groups, People Living with mentally and physically disabled (PWSN), at-risk children and youth, ex-combatants, HIV/AIDS-affected individuals and households, religious and single headed

households, have been actively engaged in the intervention to promote social cohesion, as well as those identified as having "conflict carrying capacity".

10 - Sub question: Is access to essential health services, particularly reproductive and maternal health care, likely to be maintained?

This MTE provided evidence through stakeholder's interviews that access to essential health services, in particularly to reproductive and maternal health care, have been only affected during the first stage of the epidemic when generalized paranoia was fostered by lack of knowledge on the matter, amplified by fake news on the social sector and by international media. After this initial stage activities regained the usual trend in the health services.

2.8. PERSPECTIVE IMPACT

Evaluation Question: What building blocks have been placed by the BF for rapid recovery and resilience?

The most significant contributions of the BF to programme's impact are found in the strengthening of Government health systems at State level, combined with new and enhanced collaborative modalities across Agencies (findings b, c, e). The BF also contributed to rapid recovery and resilience by affecting positively the behaviours towards the disease (finding d). Social support packages for the vulnerable (about 18,500 beneficiaries) and for MSMEs (~9,000) could have less impact to resilience and recovery, given the relatively small coverage compared to the country size (finding e). In any case, the BF contribution to impact may require additional support at Sate level, to enable stakeholder to adapt to the changing context of the pandemic.

The ET assessment of the perspective of impact is GOOD.

The perspective of impact was assessed by all the groups of stakeholders involved.

1 - Sub question: Is the BF likely to have an impact on the national COVID-19 response? If so, how?

Replies to this sub question were in majority positive (11 out of 13 or 85%).

Stakeholders in the Government (MOH, MSDGI, NCDC, PTF) indicated the positive role of the BF in terms of bringing all the CSO together under the coordination of MSDGI. It was also stated that BF would achieve impact through enhanced collaboration between Federal and State levels, in the domain of data acquisition and sharing, which will result in enhanced capacity to analyse and manage health issues at national level, not only for the COVID-19 but also for other diseases. One reply however questioned the BF impact on communication since lack of coordination and lack of measurement of the actual effect may decrease long-term outcomes. Another BF contribution mentioned was the strengthening the existing State social registers through NASSCO.

Development partners highlighted the Board role was important, adding the Head of BF did good job in keeping the program focused. Some stressed the effectiveness of the BF (reducing reduced duplications and cost of transaction). Another entry noted the difficulty to measure/ assess impact given the short implementation cycle: it was deemed necessary to have more analytical reports that could demonstrate progress toward global outcome (since Government would need a synthetic view to appreciate usefulness of the BF). Finally, it was noted BF might have a secondary impact, in terms of the Government possibly getting additional funds or reallocating funding (re-prioritize other support).

The stakeholders in the State Health System recognized that the BF has been good for the initial stages of the pandemic, now its approach should be reviewed/shifted (coverage, oxygen supply, case management, testing, vaccination. This requires finer data (State level) and analyses. In this group, replies also indicated that BF impact would be based on the development of state health system through EOC, laboratories, and wider deployment of sample collection networks. Some respondents stated the BF created impact because it had reinforced the structure that existed before, amplified previous EU support (e.g., case management and vaccines), and allowed creating

additional or parallel response to other diseases. One reply stated an impact contribution in the fact that RCCE messages had positively changed habits, facilitating the control of the COVID-19.

2 - Sub question: Were the needs of beneficiaries defined? Have they changed?

The question was asked among PUNOs representatives. Replies pointed to the limited consultation at design stage, which led to side-lining the role of CSO, socio-economic support, and engagement with the private sector, potentially lowering the BF impact. PUNOs also reported that initial mapping of beneficiaries had been carried out. Another reply stated that needs remain to fund more infrastructure and access to vaccine.

3 - Sub-question: Have the needs of the target groups been satisfied, and if so to what extent?

The question was asked mostly during consultation in the States. Replies indicated that generally, BF support had successfully addressed the needs of target groups; however, for some CSO supporting people living with AIDS, BF had not sufficiently included that target group. It was also stated that BF helped to directly address the needs of the people, reaching the most vulnerable.

4 - Sub-question: Has the BF contributed to better health or COVID-19 policies or new priorities? which ones?

For the stakeholders in the Health System the BF impact contribution was in the enhanced coordination, which took place on a larger scale and more systematically deployed. Besides, the replies pointed to a spill-over effect e.g., the training of Rapid Response Teams (RRT) boosted the staff's capacities, resulting in improved the handling of other diseases and increasing outreach. Respondents also mentioned that the activity under the BF revealed the need for better data to structure future support; for example, the Edo State has put up a 30-year development plan, which will require more and finer data for its proper implementation.

5 - Sub question: How much would you say the BF has contributed to social & economic recovery?

Replies were all positive in respect to this contribution to impact. Government officials mentioned that the BF impact was caused by support that has led to enhanced levels of relationship within the community and interpersonal relationship between field officers. Nevertheless, it was stated that the scope and allocation of Government funding was not stable: some support measure already decided were at times shifted or repealed. Therefore, this would call for more flexibility in the BF support, and more targeted interventions to maintain the path to impact. A similar reply alluded to changes in Government approach for engagement and dialogue, calling for BF to build up impact by supporting adaptation at state level (in parallel to Government funds). Stakeholders from the State Health System and CSO pointed at BF impact through the support packages: cash transfers were useful to maintain livelihoods, although project budget was limited, while MSME packages contributed by maintaining business and employment levels. Other replies stressed the need to intensify and sustain community engagement, in particular to support RRT which can contribute to resilience, as well as the need to fight still numerous misconceptions/stigmas, and fears around the vaccine.

6 - Sub question: How much would you say the BF has contributed in terms of population resilience?

In the CSO group, replies mentioned the significance of cash transfers to help sustaining business in the villages. Another reply highlighted that the access to funds through integration into banking system completely changed the attitudes of poor women; allowing them to manage cash and set their own goal. It was also noted that among the vulnerable groups, the perception of the Government presence and outreach has been improved.

The findings relative to the BF impact include:

1. The strong achievements in output 1 and 2 augur well for the stabilization of the pandemics into a 'post-emergency' mode, and for lowered risks levels of future contamination.

Meanwhile, achievements in output 4 have enhanced resilience of, and empowered women and vulnerable groups. Output 3 and 5 might contribute less significantly to impact, while remaining positive in absolute terms.

2. The BF triggered improvements of the health system in general, with specific improvement at the States level regarding prevention, control, and treatment of persons affected by the COVID-19 (PHC)
3. An unintended positive contribution to impact was the stronger coordination and high commitment of stakeholders noted at State level; this has in many instances compensated for insufficient resources and other constraints.
4. The BF activities resulted generally in positive behavioural change in respect with personal, family and social hygiene, thus contributing to better resilience.
5. Similarly, State health officials reported that because of the elevated level of services in detection, monitoring and tracing, other communicable diseases as cholera, typhoid and other water related diseases decreased and were better detected and treated. This helped to maintain population health and contribute to fast recovery.
6. By contrast, support packages for MSMEs may not be of sufficient scale, compared to the sector size and the scale of other initiatives[28] to have a sizeable contribution to the BF impact.

[28] One stakeholder's reply to a sub-question included the wording 'it was a drop in the Ocean'; a realistic judgment if a harsh one.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1. LESSONS LEARNT

LESSONS LEARNT FROM ONE UN COVID-19 BASKET FUND

The lessons learnt were derived from the evaluation processes and usage of the development assistance committee (DAC) evaluation tools. The DAC tool which was used to assess the relevance, coherence, effectiveness, efficiency, EU added value, cross-cutting issues, sustainability and perspective impact were able to critically evaluate all aspects of the intervention and rating scale availed the ET a proper scale for the reporting. The lessons learnt and other findings revealed a road map and recommendation for review of the approaches to achieve better results, going forward.

The evaluation matrix allowed an in-depth assessment of each objective, the intervention focuses, and their interwovenness. The interwovenness is evident with the role of risk communication that helps in service delivery, served as a communication medium for the usage of procured materials. Likewise, the synergy between the project's actors enabled smooth flow of activities, feedbacks, aligned communication strategies and products distribution.

The efficient and effectiveness of the One UN BF demonstrated that a joint stakeholders' efforts can aggressively intervene in a health emergency and abate its severity. This collective effort reduced the rate of duplications and inappropriate interventions. The intervention design also creates a kind of uniform approach and framework for other COVID-19 interventions to exemplified. Though, protocols to fulfill during the intervention slow down some of the activities, but UN comparative advantage was a leverage which shows that emergency issues must be treated as one for immediate preventive needs to avoid catastrophic situation.

This Basket Fund demonstrates that with proper coordination, organizations of various kinds (government & non-governmental organizations) and at various levels (multinational, national, state and of course local level) can work collaboratively to achieve a common goal within a specific time frame. This encourages a strictly defined road map and integrated approaches by the national organ for any intervention to adapt, it will encourage coordinated efforts and synergy

The COVID-19 pandemic shows that the emergency response plan on the ground is not strong enough and call for timely review. The BF intervention design has piloted an emergency plan for governmental and non-governmental organization to learn from for a better multinational, national and local emergency response plans. The whole administration system makes the implementation to be effective and enables alignment with the national and state plans. Though, there are some identified issues of weak communication and co-ordination at state level, due to poor identification of funding source by some of the state actor and clamor for proper inclusiveness of the state actors in every bit of plans and implementation. This shows that, COVID-19 pandemic has identified the need to augment and advance the country emergency response system through timely researching and early warning system.

COVID-19 pandemic effects lead to socio-economic effects, basket fund provided the opportunity to highlight the importance of taking all accompanied social factors into consideration during a given intervention. All socioeconomic factors taken into consideration during the Basket Fund COVID-19 intervention enabled the intervention to be more effective.

The usage of community-based organization for grass root intervention especially in the area of risk communication and palliatives distribution demonstrated the need to strengthen grass root/local systems for impactful intervention. Top-bottom system cannot work always, the grass-root organization must be empowered to promote community driven initiatives for better results. Decentralization, autonomy, and prioritization of the local levels in resource allocation and activity design would produce better results in project. The top bottom system will not fully consider the peculiarities of the local environment, there is need to work with a framework that caters for the local peculiarities and factor it in the resources allocation and mobilization.

With proper engagement of local organizations and actors, communal social issues contributing to health menace would easily be identified. During the intervention, many issues around social violence being experienced by the communities were identified and addressed alongside the Intervention priorities. This is further detailed in par. 2.6 on cross cutting issues. The role funds availability played in containment of COVID-19 shows that availability of fund is critical to health interventions especially in emergency. Without funds, critical decisions and needs would not be meet in time, and the severity of the disease would have increased which the result could be catastrophic.

3.2. CONCLUSIONS

The conclusions are derived from the findings drawn in the sections above. The rating scale ranges from Very Poor, Poor, Fair/Medium, Good, to Very Good.

1. The **Relevance of this the BF is rated Good**, as a combination of perfect adequation to National plans and strategies, and the perfectible log-frame synthesizing the theory of change. Our reply to the relevance question, therefore, is that the BF design was relevant to the needs of the GoN and PUNOs portfolios. Nevertheless, this high relevance rating in contributing to the action goal and the design pertinence in respect with international practices and regional programmes had few weaknesses in its formulation and design.
2. The **Coherence of this BF is rated Very Good** with the mandate and objectives of Government and development partners, and coherent with PUNOs roles, although not well aligned with certain PUNOs mandate and objectives. The BF coherence has been described as" ***Strong and needed"*** by all interviewed stakeholders because the BF intervention modality and strategy were and are aligned with the GoN, UN and EUTF strategy in Nigeria and with other EU and policies and Member State actions. For sure the intervention had a powerful catalyser effect with a strong positive reinforcement / synergy in all involved organisations and has influenced the partners policy and interventions.
3. **This BF's Effectiveness is rated as Very Good** over the period covered by the evaluation (Apr. 2020 – Sept. 2021), as a combination of:

    1. Achievement of the outcome
    2. Findings for Output 1, 2 and 4 that are rated as very effective
    3. Findings[29] for Output 3 and 6, rated as effective

The BF was effective because support was properly channelled to cater for necessary commodities, clinical instruments, risk communication, and for strengthening of partnership for emergency response to the pandemic. The availability of COVID-19 containment commodities procured allowed cushioning the effects of the pandemic in-time. The availability of medical instruments at the point of need intervened in the severity of the disease, recuperation rate of patients and curbed further damages. The effectiveness of the commodities procurement is thus a strong contributor to the achievement of outcomes.

The BF was instrumental in modifying the mindset of people and providing proper orientation to the populace. Even though 100% compliance to preventive measures was not achieved, there was commendable increase in preventive practices, changes in the attitudes of the traditional leaders, and raised awareness and health consciousness among the populace. The RCCE strategy, going forward, could be strengthened with enforcement plans, through strong collaboration with enforcement agencies.

The cash transfers and palliatives provided help to cater for immediate needs of the people and availed them resources for care, which in turn improved their health-seeking behaviour. Although

[29] Output 5 is not assessed as it has been dropped from the programme

the pressing needs were considerable, a large number of vulnerable or marginalized people were reached out to.

For research and development, very few or negligible research were supported by the BF. It was a missed opportunity to have in-depth and robust research exploration for plans towards future recurrence.

The co-ordination from multinational, national to local levels enabled aligned plans and proper implementation which yielded desired results. State and local level co-ordination was straightened through the structured administration from the national level and UN ground team at the state level. The 'whole administration' approach made implementation to be effective and enabled alignment of state plans with the national ones. Though, a few weak points in communication and co-ordination were identified at state level, where some state actors were unable to identify the main source of the funds, and as some stakeholder's mixed-up other interventions with the BF and felt they should be more involved in the BF implementation.

4. **The efficiency of this BF is rated fair.** The management of implementation is deemed perfectible. Resources have been mobilized and disbursed timely after initial adjustment between UNDP and PUNOs. While the ET appreciate that the emergency context has induced a strong bias for action, we suggest the trade-off between efficiency and effectiveness should be balanced, especially at a time when the pandemic context is changing. The above relates to:

    1. Revising and improving log-frame and monitoring framework, especially with a built-in system aligning PUNO projects' outcomes with BF program outputs[30];
    2. Sharply improving guidance for, and interaction with PUNO to support the preparation of projects proposals.
    3. Eliminating sub-activities or tasks that don't contribute significantly to the goal and scaling up those with better potential or better coverage.
    4. Strengthening and mainstreaming narrative reporting for availing timely high-quality reports to the Board.

Despite the above issues, the BF has remained efficient, because of a strong leadership at Board and State level. The basket fund was efficient because of the timeliness and provision of emergency response to Covid-19. The fast availability of funds, and the rapid procurement of the containment commodities and instruments, despite a few delays in the initial period (Q3 2020), reflect the efficiency of the Basket fund. The UN comparative advantage was used to make the commodities available and provided Nigerians with immediate preventive needs.

The BF was able to engage all necessary channels from National to local level for risk communication. The multi-sectorial approaches comprising of both government and non-government organizations, religious and traditional institutions, helped in speedy dissemination of information and for countering, to some extent, unfounded rumours about the pandemic.

The palliatives provided through the BF were supplied mostly timely but delayed until mid-2021 in some Stats; this helped cushioning the effects of the economic instability caused by the pandemic

5. **The perspective of Impact is rated good.**

    1. The BF has countered the COVID-19 spread by providing the bulk of supplies and equipment and local level capacity building. It has also, on the one hand significantly increased resilience, inclusion and voice of women and vulnerable target groups, and

[30] A system of tiered log-frames could be considered, where BF indicative outputs would be used as PUNO project outcomes while keeping the same narrative and indicators.

on another hand has generated synergies, cooperation and commitment at Federal and state levels never witnessed before in this country.

2. The BF is thus likely to have the intended impact, based on strong contribution in strengthening the State Health System (infrastructure and capacities) and with other positive spill-over effects on coordination and collaborative work between agencies. The challenges ahead lie in navigating the emergency-development continuum, moving away slightly from an emergency-oriented platform towards a more development-oriented one, and providing additional support to enable State actors to adapt to this new context.

6. **The Sustainability of this BF is rated good.** The outputs and outcomes of the intervention are largely attained; therefore, the sustainability of this action should not be too problematic. Arrangements to guarantee the sustainability of the results brought by the Intervention will mainly consist in the financial maintenance of services provided by health facilities and laboratories in providing testing, treatment, and vaccines and of the overall equipment provided for these procedures, as well as the human resources needed to support and manage these gains and innovation. In terms of human capacity, the MoH and the hospitals' network have the technical capacities to ensure the continued flow of benefits provided by the intervention.

3.3. RECOMMENDATIONS

This chapter provide a list of recommendations to this BF based on the documentation's reviews and analysis as well as the information gathered from interviews with different stakeholders at state level and during the field phase in the six visited country regions. Few major matters have been considered by the ET as they are relevant at this stage, (beginning of March 2022) in proposing these recommendations, they are:

1. The epidemiological trends of the pandemic have changed from the beginning of the BF implementation in 2020.
2. (ii) From the meetings held with the various stakeholders during the field phase it appear that the COVID-19 is not anymore considered a country health priority however the national response (GoN) needs to remain vigilant for future possible flare-ups of the infection.
3. The overall objective of the BF has been achieved. Results 1, 2 and 3 have been rated from the ET as "Very Good"; Results 3 and 6 as "fair-medium" and Result 5 as "poor"
4. The lifespan of the BF and the Presidential Steering Committee has been extended up to December 2022, to continue to coordinate and strengthen the multi-sectoral and multi-stakeholder response to COVID-19 and provide adequate time to transit to a sustainable permanent high-level structure of a National Bio-Security Commission backed by law, strong budget, and operational framework.

Short term recommendations

- To the Government of Nigeria: the epidemiological trend of the pandemic has changed, but in line with current global practice the coordination structure under the Presidential Steering Committee should be sustained and the government should consider building a structure for the management of national biosecurity.

- To the UNDP, UN partners, EU and bilateral donors: at this stage the BF will end in December 2022 nevertheless it is recommended to organize a multipartite review of the BF programme and agreed future strategic orientation, to adapt to changes in the COVID-19 context. Options for evolving the BF include:

    1. focus on health services and infrastructure and health system strengthening support.

2. if social support (output 4) is kept on BF roadmap, consider alternative delivery such as direct funding to entities directly involved and with a good record of delivering social support (CSO, LLG, private sector, business associations, financial institutions etc)
3. elevate the output 5 research activity to a more robust component to address epidemics and other diseases
4. drop output 6 which has no operational contents

- To the UNDP and UN partners: consider future alternative delivery models however difficult in an emergency setting. The One UN approach has been reasonably efficient[31] and effective[32] however, and since emergency is gone or at least changed, support might be better delivered on project basis, with interventions more centred on the core mandate of each PUNOs - with possibly synergies with their regional programs.

- To the UNDP and UN partners: consider alternatives to manage the on-going and future trends of COVID-19 epidemic. UNDP value was based on 1) access to fast procurement, and 2) mainstreaming and coordinating operations through PUNOs. These two advantages have faded away, the former with decreased procurement needs, and the second because of a lacklustre performance in managing operations (proposal preparation, coordination, reporting). Alternatives include sub-contracting management to specialist consulting firms, or even elevating technical committee role to operation management with the support of external individual experts (technical and administrative finance assistant). Alternatives include sub-contracting management to specialist consulting firms, or even elevating technical committee role to operation management with the support of external individual experts (technical and administrative finance assistant).

- To the development partners and private sector: the critical support provided by the development partners and the contribution of the private sector in providing technical, financial, and material resources that greatly contributed to the successes achieved in strengthening the health sector should be encouraged and sustained.

- To all involved partners: for impact measurement and effective evaluation of the national response, the collaboration between national and sub-national entities should be strengthened.

- To all involved partners: by the end of 2022 some BF funds should be allocated in preparing a preparedness action plan in the event of infection resurgence a plan A and plan B. The BF identified gaps in governance (lack of enabling authority to execute policies and programmes) and resources (human and financial) that need to be addressed.

[31] **Efficiency** (Chapter 2.4 EQ 4.2) "the BF has been reasonably efficient…" Stakeholders in the PUNOs group indicated UNDP's role in first round/ advanced procurement using links with UN China, which allowed probably one of the fastest COVID-19 related procurement cycles on the Continent. Subsequent procurement rounds through WHO and UNICEF were also timely and efficient, to the extent allowed by the logistics constraints generated by the pandemics. Efficiency "procurement of disease commodity packages fast and timely", "BF has remained efficient, fast availability of funds, rapid procurement reflects the efficiency of the BF.

[32] **Effectiveness** (Chapter 2.3 EQ 3.2) "procurement was done in a strategic way; disease commodity packages were procured timely")

- To all involved partners: there is a need for continuous and sustainable co-ordination of the multi-sectoral and multi-stakeholder response to COVID-19 and health security, and more broadly on biosecurity.

Medium- and Long-term recommendations

To the Government of Nigeria:

1. There is a need for local vaccine development and manufacturing and ramping up of COVID 19 vaccination uptake as well as the need to maximize the adoption/adaptation and implementation of international frameworks and treaties for effective health security in Nigeria.
2. There is the need to explore and adopt global strategies for pandemic preparedness and response, strengthen border health security and ramp up COVID-19 testing.
3. There should be a continuous engagement of the private sector to fund health security in a sustainable manner. Private sector players should be encouraged to donate a percentage of their profits with earmarked taxes channelled directly to health sector.
4. The NAPHS implementation should receive priority at the national and subnational levels and be fully funded.
5. Primary Health Care structures should be strengthened to ensure UHC.
6. There should be a dedicated budget line in the future national budget, for the coordination role and pandemic containment activities of the PSC.
7. The NPHCDA should strengthen partnership and communication with State commissioners of health and its State level PHCDAs to improve the uptake of vaccines and work together and harmoniously to improve the rewarding and punishment systems via joint taskforces and other related mechanisms.

ANNEX 1: TERMS OF REFERENCE

Attached as separate file

ANNEX 2: NAMES OF THE EVALUATORS

Mr. Eric Donelli, Health, WaSH and Nutrition Expert.
Dr. Eric Donelli is a medical doctor with Phd and Masters' Degree, specializing in health care support to developing countries, including Nutrition and WASH components. Dr. Donelli has an extensive international experience in programme development, design, implementation, management, monitoring, and evaluation (including Health Information Systems and development of Health Indicators). He is experienced in both clinical activities and national/district health system, health policies and systems. He has an extensive experience of over 30 years in the evaluation of projects related to Health system support, both national and at district level, including management and evaluation of health information systems; formulation, implementation, and coordination of operational research projects; planning and evaluation of health programs; health of refugee and displaced populations, research and design of bilateral and multilateral support programmes. In addition, he has been involved in clinical projects include Maternal and Child Health, HIV/AIDS, and sexually transmitted diseases, CDD, Malaria, EPI, Vaccine, Drugs supply procurement and management, Tuberculosis, GW, ARI, Reproductive Health, Nutrition and Micronutrients, WASH, Medical equipment (including sterilization), Polio and PHC, Epidemiology of Communicable and Tropical diseases, and investigation of epidemics. In 2017 he participated as Health Expert and Evaluator to the Monitoring and evaluation mission on the development project financed by the European Union: "Support to the Expanded Programme of Immunization (EPI) in Nigeria". As Business and Value-chain Development Expert we propose Mr. Alain Peyré.

Mr. Alain Peyré, Business and Value-chain Development Expert.
Mr. Alain Peyré holds a Degree in Biology-Chemistry and an Engineer's Diploma (Master's Degree). He has over 18 years of professional experience as Team Leader, M&E and Value Chain Development Expert in international projects. He has excellent skills in evaluation and monitoring and has developed and implemented M&E frameworks in several large projects funded by EC, bilateral, USAID. He has gained in-depth knowledge of issues pertaining to agriculture and rural development, and improvement of rural value chains by, for instance, carrying out the final monitoring of the project 'Value chain development support services and service delivery capacity of local government in the Highlands in Papua New Guinea' and delivering capacity building on value chains and local development; by managing a large complex SME support project in Afghanistan, where he performed business environment enabling and investment activities; by designing several value chain surveys, organizing intra-chain linkages and enhancing value chain performance in Laos, Vietnam, Cambodia; and so on. Last but not least, he has strong capacities in designing and implementing quality management systems and, since 2013 he is a certified Quality Auditor.

Mr. Olugbenga Akinyemi Akinbiyi, Infectious disease Expert
Mr. Olugbenga holds a PhD in Public Health and is a Nigerian Public Health Practitioner with over 20 years progressive experience in public health practice. He has more than 15 years' experience in technical and full cycle management of Infectious and Communicable Diseases Control Programmes. Since the COVID-19 outbreak, he has been working as Infectious Disease Expert in the World Bank funded project "Regional Disease Surveillance Systems Enhancement (REDISSE) Project" as well as he carries out tasks at the Nigeria Centre for Disease Control. He has excellent knowledge in M&E, quantitative and qualitative research methods, grant proposal development, technical report writing and software data analysis (SPSS, STATA, Epi-info, End note and PITT). He has sound knowledge of advanced statistics and research methodology including skills in sampling techniques and use of computer software for statistical and other related applications and demonstrated ability in report writing and presentation. Lastly, he has a solid understanding of the management of cross cutting issues with a focus on participatory process, integrated programming, protection, and gender issues.

ANNEX 3: EVALUATION MATRIX

Attached as separate excel file

ANNEX 4: INTERVENTION LOGIC – LOGICAL FRAMEWORK MATRIX

Inputs 	▪ Technical assistance & training services ▪ Studies and other subcontracted services ▪ Purchased goods and supplies ▪ Cash transfer and in-kind donation to final beneficiaries ▪ Management & Admin services (UNDP and PUNO) Total resources used over the period covered by the evaluation = USD 33,304,555
Activities 	Procurement of medical supplies including PPE items, equipment and medicines Procurement and distribution of testing kits to laboratories. Establishment of triage stations at States level Setting up new laboratories and expansion of existing laboratories Dissemination of tailored messages to different segments of the population including vulnerable groups through integrated communication strategies, visibility events, and awareness campaigns on preventive measures and recovery intervention Cash transfer programmes for vulnerable population and MSMEs Training of health care workers and volunteers in case management and IPC, of health professionals on intensive care, and of master trainers Conduct - a baseline survey on knowledge, attitudes and practices of community members and health workers, and - a rapid gender assessment on the social and economic impact of COVID-19 in key states Support NCDC for the analysis of COVID-19 data and monitoring of epidemic trends Undertake study to investigate the prevalence and geospatial distribution of symptom profiles in Lagos State (LaSURE study) Hold Intersectoral coordination sessions (PTF) Staff the BFP Secretariat Collect and manage financial resources
Outputs 	Output 1: Improved Rapid Procurement of Disease Commodity Packages for Surveillance, prevention and Control, and Clinical Management Output 2: Complementary on-going risk communication strategies for sustained community engagement and cooperation are supported Output 3: Development of tailored and decentralized response strategies at state-level aligned with the coordinated framework at the Federal level is supported Output 4: Access to essential health services maintained through socio-economic analytics, pro-active early recovery, and social protection activities targeting vulnerable groups. Output 5: Capacities for R&D and Modelling are strengthened Output 6: Coordination of partnerships and mobilization of resources for collective response are improved

Specific objective (Outcome)	Rapid implementation of Nigeria's National COVID-19 Multi-Sectoral Pandemic Response Plan strengthened
Overall objective (Impact)	Nigeria response to the COVID -19 pandemic supported by ensuring optimum care of the confirmed cases and contain further spread of the outbreak and pathway for rapid recovery and resilience is established"

ANNEX 5: MAP OF NIGERIA

ANNEX 6: LIST OF PERSONS – ORGANISATIONS CONSULTED

Name	Position	Organisation
ABUJA		
Dr. Anthony Ayeke	Programme Officer	EUD
Leila Ben Amor Mathieu	Team leader of Human Development	EUD
Patience Ekechukvu	Community engagement Officer	UN-Women
Claes Johansson	Chief Management for result	UNICEF
Jarl Hansstein	Chief Technical Advisor	UNIDO
Oluwaseyi Ladejobi	National Programme Coordinator	UNIDO
Dr. Ibrahim Atta	Manager Resource Mobilisation	PSC
Dr. Mukthar Muhamad	Technical Head	PSC
Dr. Amede Osakal	Technical Adviser	PSC
Renata Pistone	First Secretary	Canada Embassy
Martin Osubor	Senior Development Officer	Canada Embassy
Catherine Hughes	Senior Development Officer	Canada Embassy
Esther Christen	Administrator Officer	Swiss Embassy
Lealem Berhanu Dinku	Deputy Representative	UNDP
Uchenna Onyebuchi	Programme Officer	UNDP
Clare Henshaw	National Programme Officer	UNDP
Anthony Omata	Coordinator Officer	UNDP
Carine Yengayenge	Deputy Resident Representative. Operation	UNDP
Peter Hawkins	Country Representative	UNICEF
Ukwuije F. Nwachukwu	Coordinator Officer	WHO
Ether Melissa Lucinda	External Relation Officer	WHO
Dr. Rex Mpazanje	Programme Officer	WHO
Dr. Geofrey Namara	Programme Officer	WHO
Mohamed Yahya'	Resident Representative	UNDP
Daisy Foday	Project Manager	UNDP
Paula Beltran	Project Manager	UNICEF
Ridwan Hasan	Project Manager	UNICEF
Robert Mombissi	Project Manager	UNICEF
Babantunde Adelekan	Project Officer	UNFPA
Victor Ajieroh	Member Technical Committee	Bill & Melinda Foundation
Nasir Baba-Saleh	As. Director. Women Organization	Federal M. of Women Affairs
Dr. Precillia Ibekwe	Director, Partnership Coordination	Nigeria NCDC
Momodu Zakare	Project Manager	Dangote Foundation
Dr Sam Agbo	Senior Health Advisor, health programme, HDD	FCDO
Mrs SkjØlaas	Minister-Counsellor	Embassy of Norway
SOKOTO		
Dr. Jalal-Eddeen Saleh	North West Regional Coordinator	WHO - Kano
Dr. Habib Yahaya	Sokoto State Coordinator	WHO
Glorisa Enueze	Gender & Reproductive Health Analyst	UNFPA
Danjuma Nehemiah	Health Specialist	UNICEF
Uche Nwaneri	Program Manager	Wazobia Radio
Dr. Lariah Aliyu	Programme Officer	WHO
Dr. Bala Mukhele	Programme Officer	WHO
Bello Idrisa	Health Specialist	WHO
Ogieva Adesula	Coordinator	WHO
Abdullah Maigore	Programme Officer	WHO
Dr. Maryam Bello	Programme Officer	WHO
Alkassim Amahad	Programme Officer	WHO
Dr. Bashir H. Iss	Programme Officer	WHO
Yahaya Ahmed	Programme Officer Immunisation	WHO
Dr. Amin Zauro	Health Specialist	WHO
Awa Sanyang	STOP TB Officer	WHO
Dr. Mayana Sa	Health System Strengthening	WHO
Dr. Habibu Yahagu	Programme Officer	WHO

Dr. M. Aliiunwae	Health Officer	Ministry Of Health
Abubakar Ilmar	Health Officer	SSP-PHCDA
Adamu Romo	Health Officer	SSP-PHCDA
Abdullaraman Ahmed	Health Officer	Ministry Of Health
Pharm Sanusi Mode	Programme Officer	SSPHC-DA
Abubakar Dammafora	Programme Officer	Ministry Of Health
Shebu Ahmad	Programme Officer	Ministry Of Health
Asfatu Halilu Bello	Programme Officer	PPF-N Sokoto
Zaunab Althiassan	Programme Officer	PPF-N Sokoto
Hasfatu Halila	Focal Point Covid-19	PPF-N Sokoto
Laflefat Kabirn	Independent Monitor Covid-19	WHO
Umaims Muhammad	Independent Monitor Covid-19	WHO
Munira Abubakar	Independent Monitor Covid-19	WHO
Aisha Abubakar	Independent Monitor Covid-19	WHO
Dr. Hadiza Yaro	Deputy Director Public Health	Ministry Of Health
Isam Blessing O.	Youth Ambassador Support	Y.I.S.
Dr. Sadya Umar	Director Disease Control & Immunization	SSPHC -DA
Shaferatu Musa	Youth Ambassador Support	CSO
Umar Acmastuole	Youth Ambassador Support	CSO
Ayuba Sunday	Youth Ambassador Support	CSO
Hadiza Abubakar	Youth Ambassador Support	CSO
Dr. U. Mohamad Bello	Isolation Centre Covid-19	IDH Amanawa - Sokoto
Dr. Bilaminu Balarabe	Isolation Centre Covid-19	IDH Amanawa - Sokoto
Marine Shehu Adili	Administrator Director	IDH Amanawa - Sokoto
Ach Sami Ulmar Talabi	Traditional Leader (Sultan)	Sokoto
16 Women	Different Professions - Covid Response	Sokoto
11 Men	Different Professions - Covid Response	Sokoto
Dr. Sabitu Mazr	Consultant Microbiologist In charge of Laboratory	Sokoto Teaching Hospital
ADAMAWA		
Dr. Danladi Idrisa	Humanitarian Analyst Officer	UNFPA
Abubaka Mukthar	Capacity Building Programme Associate	UNFPA
Adiel Adamu Apiagu	Health Sector Coordinator	WHO
Haukla Musa	Director Community Health Services	State PHCDA
Amma A. Alahira	Director Women Affair	Ministry of Women Affair
Ahmed Akar	Medical Officer	DPHCC – Dougirei PHC
Gabriel Kgware	Medical Officer In charge	DPHCC - Dougirei PHC Centre
Asmau Amadu	Midwife	UNFPA Malkoni
Mackwondo Pwasato	Staff of Min. Women Affair	Ministry of Women Affair
Jemila Bokar	Master Trainer	UNFPA Malkoni
14 Women + 6 children	Focus Group Discussion	UNFPA Malkoni Centre
Salama Tukawu	Manager	Malkoni PHC Centre
Michail Abubakar	EPI Officer	Malkoni PHC Centre
John Japtu Thliza	Safety Officer	Federal Medical Centre Yola
Shueubu Rukaiya	Laboratory Manager	Federal Medical Centre Yola
Didam J. Alone	Laboratory Quality Officer	Federal Medical Centre Yola
KANO		
Dr. Aminu Ibrahim	Honourable Commissioner	MoH
Amina A. Musa	Permanent Secretary	MoH
Dr Ashiru Rajab	Director Of Public Health	MoH
Dr Ahmed T. Habibu	PM SERICC	State PHC Management Board
Shehu Dabo	State Health Educator	MoH
Bashiru Abba	State Coordinator	WHO
Auwal Idris	Director Surveillance and Notification.	State PHC Management Board
Hamza S. Fagge	Officer	MoH
Dr. U.J. Abubakar	CMI & PHR	DSS/ONSA
Dr. A. I. Kau	I.M EOC	MoH
Ado Jibrin	SMO	State PHC Management Board
Dr. Imam Wada Bello	Director OC &E	State PHC Management Board
Adamu Haruna	Intern	NYSC

Ahmad Muhammad	Intern	NYSC
Abidah Abubakar	Intern	NYSC
Bashir Alhasa	State PHC Management Board	PEG/FP
Dr. Sabitu Shanowo	SACA	Director General
Dr Serekeberehm	Health Monitor	UNICEF
Bahijjatu Bello Garko	ASRH/YD	UNFPA
Mohal Wuga Yahaqq	State PHC Management Board	HBCD/DSL CMGT
Nazir R. Ali.	SCC	EHA/EOC
Dr. Imam Wale Bello	DNC & E	State PHC Management Board
Bello Zainab Yakasai	Zemma Awareness Initiative	Zemma Awareness Initiative
Dr. Bshr Abba	Project Officer	WHO
Abdulazeez Musa	Staff Member	Bridge Connect Africa Initiative
Rahama Moha	Mmed Master of Medicine	UNICEF
Dr. Muhid Bashir	Project Officer	WHO
Dr. Musa M. Bello	Staff Member	CHR, Kano
Hadiza Bala Faggae	Staff Member	WINODI - KANO
Salisu Musa Muhd	CHR Staff	CHR
Sulaiman Umar Jalo	CHR Staff	CHR
Muhammod Abdullahi	CHRST Staff	CHR
LAGOS		
Dr. Akinbaja A.E.	MH/FP Analyst	UNFPA
Dr Esan	CC/TCC	WHO
Folarin Tolulope	Response Coordinator, Covid-19	WHO
Dr Temitope Fadiya	NPO	UNAIDS
Gift-okorie, E. Chinyere	Head Grant Management office	Lagos State MoH Repres.
Dr. Hussein A. Razaq	Lagos State MoH Representative	HHR
Ms Akinwusi Titilayo d.	LASURE Study manager	Lagos State MoH Repres.
Dr Olumide Okulaja	TA HCH	Lagos State MoH Repres.
Mrs Kemi Adedeji	State Coordinating Officer for UNDP	Lagos State Coordinating Unit
Tunde Ajayi	SA (Health)	Lagos State MoH Repres.
Dr Akintunde Disu	Assistant IPO	Lagos State PHC Board
Itunu babrinde	EU Focal Point	Lagos State MoWA
Kadiri Oluseyi	State Coordinator	Ass. of Women living HIV/AIDs
Dabiri Nusirat I	Med. Social Welfare	Randle Health Centre Surele
Idiris Folake	Local Level	WOWICAN
Juliah Akerele	NAT. Secretary State Co-ordination	WOWICAN
Kajola Abiodun	LILG Community	Community Volunteers
Bamidele Oyewumi	CSO	HACEY Health
Omononuga Aluko	CEO	HACEY Health
Oketayo Oluwafemi	Program officer	TWHHI
Orolugbagbe Modupe	HEO	LILG
Ajayi Toyin	CEO	Tender Care Initiative
Adeyemo Busayo	Co-coordinator	Nigeria Girls Guide Assoc.
Gambo Aisha	Beneficiary	Hausa Agege Community
Patrick Akpan N.	State Co-coordinator	NEPWHAN
Aba Patricia	Health Educator	Agege LGA
Olusanya Olusola	Medical Social Welfare	Health Service Commission
Odukoya Oluwabunmi	ACSWO Social Worker	Ikorodu General Hospital
Olajide Hannah	Private Health Worker	Ayodeji Medical Centre
Bankole Racheal	COVID-19 Positive	Gender Based-Survivor
Lawal Abiodun	COVID-19 Positive	Gender Based-Survivor
EDO STATE		
Mrs. Barbara Nekpen Osobajo	Hon. Commissioner	MSDGI
Dr. Osagie Ehanire	Hon. Commissioner	MoH
Dr. Mrs. Faith Ireye	State coordinator	WHO
Dr. Onoghoete Ikiroda	State Representative	WOWICAN

Prophetess Clara Taiwo	senior executive	WOWICAN
Imonikhe Rose E	Executive	SOCU
Asemota Festus	Deputy director	EDO-SOCU
Musa Halimat Sadiq	State representative	FOMWAN
H.O. Ekhafor	Director, vulnerable groups	MSDGI
Otokumrine	Staff	SOCU
Precious Okpaise	Director	MSDGI
Arogundale V. Toyin	Coordinator	MSDGI
Promise A. Onyiwe	Coordinator	MSDGI
Rebecca Agu Obiageli	State representative	NGGA
Victoria A. Igbinosun	State representative	WOWICAN
Nana Sani Aishent	State representative	FOMWAN
Margaret Alegbe	Staff	OREDO LGA
Doris I. Oronsage	Staff	Egor LGA
J.I. Ihensekhien	manager	MSDGI
Edeko Mara	manager	MSDGI
Imuso Okafor	manager	MSDGI
ANAMBRA		
Dr. Okeke Ngozi	Staff	Ihiala South LGA H. Authority
Dr. Ume Frank	Staff	Awka South LGA H. Authority
Nwude Ifeanyi	Staff	State Emergency Operations
UDE Chris	Staff	State Emergency Operations
Maureen Zubie Okolo	Monitoring & Evaluation Specialist	State PHC Management
Dr I. Chukwumuanya	State Coordinator	MoH
Dr Okeke Edward	Surveillance officer COVID IMS	MoH
Oji Ndubuisi	EU HSS Program Officer	EU
Dr Anosike Adaoha	Staff	State PHC Management Board
Dr Emembulo Chuma	State Epidemiologist	State PHC Management Board
Dr Okpala Vincent	Staff	Commissioner of Health
Nwankwo Linus	Permanent Secretary	Commissioner of Health
Dr Chioma Ezenyimulu	Executive Secretary	Commissioner of Health
Dr Uliagbafusi Placid	Director of Immunization	MoH
Oonwuvunka Nkechi	State Social Mobilization Officer	MoH
Onwuegbuzina Uju	State Social Mobilization Officer	MoH
Gbofeyn Diden	Vaccine logistics officer	MoH
Ifeany Chinyere	Staff	Awka South LGA Health
Ndefo Philomena	Staff	Idemili LGA Health Authority
Dr Ezedinachi	Staff	Onitsha North LGA
Ida Georgina	Staff	Onitsha North LGA
Okeke Stella	Staff	Awka South LGA Health
Okeke Chinwe	Staff	Onitsha North LGA
Dr Obi Ken	Staff	State Emergency Operations
Dr Okeke Edward	State coordinator	WHO
Dr Anyaya Ifenyinwa	State	UNICEF
Gladys Ezembu	Local executive	Network of People Living HIV
Chizoba	State representative	Network of People Living HIV
Ume Okey	Chukwuemeka Odumegwu Ojukwu University Teaching Hospital Awka	
Muogbo Ifeanyi	Medical Officer	General Hospital Onitsha
Okonkwo Virginia	Staff	Onitsha North LGA Authority
Azo Chris	Local Representative	CSO Anambra State

ANNEX 7: LITERATURE AND DOCUMENTS CONSULTED

- Action Document “The European Union Emergency Trust Fund for Africa; Addressing COVID-19 in Nigeria
- Mission Report Bauchi State Date 14th -19th November 2021
- Mission Report Lagos State: Alaosa, Ikeja LGA
- The Global Network for Health Financing and Social Health Protection P4H Annual Review 2020-2021
- One UN COVID-19 response for Nigeria basket fund project consolidated annual progress report (May 2020 to April 2021)
- Q-1 ONE UN COVID-19 response for Nigeria basket fund project consolidated quarter one progress report (May to July 2020)
- Q-2 ONE UN COVID-19 response for Nigeria basket fund project consolidated quarter two progress report (august to October 2020)
- Q-3 ONE UN COVID-19 response for Nigeria basket fund project consolidated quarter three progress report (November 2020 to January 2021)
- Contact list Project Board, Technical Committee, Donors
- European Union contribution agreement - T05-eutf-sah-ng-09-01
- ONE UN COVID-19 response plan for Nigeria basket fund project document Project title: one UN COVID-19 response plan for Nigeria project number: tbc start date: 1 May 2020 end date: 30 April 2022
- National COVID-19 Multi-Sectoral Pandemic Response Plan March 2020 one un response plan to covid19 in Nigeria ‘...prepare for the worst and prepare today’ Dr. Tedros Adhanom Ghebreyesus, WHO Executive Director
- Audit Covid 19 Outbreak Report Nigeria, UNDP
- The COVID-19 pandemic in Nigeria citizen perceptions and the secondary impacts of Covid-19, UNDP
- COVID-19 Position paper | 26 April 2020, WHO, EU, WB
- European Union Contribution Agreement T05-EUTF-SAH-09-01
- UNDP Covid 19 Brief 2020 April
- UNDP Covid 19 Brief 2020 March
- UN Brief 3 Impact
- The Impact of COVID-19 on business
- Q3 Joint Monitoring Report
- Board Meeting Reports 1,2,3,4,5,6 2020 and 2021
- One UN COVID-19 Response Plan
- The COVID-19 Pandemic in Nigeria: socioeconomic implications of delayed access to vaccines, UNPD Nigeria
- WHO Reports Documents
- UNICEF Reports Documents
- UNFPA Reports Documents
- Epidemiological States Reports, Lagos, Kano, Sokoto, Amadawa, Edo and Anambra
- The COVID-19 pandemic in Nigeria potential impact of lockdown policies on poverty and well-being UNDP
- One UN COVID-19 response for Nigeria basket fund project consolidated annual progress report (May 2020 to April 2021)

ANNEX 8: DETAILED ANSWERS TO EVALUATION QUESTIONS, JUDGEMENT CRITERIA AND INDICATORS

	SUB-QUESTION	NCDC Abuja 18-Feb
EFFECTIVENESS	Did the implementation strategy prove appropriate/ effective? How much so?	Yes There was collaboration with Government system (response plan)
	Was the implementation methods for (your) respective activities appropriate?	yes. They used their comparative advantage to make things work and to add scale to Nigeria response , working within the confines of where they found themselves. (O1)
	Is the expected outcome (likely to be) achieved?	Yes, the BF contribution to national plan is positive
	Could the same outcome be achieved in a better way?	NA
	Are the respective outputs (1-6) achieved?	No. Negligible investment in research, development and modelling for Covid-19 response in Nigeria is a missed opportunity for gathering local evidence for strategic decision making (O5)
	How would you rate the fairness of the distribution of effects? were effect equally felt across different groups?	NA
	Has the intervention created any unintended positive or negative effects?	NA
	Were the negative effects considered for possible (risk) mitigation?	
EFFICIENCY	Are the inputs/ resources provided by the various stakeholders adequate for achieving the planned results?	
	Have the disease commodity packages been delivered timely?	The delivery of the procured material was timely and centralized. it assist in rapid procurement and supply.(o1)
	Is spending in line with the timeline and budget?	
	Has the intervention encountered delays and was the planning revised accordingly?	
IMPACT	What building blocks have been placed by the BF for rapid recovery and resilience?	
	Were the needs of beneficiaries defined? Have they changed?	
	Have the needs of the target groups been satisfied, and if so to what extent?	
	Has the BF contributed to better health or COVID-19 policies or new priorities?which ones?	
	How much would you say the BF has contributed to social & economic recovery?	
	How much would you say the BF has contributed 'in terms of population resilience?	
EU VALUE	What specific benefits has the Government got from BF, as compared to separate interventions amounting to the same funding?	
	Would EU added-value aspects be possibly replicated in new projects (incremental portfolio?)	
	Has the BF support been benefitting the EU image in the country/region?	

	SUB-QUESTION	Dangote Foundation (Abuja) 17-Feb
EFFECTIVENESS	Did the implementation strategy prove appropriate/ effective? How much so?	Yes It is strategic, was able to mobilize significant resources in relative short time that were dedicate to Covid-19 and subsequently have manageability. The funds are good in both resources generation, responsiveness, and responsibility.
	Was the implementation methods for (your) respective activities appropriate?	NA
	Is the expected outcome (likely to be) achieved?	NA
	Could the same outcome be achieved in a better way?	NA
	Are the respective outputs (1-6) achieved?	Yes The procurement was strategic and devoid of waste and questionable deployment of resources(O1) However, the project struggled on the risk communication aspect, the government of Nigeria and all struggled to make it.
	How would you rate the fairness of the distribution of effects? were effect equally felt across different groups?	NA
	Has the intervention created any unintended positive or negative effects?	NA
	Were the negative effects considered for possible (risk) mitigation?	
EFFICIENCY	Are the inputs/ resources provided by the various stakeholders adequate for achieving the planned results?	
	Have the disease commodity packages been delivered timely?	Some bureaucratic layer in the system, delay in deployment of funds.
	Is spending in line with the timeline and budget?	
	Has the intervention encountered delays and was the planning revised accordingly?	
IMPACT	What building blocks have been placed by the BF for rapid recovery and resilience?	O2 not really successful whether it [was targeting] risk at HF level, at health workers level and even the larger public. The issue is all about impact are not well aligned to be measured
	Were the needs of beneficiaries defined? Have they changed?	
	Have the needs of the target groups been satisfied, and if so to what extent?	
	Has the BF contributed to better health or COVID-19 policies or new priorities?which ones?	Coordination has been on a larger scale and more systematically deployed.
	How much would you say the BF has contributed to social & economic recovery?	
	How much would you say the BF has contributed 'in terms of population resilience?	
EU VALUE	What specific benefits has the Government got from BF, as compared to separate interventions amounting to the same funding?	
	Would EU added-value aspects be possibly replicated in new projects (incremental portfolio?)	
	Has the BF support been benefitting the EU image in the country/region?	

	SUB-QUESTION	Min. Women Affairs Abuja 17-Feb
EFFECTIVENESS	Did the implementation strategy prove appropriate/ effective? How much so?	yes but UN agencies (activities) could by-pass the ministry to implement at the grass root.
	Was the implementation methods for (your) respective activities appropriate?	Yes, It gave access and openness to rural communities to strengthen the risk communication activities. Also RCCE helped to reach out to the hard to reach environment and also gather information and feedback from audience.
	Is the expected outcome (likely to be) achieved?	NA
	Could the same outcome be achieved in a better way?	NA
	Are the respective outputs (1-6) achieved?	Yes-O2, O4 Donation of commodities such as PPES to the community helps to protect the community members, the text for life initiative assist the community people to assess health services
	How would you rate the fairness of the distribution of effects? were effect equally felt across different groups?	NA
	Has the intervention created any unintended positive or negative effects?	NA
	Were the negative effects considered for possible (risk) mitigation?	
EFFICIENCY	Are the inputs/ resources provided by the various stakeholders adequate for achieving the planned results?	
	Have the disease commodity packages been delivered timely?	
	Is spending in line with the timeline and budget?	Yes, but release of funds was not initially swift.
	Has the intervention encountered delays and was the planning revised accordingly?	
IMPACT	What building blocks have been placed by the BF for rapid recovery and resilience?	The BF brought all the CSO together for implementation which is being coordinated by the Federal Women Affairs. It Strengthened the weak social register that already been existing in the country through NASCO.
	Were the needs of beneficiaries defined? Have they changed?	
	Have the needs of the target groups been satisfied, and if so to what extent?	
	Has the BF contributed to better health or COVID-19 policies or new priorities?which ones?	
	How much would you say the BF has contributed to social & economic recovery?	It enhanced the level of relationship at community level and interpersonal relationship between field officers.
	How much would you say the BF has contributed 'in terms of population resilience?	It helped in cash transfer project to help in their business in the villages in the country.
EU VALUE	What specific benefits has the Government got from BF, as compared to separate interventions amounting to the same funding?	There was strong coordination among the partners which make the project to function well.
	Would EU added-value aspects be possibly replicated in new projects (incremental portfolio?)	
	Has the BF support been benefitting the EU image in the country/region?	

	SUB-QUESTION	UNDP
EFFECTIVENESS	Did the implementation strategy prove appropriate/ effective? How much so?	Yes although reaching agreements with PUNOs took time
	Was the implementation methods for (your) respective activities appropriate?	Yes yet PUNO were responsible for their own financial management
	Is the expected outcome (likely to be) achieved?	yes
	Could the same outcome be achieved in a better way?	no, the advantage was that partnership of UN agencies were already endorsed, where external players would need go through vetting process.
	Are the respective outputs (1-6) achieved?	yes. Note that O5 and O6 didn't receive any funds
	How would you rate the fairness of the distribution of effects? were effect equally felt across different groups?	Coverage, 7 States selected by Board, geographic balancing was done based on NCDC recommendations (NCDC as board observers)
	Has the intervention created any unintended positive or negative effects?	Yes: Strengthening NAFCO capacities, for better inclusiveness.
	Were the negative effects considered for possible (risk) mitigation?	
EFFICIENCY	Are the inputs/ resources provided by the various stakeholders adequate for achieving the planned results?	UNDP role crucial in first round/ advanced procurement using links with UN China.
	Have the disease commodity packages been delivered timely?	There were delays in O4 since data from national register was a bit obsolete, needed coordination with SOCU and verification (ascertaining no one left behind)
	Is spending in line with the timeline and budget?	
	Has the intervention encountered delays and was the planning revised accordingly?	
IMPACT	What building blocks have been placed by the BF for rapid recovery and resilience?	
	Were the needs of beneficiaries defined? Have they changed?	
	Have the needs of the target groups been satisfied, and if so to what extent?	
	Has the BF contributed to better health or COVID-19 policies or new priorities?which ones?	
	How much would you say the BF has contributed to social & economic recovery?	
	How much would you say the BF has contributed 'in terms of population resilience?	
EU VALUE	What specific benefits has the Government got from BF, as compared to separate interventions amounting to the same funding?	
	Would EU added-value aspects be possibly replicated in new projects (incremental portfolio?)	
	Has the BF support been benefitting the EU image in the country/region?	

	SUB-QUESTION	PUNO Abuja 10-Feb
EFFECTIVENESS	Did the implementation strategy prove appropriate/ effective? How much so?	yes, quick disbursement; strong cooperation system with government channels, but BF would have been stronger with proper program planning and management
	Was the implementation methods for (your) respective activities appropriate?	
	Is the expected outcome (likely to be) achieved?	yes globally effective
	Could the same outcome be achieved in a better way?	Some packages procured unilaterally by UNDP for quick delivery; there was at this time no representation /inclusion in the global procurement systems which may have decreased Nigeria position for supplies
	Are the respective outputs (1-6) achieved?	yes O1-O4
	How would you rate the fairness of the distribution of effects? were effect equally felt across different groups?	First served were person working in offices, not Primary health care staffs, which were served later by 2021
	Has the intervention created any unintended positive or negative effects?	NA
	Were the negative effects considered for possible (risk) mitigation?	
EFFICIENCY	Are the inputs/ resources provided by the various stakeholders adequate for achieving the planned results?	Since PUNO were not associated to design: mismatch have occurred between PUNOs directions and expectations, and UNDP allocations and management
	Have the disease commodity packages been delivered timely?	yes after initial slight delays
	Is spending in line with the timeline and budget?	BF fully spent
	Has the intervention encountered delays and was the planning revised accordingly?	
IMPACT	What building blocks have been placed by the BF for rapid recovery and resilience?	Board role was important, the Head of BF did good job in keeping the program focused
	Were the needs of beneficiaries defined? Have they changed?	
	Have the needs of the target groups been satisfied, and if so to what extent?	
	Has the BF contributed to better health or COVID-19 policies or new priorities?which ones?	
	How much would you say the BF has contributed to social & economic recovery?	
	How much would you say the BF has contributed 'in terms of population resilience?	
EU VALUE	What specific benefits has the Government got from BF, as compared to separate interventions amounting to the same funding?	
	Would EU added-value aspects be possibly replicated in new projects (incremental portfolio?)	
	Has the BF support been benefitting the EU image in the country/region?	

	SUB-QUESTION	PUNO Abuja 10-Feb
EFFECTIVENESS	Did the implementation strategy prove appropriate/ effective? How much so?	yes , modality through project submission was necessary to provide for UN cooperation (whereas GoN had wished one agency for one outcome)
	Was the implementation methods for (your) respective activities appropriate?	No -Difficulties in preparation, but it's rather UN agencies to adapt their ways of preparing CN - Some GoN stakeholder were not always able to express their needs; this may have led to situations where PUNOs have made their projects 'acceptable' for GoN/ Board
	Is the expected outcome (likely to be) achieved?	Yes, globally effective
	Could the same outcome be achieved in a better way?	All in all there could have been better interaction within UN and between UN agencies and GoN agencies
	Are the respective outputs (1-6) achieved?	Yes: On O3, WHO focus was at federal level (review of response strategies, national monitoring), and this support helped adjust specific response at States level For O5, little done under BF, this activity met difficulties for inter-agency coordination
	How would you rate the fairness of the distribution of effects? were effect equally felt across different groups?	WHO worked in all states, BF support in States selected by PTF/BF
	Has the intervention created any unintended positive or negative effects?	NA
	Were the negative effects considered for possible (risk) mitigation?	
EFFICIENCY	Are the inputs/ resources provided by the various stakeholders adequate for achieving the planned results?	
	Have the disease commodity packages been delivered timely?	Yes despite initial delay due to lock down of national airports
	Is spending in line with the timeline and budget?	
	Has the intervention encountered delays and was the planning revised accordingly?	
IMPACT	What building blocks have been placed by the BF for rapid recovery and resilience?	BF has been good for initial stage, now its approach should be reviewed (coverage, O2 supply, case management, testing,). Also need for finer data (State level) and analyses
	Were the needs of beneficiaries defined? Have they changed?	
	Have the needs of the target groups been satisfied, and if so to what extent?	
	Has the BF contributed to better health or COVID-19 policies or new priorities?which ones?	
	How much would you say the BF has contributed to social & economic recovery?	Positive overall. Yet the scope and allocation of Government funding remain not stable: some support measure already decided are at times replealled. Therefore this would call for more flexibility in BF, and more targeted interventions
	How much would you say the BF has contributed 'in terms of population resilience?	
EU VALUE	What specific benefits has the Government got from BF, as compared to separate interventions amounting to the same funding?	
	Would EU added-value aspects be possibly replicated in new projects (incremental portfolio?)	
	Has the BF support been benefitting the EU image in the country/region?	

	SUB-QUESTION	PUNO Abuja 09-Feb
EFFECTIVENESS	Did the implementation strategy prove appropriate/ effective? How much so?	In terms of implementation modality, decentralized management through UNDP and operational implementation by PUNOs introduced some financial constraints for PUNOs as management fees had to be reduced and balanced to match EU requirements. This created delays in the release of EU funds until these issues were solved after mid 2020
	Was the implementation methods for (your) respective activities appropriate?	Yes Overall the implementation through UNDP is seen not ideal, but given the need to develop the BF quickly, it would have been impossible to study alternative models (e.g. a multi-partners implementation agreement with associated TA services).
	Is the expected outcome (likely to be) achieved?	yes, BF successful to tacke pandemics
	Could the same outcome be achieved in a better way?	Impl modality? Indirect management was perhaps the only practical modality
	Are the respective outputs (1-6) achieved?	yes O1-O4, strong commitment to results at all levels; O2 had poor metrics and could lack homogeneity across states; O3 no strategies developped; O4 initial drop but later access to services was restaured; O4 socio-economic packages were small in proportion of other Govt support
	How would you rate the fairness of the distribution of effects? were effect equally felt across different groups?	In term of coverage, UNICEF country programme was focused (based on resources) to 19 States, with offices in 9 States. The strategy was to develop successful models in specific stae, which could demonstrate usefulness and be replicated in other States.
	Has the intervention created any unintended positive or negative effects?	NA
	Were the negative effects considered for possible (risk) mitigation?	
EFFICIENCY	Are the inputs/ resources provided by the various stakeholders adequate for achieving the planned results?	Yes, supply was alltogether matching needs- in place quantities not sufficient. Info on fund allocations for non-government stakeholder was scarce.
	Have the disease commodity packages been delivered timely?	Yes, Procurement ensured by UNDP and UNICEF, went well given emergency conditions
	Is spending in line with the timeline and budget?	
	Has the intervention encountered delays and was the planning revised accordingly?	
IMPACT	What building blocks have been placed by the BF for rapid recovery and resilience?	BF response was good for initial phase; now there has been a shift; focus would be more on vaccination.
	Were the needs of beneficiaries defined? Have they changed?	Needs remain to fund infrastructure and access to vaccine.
	Have the needs of the target groups been satisfied, and if so to what extent?	
	Has the BF contributed to better health or COVID-19 policies or new priorities?which ones?	
	How much would you say the BF has contributed to social & economic recovery?	
	How much would you say the BF has contributed 'in terms of population resilience?	
EU VALUE	What specific benefits has the Government got from BF, as compared to separate interventions amounting to the same funding?	
	Would EU added-value aspects be possibly replicated in new projects (incremental portfolio?)	
	Has the BF support been benefitting the EU image in the country/region?	

	SUB-QUESTION	Development Partner 06-Feb
EFFECTIVENESS	Did the implementation strategy prove appropriate/ effective? How much so?	Yes BF is seen as a very good delivery model in particular with the TWG. However, Quality of project concept was low in design and narrative; this may be caused by the weak log-frame of the BF that has no smart objectives and unclear outputs.
	Was the implementation methods for (your) respective activities appropriate?	yes UNDP proved to be an effective and excellent managing agent – using the governance system as at when necessary
	Is the expected outcome (likely to be) achieved?	yes, BF has delivered strong contribution to COVID response
	Could the same outcome be achieved in a better way?	
	Are the respective outputs (1-6) achieved?	Yes: The low implementation of the Research and development component can be improved by broadening the call to bid or invitation to bid to strategic agencies and/or academic institutions
	How would you rate the fairness of the distribution of effects? were effect equally felt across different groups?	NA
	Has the intervention created any unintended positive or negative effects?	NA
	Were the negative effects considered for possible (risk) mitigation?	
EFFICIENCY	Are the inputs/ resources provided by the various stakeholders adequate for achieving the planned results?	
	Have the disease commodity packages been delivered timely?	
	Is spending in line with the timeline and budget?	
	Has the intervention encountered delays and was the planning revised accordingly?	
IMPACT	What building blocks have been placed by the BF for rapid recovery and resilience?	The UN basket fund project was a timely and a very great pooled funding mechanism that helped to reduced duplications, cost of transaction and a VfM approach for participating donors and UN agency recipients
	Were the needs of beneficiaries defined? Have they changed?	
	Have the needs of the target groups been satisfied, and if so to what extent?	
	Has the BF contributed to better health or COVID-19 policies or new priorities?which ones?	
	How much would you say the BF has contributed to social & economic recovery?	
	How much would you say the BF has contributed 'in terms of population resilience?	
EU VALUE	What specific benefits has the Government got from BF, as compared to separate interventions amounting to the same funding?	The basket funding mechanism is a complementary approach and very much aligned with the BPHCPF (government driven) and consistent with the application of the Paris Aid modality in both Humanitarian and development
	Would EU added-value aspects be possibly replicated in new projects (incremental portfolio?)	
	Has the BF support been benefitting the EU image in the country/region?	

	SUB-QUESTION	Development Partner (Abuja)
EFFECTIVENESS	Did the implementation strategy prove appropriate/ effective? How much so?	Yes: Given the crisis background and short-time allowed to implement, board governance was adequate. Board provided a good platform for exchanging views/info, preparing activities, following progress, and discussing funds allocation
	Was the implementation methods for (your) respective activities appropriate?	Yes Board meetings were altogether good and improving after the first ones, better preparation and technical backstopping - Implementation modality through subsequent CN was prehaps the best due to time constraints and crisis context.
	Is the expected outcome (likely to be) achieved?	Yes. The BF seems overall effective, useful. It allowed joint work with Government and between Donors. It is a recent instrument, so it seem necessary to have a slightly longer time frame for BF to prove effectiveness
	Could the same outcome be achieved in a better way?	Unlikely: it was better to implement activities, even if there was some imprecision in preparation, rather than to wait and have better defined modality and/or projects
	Are the respective outputs (1-6) achieved?	Overall yes, but more accurate info on progress would have been useful
	How would you rate the fairness of the distribution of effects? were effect equally felt across different groups?	NA
	Has the intervention created any unintended positive or negative effects?	NA
	Were the negative effects considered for possible (risk) mitigation?	
EFFICIENCY	Are the inputs/ resources provided by the various stakeholders adequate for achieving the planned results?	NA
	Have the disease commodity packages been delivered timely?	NA
	Is spending in line with the timeline and budget?	NA
	Has the intervention encountered delays and was the planning revised accordingly?	NA
IMPACT	What building blocks have been placed by the BF for rapid recovery and resilience?	Difficult to measure/ assess impact; necessary to have more analytical reports that can demonstrate progress toward global outcome and lessons learnt; Govt need a synthetic view to appreciate usefulness of BF
	Were the needs of beneficiaries defined? Have they changed?	
	Have the needs of the target groups been satisfied, and if so to what extent?	
	Has the BF contributed to better health or COVID-19 policies or new priorities?which ones?	BF may have had secondary impact, interesting to know whether Government has been able to get additional funds or reallocate funding (re-prioritize other support)
	How much would you say the BF has contributed to social & economic recovery?	
	How much would you say the BF has contributed 'in terms of population resilience?	
EU VALUE	What specific benefits has the Government got from BF, as compared to separate interventions amounting to the same funding?	The EU value added was to leverage the access to Government at political through and beyond Board meetings.
	Would EU added-value aspects be possibly replicated in new projects (incremental portfolio?)	
	Has the BF support been benefitting the EU image in the country/region?	

	SUB-QUESTION	PUNO Abuja
EFFECTIVENESS	Did the implementation strategy prove appropriate/ effective? How much so?	Yes As part of UN, partnership with other agencies was relatively easy
	Was the implementation methods for (your) respective activities appropriate?	Yes it was appropriate since UNW had been associated with identification of components (O2). UNW worked in close collaboration with usual partners Ministry (MSDGI) and with CSO,
	Is the expected outcome (likely to be) achieved?	Yes - communication output facilitated work in O1, O3
	Could the same outcome be achieved in a better way?	NA
	Are the respective outputs (1-6) achieved?	Yes , O2 has been fully implemented, but no provision in design or later to measure effect of the message. Anecdotal evidence was collected showing changes in practices (e.g. use of masks) and also changes in attitudes (e.g. leader communicating more frequentlyand taking action against GBV); Cash transfer has reached disabled, elderly, persons with chronic diseases
	How would you rate the fairness of the distribution of effects? were effect equally felt across different groups?	Lists of vulnerable persons used were from SOCU, these have been fully aligned with those of NAFSO.
	Has the intervention created any unintended positive or negative effects?	yes Positive side effect: many women have got a bank account.
	Were the negative effects considered for possible (risk) mitigation?	
EFFICIENCY	Are the inputs/ resources provided by the various stakeholders adequate for achieving the planned results?	Yes funding was received timely fm BF
	Have the disease commodity packages been delivered timely?	Fund disbursement was fine however slow start, due to a) initial difficulty to adjust to work in common: planning, reporting, decision making and b) delay to adapt the cash transfer delivery strategy: it has proven difficult to work with direct transfer through local agent and local banks had to be used, with additional time to comply with their financial management
	Is spending in line with the timeline and budget?	Yes overall, RC and CT completely disbursed as of Q3 2021
	Has the intervention encountered delays and was the planning revised accordingly?	
IMPACT	What building blocks have been placed by the BF for rapid recovery and resilience?	messages on risk have poisitvely changed habits, facilitating the control
	Were the needs of beneficiaries defined? Have they changed?	
	Have the needs of the target groups been satisfied, and if so to what extent?	
	Has the BF contributed to better health or COVID-19 policies or new priorities?which ones?	
	How much would you say the BF has contributed to social & economic recovery?	through O4, cash transfert were useful to maintain livelihoods , although project budet was limited (covering 10 states -cash transfer (11,500 benef vs 10,000 target, spent 855,000USD)
	How much would you say the BF has contributed 'in terms of population resilience?	as above
EU VALUE	What specific benefits has the Government got from BF, as compared to separate interventions amounting to the same funding?	
	Would EU added-value aspects be possibly replicated in new projects (incremental portfolio?)	
	Has the BF support been benefitting the EU image in the country/region?	

	SUB-QUESTION	PUNO Abuja - 02 Feb
EFFECTIVENESS	Did the implementation strategy prove appropriate/ effective? How much so?	Yes. This project could be seen a proof of concept; the agencies have been learning to work efficiently together after initial difficulties.
	Was the implementation methods for (your) respective activities appropriate?	yes, as aligned with Govt 9MTI) and Industry associations strategies.
	Is the expected outcome (likely to be) achieved?	NA
	Could the same outcome be achieved in a better way?	NA
	Are the respective outputs (1-6) achieved?	O4 Yes, target 170 MSME will be reached, additional equipment will be delivered in 2022
	How would you rate the fairness of the distribution of effects? were effect equally felt across different groups?	NA
	Has the intervention created any unintended positive or negative effects?	NA
	Were the negative effects considered for possible (risk) mitigation?	
EFFICIENCY	Are the inputs/ resources provided by the various stakeholders adequate for achieving the planned results?	NA
	Have the disease commodity packages been delivered timely?	NA
	Is spending in line with the timeline and budget?	slow spending in2021, (CB and TA inputs), in 2022 investment support to MSME will completely utilize the budget
	Has the intervention encountered delays and was the planning revised accordingly?	late start of activities (2021) because of selection process for MSME
IMPACT	What building blocks have been placed by the BF for rapid recovery and resilience?	UNIDO project contribute to improving quality levels of PPE and sustaining MSMEs business and employement level. This could be seen as a pilot to be scaled up, since many more MSME are active in the health product sector.
	Were the needs of beneficiaries defined? Have they changed?	yes UNIDO caried out mapping of MSMEs
	Have the needs of the target groups been satisfied, and if so to what extent?	Project ahs helped the selected beneficiaries, small group of 170
	Has the BF contributed to better health or COVID-19 policies or new priorities?which ones?	NA
	How much would you say the BF has contributed to social & economic recovery?	By maintaining business and employement levels
	How much would you say the BF has contributed 'in terms of population resilience?	NA
EU VALUE	What specific benefits has the Government got from BF, as compared to separate interventions amounting to the same funding?	
	Would EU added-value aspects be possibly replicated in new projects (incremental portfolio?)	
	Has the BF support been benefitting the EU image in the country/region?	

ANNEX 9: DESCRIPTION OF UN CONTRIBUTION TO EPIDEMIOLOGY RESEARCH

As part of the comments to the implementation of Output 5, UNDP shared the following text:

The Epi Advisor contributed to several research products including for instance:

- "Nigeria's Public Health Response to the COVID-19 pandemic: January to May 2020" was accepted for publication by the Journal of Global Health.
- "Patient characteristics associated with COVID-19 positivity and fatality in Nigeria: a retrospective cohort study" (accepted for publication by the BMJ Open Journal)
- "Descriptive epidemiology of coronavirus disease in Nigeria: January to June 2020" published in Epidemiology & Infection Journal (See:
- https://www.cambridge.org/core/journals/epidemiology-and-infection/article/descriptive-epidemiology-of-coronavirus-disease-2019-in-nigeria-27-february6-june-2020/C6BC9459D1625C5894BE8BF2585AB098)
- "Nigeria's Public Health Response to the COVID-19 pandemic: January to May 2020" submitted to BMC Public Health

There were challenges on coordination of epi research. The Advisor worked closely with the Knowledge Management Team of NCDC to maintain a register of research on COVID-19 in Nigeria with plans of it being developed to an online open access inventory.
Working with the Research, Training and Knowledge Management Team of NCDC, there was a project to chronicle non-pharmaceutical interventions developed in response to COVID-19 in Nigeria

The PTF's modelling think-tank that bought together analysts from University College London, NIMR, NCDC, NBS, Flow Minder among others were largely responsible for the epi modelling – while UNDP participated in the technical meetings, the research agenda on the epi side were largely carried out by the team.

Weak data collection and lack of capacity in the States hindered research. And several of UNDP's support were from this angle – so as to enable further research. For instance, UNDP supported the development of a data dashboard containing up to date visuals of epi trends. In consultation with NCDC and its Surveillance team, analysis was provided at both national and state levels including on the geographical distribution of cases, testing, lab turnaround, as well as forecasting the potential trajectory of confirmed cases (although not from epi angle). All source codes were transferred to NCDC with the dashboard being used internally and by EOCs. In addition, UNDP also supported NCDC through provision of 2 IT Web Developers to support maintenance of the SORMAS surveillance platform and to carry out data management and analysis.

ANNEX 10: EVALUATION METHODOLOGY

The table below summarises the phases and outputs of the evaluation.

Phase	Output
Inception	Desk review: background analysis
	Stakeholder analysis
	Donor mapping
	Intervention logic
	Evaluation questions
	Evaluation matrix
	Presentation of inception report
Desk	In-depth document analysis
	Identification of information gaps and hypotheses to be tested in the field phase
	Design of the field phase
	Desk Note
Field	Initial meetings at country level with key stakeholders (Nigeria)
	Gathering of primary evidence with the use of the most appropriate techniques (Nigeria)
	Data collection and analysis (Nigeria)
	Presentation of preliminary findings
	Intermediary Note
Synthesis	Final analysis of findings
	Formulation of the overall assessment, conclusions and recommendations
	Submission of draft final report
Dissemination	Final presentation seminar

The EM used in this exercise is annexed as Annex 3.

The ET clarified that the following terminology is used:

Stakeholders are all the parties involved in the project either at state or local level;
Development partners is a wording used to mention international organizations, or international banks, or countries, cooperating with countries or regional blocks to achieve development objectives.

The ET encountered the following **difficulties**:

• The UNDP BF coordinator left the country for health reason, before the ET arrival, therefore she was not available to coordinate and guide the ET for stakeholders' meetings as well as the state visits.
• During the first week of the assignment many UN agencies staffs were not present in Abuja as they were involved in a UN retreat outside the capital.
• Visits to States were clearly too short in time
• The ET experiences several flights delays in reaching the states 4,6, up to 15 hours which perturbated the tentative schedule prepared to roll out of the field visits.
• Debriefing venue and date were shared at the last moment.

Mitigation measures have been represented by the flexibility and the commitment of the ET in implementing their tasks and the great support provided by UNDP in Abuja, and from the WHO, UNFPA and UNICEF at the State level, which allowed smooth development of the activities on the ground.

Research Ethics

Conforming to ethical considerations in research regulates the behaviour of participants and collaborators in the project, safeguarding the participants' rights and protecting them from harm (Henneck M., Hutter I. and Bailey A. (2011). Qualitative Research Methods.).

Adhering to the core principle of respect for human dignity, the evaluators will give prospective participants full information about the evaluation to enable them to make their personal judgment on consent to participate (TCPS, Canadian Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans, 2018).

Anonymity and confidentiality will be attained by not disclosing a participant's identity. The evaluators will safeguard information entrusted to them and not misuse or wrongfully disclose it to the detriment of the participants (TCPS, 2018).

Throughout the evaluation there will be transparent collaborative efforts to share and disseminate research findings among stakeholders, accommodating and respecting their inputs throughout the process.

ANNEX 11: EVALUATION DAC RANKINGS

	Very poor	Poor	Medium/Fair	Good	Very Good
The Criteria has been: (one or more of each situation)	- Absent or ineffectively addressed in design - Rated negatively by beneficiary (Gov't) - Rated negatively (with documented cases) by two or more different stakeholder groups - Flagged in ROM reports and not sufficiently addressesd	- Addressed with significant weakness(es) in design - Assessed as 'insufficient' or 'perfectible' by beneficiary - Rated negatively by a minority of stakeholder groups, or rated negatively without documented cases - Flagged in ROM reports and partly addressed	- Addressed 'at minima' in the design - Assessed as 'good overall' by the beneficiary, despite some weaknesses decreasing value - Rated positively by the key target groups (even if not majority of stakeholders) - Mixed reviews, opposing views on some sub-criteria	- Well covered in design only minor weaknesses - Assessed as 'adequate' or 'useful' by beneficiary - Rated positively by a majority of stakeholder groups, or rated positively without strong evidence/documented cases - Rated very positively by the key target groups (even if not a majority of stakeholders)	- Very well covered in design incl. SPICED indicators - Assessed as good or very good by a majority of stakeholders - Rated good or very good by key target groups with provision of documented success stories - Signalled as good in ROM reports