THE EUROPEAN UNION'S PROGRAMME FOR ECOWAS

FINAL EVALUATION OF THE EU SUPPORT TO THE REGIONAL CENTRE FOR DISEASE SURVEILLANCE AND CONTROL IN THE ECOWAS ZONE (ECOWAS-RCDSC)

Letter of Contract N°300028492

FINAL REPORT

Prepared by
Ranieri Guerra
Natalia Conestà

October 2022, 1st revision November 2022,
2nd revision January 2023

The project is financed by
the European Union

The project is implemented by IBF International Consulting
In collaboration with EuroPlus

“The contents of this publication are the sole responsibility of the
author and can in no way be taken to reflect the views of the European Union.”

// ACKNOWLEDGEMENTS

The evaluation team would like to thank the EU Delegation in Nigeria, and in particular the evaluation manager, for the support and guidance provided throughout the evaluation phases. We appreciate as well the EUDs of Ghana and Togo that received us during the field visit.

We would like also to express our appreciation for the collaboration received from the GIZ staff in Abuja, Ghana and Togo. Their frank and continuous support has been crucial for the collection of relevant information and documentation, as well as for conducting effective meetings with relevant stakeholders.

Their availability and openness contributed to the success of this assignment.

Table of Contents

Acknowledgements 3
Abbreviations and Acronyms 7
1 Background 9
2 Methodology 14
2.1 Desk phase 16
2.2 Field phase 19
2.3 Analysis Phase 19
3 Limitations 19
4 Findings and answers to evaluation questions 21
4.1 Evaluation question 1a 21
4.2 Evaluation question 2a 25
4.2.1 Result 1 25
4.2.2 Result 2 26
4.2.3 Result 3 27
4.2.4 Result 4 28
4.3 Evaluation question 2b 29
4.4 Evaluation question 3a 30
4.5 Evaluation Question 4a 31
4.6 Evaluation question 4b 32
4.7 Evaluation question 5a 33
4.8 Evaluation question 5b 35
4.9 Evaluation question 6a 38
4.10 Evaluation question 7a 39
4.11 Evaluation Question 8a 40
5 Conclusions and recommendations 42
5.1 Conclusions 42
5.1.1 Conclusion 1 (EQ 1a): Relevance 44
5.1.2 Conclusion 2 (EQ 2a, 2b): Effectiveness 45
5.1.3 Conclusion 3 (EQ 3a, 4a, 4b): Efficiency 47
5.1.4 Conclusion 4 (EQ 5a, 5b): Sustainability 48
5.1.5 Conclusion 5 (EQ 6a): Coherence 50
5.1.6 Conclusion 6 (EQ 7a) Visibility and EU added value 50
5.1.7 Conclusion 7 (EQ 8a) Perspective impact 50
5.2 Recommendations 51
5.2.1 To ECOWAS 51
5.2.2 To WAHO (and RCSDC) 51
5.2.3 To MS 52
5.2.4 To the EUD 52
5.2.5 To GIZ 53
5.2.6 To GIZ and the EUD 54
5.3 Lessons learnt 57

Figures and Tables

Figure 1 Programme details 9
Figure 2 Implementation partners 10
Figure 3 ECOWAS region main stakeholders relevant to the programme 11
Figure 4 Programme expected results 11
Figure 5 RCSDC structure 12
Figure 6 WAHO structure 12
Figure 7 JEE technical areas related to IHR core objectives 32
Figure 9 Spider diagram of DAC evaluation dimensions (bilateral programme) 43
Figure 8 Spider diagram of DAC evaluation dimensions (EU contribution) 43
Figure 10a RCSDC November 2019 45
Figure 10b March 2021 45
Figure 10c November 2021 46

Table 1 Programme budget 9
Table 2 Evaluation questions 15
Table 3 Logframe and matrix of indicators 18
Table 4 Result area 1 25
Table 5 Result area 2 26
Table 6 Result area 3 27
Table 7 Result area 4 28
Table 8 Budget allocation by result area 48

ANNEXES (PROVIDED AS A SEPARATE VOLUME)

Annex 0. Terms of Reference
Annex 1. CVs of evaluators
Annex 2. Evaluation methodology
Annex 3. Evaluation matrix. Detailed Answer to the Evaluation Questions
Annex 4. Intervention logic/logical framework matrices
Annex 5. ECOWAS geographic map
Annex 6. List of persons/organizations consulted
Annex 7. Detailed activities implemented, and results achieved in each focus country
Annex 8 Quantitative information available and captured by the EVAL Team
Annex 9 Regional initiatives and networks
Annex 10 References
Annex 11 Stakeholders' questionnaire

Abbreviations and Acronyms

ACDC	Africa Centres for Disease Control and Prevention
AfDB	African Development Bank
ANSS	Agence de Sécurité Sanitaire NCI of Guinée
AMP	Agence de Médecine Préventive
BMZ	German Federal Ministry for Economic Cooperation and Development
CBS	Community Based Surveillance
CDC	Centre for Disease Control
CORDS	Connecting Organisations for Regional Disease Surveillance
COVID-19	Coronavirus Disease 2019
DAC	Development Assistance Committee
DHIS2	District Health Information Software 2
DoA	Description of the Action
EC	European Commission
ECOWAS	Economic Community of West African States
EOC	Emergency Operations Centre
ERC	Emergency Risk Communication
EU	European Union
EVD	Ebola Virus Disease
GFA	GFA Consulting Group
GHPC	German Health Practice Collection
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
ICT	Information and Communication Technology
IEC	Information, Education, Communication
IPC	Infection prevention and control
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IPC	Infection prevention and control
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IICC	Interinstitutional Communication and Coordination
IRSP	Institut Régional de Santé Publique
JEE	Joint External Evaluation
KfW	German Development Bank
LGA	Local Government Area
MS	Member State
NCI	National Coordinating Institution
NIHP	National Institute for Health Protection (UK)
NPHIL	National Public Health Institute of Liberia
NRRT	National Rapid Response Team
OECD	Organisation for Economic Co-operation and Development
PAGoDA	Pillar Assessed Grant or Delegation Agreement
PHEIC	Public Health Emergencies of International Concern
RAHC	Regional Animal Health Centre
RC	Risk Communication
RCSDC	Regional Center for Surveillance and Disease Control
REDISSE	Regional Disease Surveillance Systems Enhancement Programme

RIPOST	Network of public health institutions of West Africa
RKI	Robert Koch Institute
RPPP	Regional Programme Support to Pandemic Prevention in the ECOWAS Region
RRT	Rapid Response Team
RRRT	Regional Rapid Response Team
SC	Steering Committee
SDG	Sustainable Development Goal
SEEG	Rapid Deployment Expert Group to Combat Health Threats
SOP	Standard Operating Procedure
SORMAS	Surveillance Outbreak Response Management and Analysis System
ToC	Theory of Change
TC	Technical cooperation
ToR	Terms of Reference
USAID	United States Agency for International Development
USCDC	United States Center for Disease Control
WAHO	West African Health Organisation
WB	World Bank

1 BACKGROUND

This is the final evaluation of the programme "Support to the Regional Centre for Disease Surveillance and Control (RCSDC) in the ECOWAS Zone" (Fig. 1), TORs in Annex 0. The programme was implemented under the "Regional Programme Support to Pandemic Prevention in the ECOWAS Region (RPPP)". The RPPP was commissioned by the German Federal Ministry for Economic Cooperation and Development (BMZ) and co-financed by the European Union (EU) through the RCSDC component. The aim of the programme was to assist the ECOWAS Commission, the West African Health Organisation (WAHO) and the Regional Centre for Surveillance and Disease Control (RCSDC) in supporting ECOWAS Member States to improve the implementation of the International Health Regulations (IHR). This included support to the National Coordinating Institutions (NCIs) of the Member States connected to the RCSDC.

Title of the Intervention to be evaluated	• EU Support to the Regional Centre for Disease Surveillance and Control in the ECOWAS Zone (ECOWAS-RCDSC)
Budget of the Intervention to be evaluated	• 8,050,000EUR • EDF
CRIS and/or OPSYS number of the Intervention to be evaluated	• FED/2018/399-751
Dates of the Intervention to be evaluated	• Start: 01/01/2019 • End: 30/08/2021

Figure 1 Programme details

The programme officially started on 1st January 2019 and its total cost was initially estimated at EUR 4,741,000. The EU contributed an initial co-financing amount of EUR 4,000,000 with a further EUR 4,000,000 to address COVID-19-specific actions in the ECOWAS zone[1]. The overall EU budget amounted to EUR 9,000,000 and was further integrated with an additional BMZ contribution of EUR 135,000.

Objective: Support to the recommendations and the implementation of the IHR in the Member States of the ECOWAS region	Initial budget	Addendum No. 2	Final Budget
Procurement of services (direct management)	400 000		**400 000**
Indirect management with the GIZ (Overall objective)	4 050 000	4 000 000	**8 050 000**
Evaluation, Audit	150 000		**150 000**
Communication and visibility	50 000		**50 000**
Contingency provisions	350 000		**350 000**
Total	**5 000 000**	**4 000 000**	**9 000 000**

Table 1 Programme budget

The programme's overall objective was to improve the functioning of country-specific surveillance and response networks by supporting National Coordination Institutions, aligning with WAHO-OOAS and AU-CDC priorities for the full implementation of International Health Regulations (IHR) in the region.

[1] *In line with the Financing Agreement No. MZ/FED/040-214, the response by the EU to the effects of the COVID-19 crisis calls for an adaptation of existing EU programmes.*

The programme rationale lay in the need to improve the preparedness and response of the regional and national entities in the ECOWAS area to outbreaks of emerging and/or re-emerging diseases. The Ebola crisis and the COVID-19 pandemic as well as ongoing disease outbreaks in Western Africa have highlighted several areas for improvement at the regional and national levels:

- The overall low level of preparedness to predict and respond to outbreaks and epidemics, particularly the limited surveillance, outbreak management, and adequate laboratory capacities.
- The inadequate communication on health risks.
- The erratic coordination and communication between the institutions and between the various levels, resulting in poor coordination and synergy among partners.

As a result, the regional and national institutions' competence to comply with the IHR core capacities was limited and needed support for improvement.

A combination of poor advisory skills, strategies, procedures, and tools was recognized as a crucial constraint to provide effective risk communication at regional and MS levels, granting rapid, comprehensive, culturally appropriate and gender-sensitive information to the population and the experts and officials. Constraints on health risks communication, infection preventive means and protocols to treat diseases, were identified as well in the collaboration with media and other stakeholders. Mechanisms and arrangements for inter-institutional coordination and communication (IICC) at the regional and national level, including development partners, were unclear. Regular simulation exercises (SimEx), on how to plan and prepare for appropriate communication in disease outbreaks or disasters, especially in cross-border settings, are not yet adequately conducted.

The intervention logic was therefore the improved communication of health risks (programme result 1) based on real-time surveillance and outbreak management (programme result 4) in a strengthened organisational architecture, equipped with sufficient quality staff (programme result 3) and improved inter- and intra-institutional communication (programme result 2) improving the functioning of the regional surveillance and response network (overall objective).

The programme-specific objective was to improve advice from the ECOWAS Commission, by specialized institutions and agencies, to ECOWAS MS, on setting up selected disease control mechanisms in line with the International Health Regulations (IHR). Several implementation partners were foreseen by the programme (Fig. 2): in particular, WAHO and the RCSDC were identified as

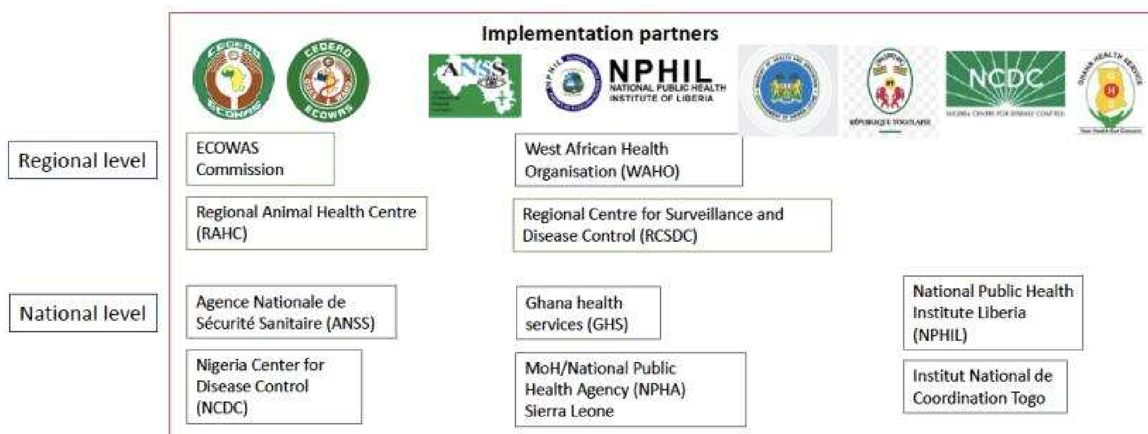


Figure 2 Implementation partners

the key players for programme implementation (RCSDC being a primary target to be strengthened and equipped with necessary skills to assist at national level)[2]. Six selected national entities from the

[2] The Commission of the Economic Community of West African States (ECOWAS) and the West African Health Organisation (WAHO) are mandated to assist MS in controlling epidemics. The WAHO's mandate is to promote integration by the harmonisation of MS policies, pooling of resources, and cooperation with one another and with others for a collective and strategic response to the health problems of the ECOWAS Space. In close collaboration with WHO, WAHO supports MS on the implementation of the IHR. WAHO is located in Bobo Dioulasso, Burkina Faso, and is divided into 5 directorates: a) Internal Services, b) Planning, Research and Health Information, c) Disease and Epidemic Control and d) Health Care Services, d) more recently, the RCSDC located in Abuja, Nigeria.

focus countries (Nigeria, Ghana, Sierra Leone, Liberia, Togo, Guinea) were the main beneficiaries and direct players at the national and sub-national levels, benefitting from a regional level of qualified support.

Programme governance was supported by a steering committee composed of the EUD, the ECOWAS Commission, WAHO, RCSDC, NCIs, IHR focal points at the Member States and GIZ.

The programme had four focus countries, Sierra Leone, Liberia, Guinea (the three countries mainly affected by the West African Ebola outbreak of 2014-16), and Togo. Two other countries, Nigeria and Ghana, were targeted for Result 4, surveillance through SORMAS tool implementation and scaling up.

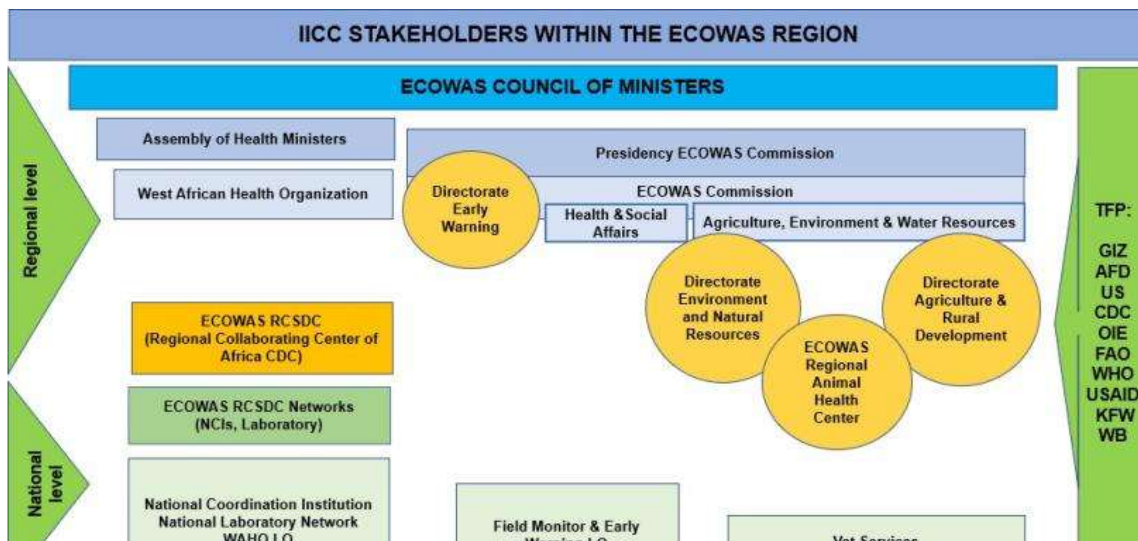


Figure 3 ECOWAS region main stakeholders relevant to the programme

The programme expected results in the focus countries are shown in the Figure 4.

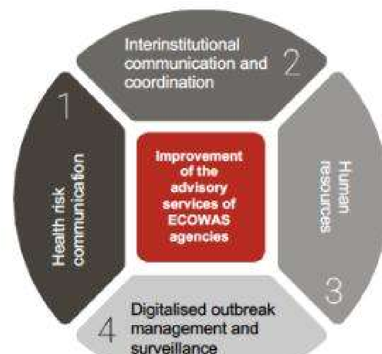


Figure 4 Programme expected results

a. *RESULT 1*: Improved risk communication in the ECOWAS region on health risks due to infectious diseases, considering Gender and One Health aspects, based on the stakeholders' map below (Fig. 3).
b. *RESULT 2*: Improved communication and coordination between ECOWAS specialized institutions, agencies and National Coordinating Institutions according to defined regulations, linking all the levels.
c. *RESULT 3*: Strengthened human resources in epidemic control of the ECOWAS Commission, WAHO, RCSDC and NCIs.
d. *RESULT 4:* Strengthened digitalized surveillance and outbreak management system in Nigeria and Ghana, by extending the Surveillance Outbreak Response Management and Analysis System (SORMAS) coverage in Nigeria and Ghana.
e. *COVID-19*: Specific Objective for such additional support was to prevent the spread of and control the COVID-19 outbreak in the ECOWAS zone by improving the quality and availability of critical illness care in the ECOWAS MS[3].

[3] *The full and regular programme implementation was influenced significantly by the COVID-19 pandemic. MS had to reconsider their priorities for action due to compulsory containment and mitigation provisions (such as closures and border control). Partners at the regional and national levels had to realign. International staff in the programme were repatriated and all the office sites had to comply with*

The RCSDC (Fig. 5) is one of the five collaborating centres of the African Centre for Disease Control (ACDC), whose tasks are to build and operate surveillance and disease control systems, information and laboratory networks, to provide support to MS in the preparedness and response to public health emergencies and to conduct public health research. RCSDC is mandated to:

- support ECOWAS MS to build capacities to effectively conduct disease surveillance, prepare, respond, and communicate risks for public health events,
- address complex health challenges in a coordinated manner, to empower the MS to achieve the ECOWAS set objective of keeping the people of Western Africa healthy; and
- act only in cooperation with the relevant competent authority and upon request from Member States to carry out its mission, working under WAHO's close supervision (Fig. 6).

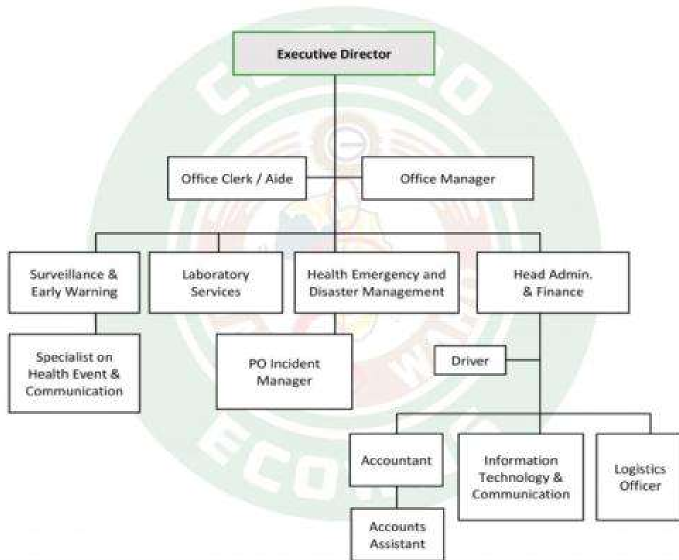


Figure 5 RCSDC structure

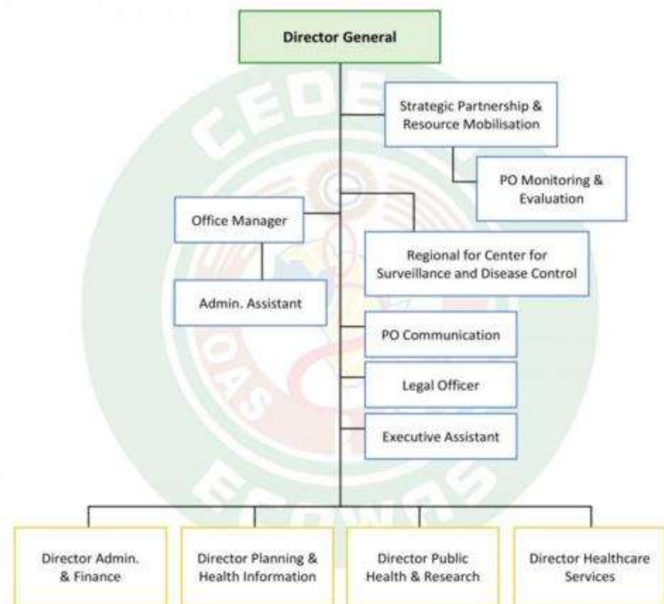


Figure 6 WAHO structure

The National Coordinating Institutes (NCIs) have been established in all fifteen ECOWAS MS where they support disease surveillance, early warning, and rapid response interventions, and oversee laboratory networks.

Each of the four result areas was disaggregated into specific activities and each activity attributed to either the bilateral component or to the EU support to facilitate attribution and to prevent overlapping or duplication of expenses and investments.

Activities for Result 1 (Improved communication in the ECOWAS region on health risks) funded by the EU contribution were:

lockdowns. Regularly planned operations were suspended, while the programme supported ECOWAS and MS with the requested emergency measures. These measures were funded with additional financial resources mobilized by the EU and the German government into the ECOWAS/WAHO COVID-19 emergency fund, including the procurement of urgently needed equipment and materials for all the MS.

At the end of 2020 containment and mitigation measures started to be relaxed and the regional and national institutions are now practically back to regular operations, despite the recent increase in the number of COVID-19 cases in some MS, in line with the global epidemiology of variants and related severity decrease. This has contributed to the gradual termination of COVID-19 emergency measures with the programme returning to the implementation of regular activities, however leaving substantial funds provided by the EU unspent and ready for reallocation.

The additional funds were used within the programme framework and the areas of action agreed with the partner while also responding to immediate needs. Parts of the additional funds were used to procure protection material, clinical equipment, and other urgently needed equipment for the fifteen ECOWAS MS. The distribution was carried out by WAHO.

a. *Develop SOPs in alignment with the regional strategy for coordination of risk communication between countries in emergency situations and approaches for SOPs involving different sectors and disciplines[4].*
b. *Support the development and/or improvement of national risk communication plans[5].*
c. *Conduct operational research on gender-sensitive risk communication[6].*

Activities for Result 2 (Improved communication and coordination between ECOWAS institutions, agencies, and NCIs according to defined regulations) supported by the EU contribution were:

a. *Implement the regional strategy on Inter-Institutional Communication and Coordination (IICC)[7].*
b. *Conduct simulation exercises[8].*
c. *Strengthen the capacity of NCIs[9].*
d. *Support organizational development at WAHO/RCSDC[10].*

Activities for Result 3 (Strengthened human resources in epidemic control of the ECOWAS Commission, WAHO, RCSDC and NCIs) funded by the EU contribution were:

e. *Strengthen the capacity of national rapid response teams (NRRTs)[11].*
a. *Conduct training on pandemic preparedness and response incl. One Health in collaboration with AMP (STOPPED with addendum 1 and funds reallocated to support the Emergency Operations Centers (EOCs) in the four focus member states).*
b. *Improve community surveillance[12].*

Activities for Result 4 (Strengthened digitalized surveillance and outbreak management system in Nigeria and Ghana.) supported by the EU contribution were:

a. *Harmonize and coordinate multiple stakeholder support for the implementation of SORMAS[13].*

---

[4] In order to translate the regional risk communication strategy into action for an improved coordination of risk communication between countries in emergency situations involving multiple countries and involving different sectors. Adequate involvement of relevant actors was aimed at with use of existing structures for the communication on health risks in the region to provide guidance for action.
[5] In Sierra Leone, Guinea, Liberia, and Togo support was provided to either develop national risk communication plans or adapt existing plans to the regional gender-sensitive risk communication strategy that also considers One Health aspects. This activity aimed to align risk communication efforts between the regional level and national level in the four countries.
[6] The operational research was used as an improvement-oriented investigation into gender-sensitive risk communication. Key topics investigated were: a) Access to information by women and men. b) Communication needs of women and men (such as type of information, key messages, channels used). The results of the operational research were presented in a conference and published on WAHO's website, as foreseen by the programme.
[7] In complementarity to activity R 2.1 (RPPP) the action supported and technically accompanied the implementation of the IICC strategy. This included support to the establishment of mechanisms of coordination and communication between institutions such as mechanisms for communication or coordination related to cross border activities or to the One Health approach.
[8] Simulation exercises described under R2.3 RPPP were extended considering cross border activities (ie: the SimEx was jointly conducted with the MoH in the respective MS, WHO, WAHO and RCSDC).
[9] WAHO and CORDS (https://www.cordsnetwork.org/wp-content/uploads/2014/05/News-CORDS-WAHO-MoU-BS-250216.pdf) undertook an evaluation of the NCIs in the ECOWAS Member States which revealed certain gaps that the programme was expected to address in the 4 focus countries, i.e. Liberia, Sierra Leone, Guinea and Togo. These included, among others, regulatory aspects such as revision of legal texts to assert the responsibilities of the NCIs in relation to the ECOWAS regulations. Likewise, most Emergency Operations Centre (EOC), attached to each NCI needed support in terms of making available SOPs, procedures, and preparedness plan for their full operationalization. The following activities were to be implemented: a) Technical support to four NCIs on regulatory aspects or in other gap areas as per evaluation report; b) Technical support to the development of revision of preparedness plans of the four NCIs; c) Assessment of the EOCs in the four focus countries; d) Technical support to the establishment or strengthening of the EOCs in the four countries aimed at ensuring their functionality.
[10] As outlined, RCSDC is now the 5th directorate of WAHO. The programme had to accompany the organizational reform process and provide technical support based on identified needs. This included, for example, the provision of technical support to regulatory aspects of RCSDC or the development of a 'procedures manual'.
[11] Similar to the RPPP activity on RRRT strengthening, the organizational and individual capacity of the NCIs in the focus countries was enhanced to contribute effectively to epidemic control. An assessment of the four NRRTs was carried out to inform activities. SEEG was also consulted.
[12] As part of the RIPOST project, AMP implemented a component on community surveillance. The programme sought close collaboration with AMP on this topic and planned to expand their approach to the two Anglophone focus countries and possibly one Francophone country (Togo). Activities included, among others: a) Undertook a situational analysis of the CBS system in the mentioned countries; b) Implemented a knowledge, attitude, practice survey of key informants, managers, and targeted populations; c) Conducted qualitative surveys to collect qualitative data on community surveillance, alert, and response behaviors; d) Implemented trainings on CBS; e) Supported the development of the training already planned. The research and training materials developed by AMP were to be translated into English. Trainings described under R 3.2 RPPP were extended also including the 4th focus country, Togo.
[13] SORMAS Core funders are the German Federal Ministry of Education and Research and BMZ through the GIZ RPPP project, the Nigerian CDC, WHO and others. Core implementing partners of HZI are the Nigerian CDC and AFENET. It was used in 155 Nigeria local government areas out of 774 (LGAs).

b. Roll out SORMAS in additional LGAs in Nigeria[14].
c. Pilot SORMAS in selected districts in Ghana[15].
d. Conduct operational research[16].

COVID-19 related activities

a. Support the 15 ECOWAS Member States with materials and equipment for the Intensive Care Unit facilities and with PPEs (personal protective equipment) for healthcare practitioners to improve the intensive care of COVID-19 patients and reduce hospital-acquired infections.
b. Organize regional online training of trainers on the transport and management of Severe Acute Respiratory Infection.
c. Support the organization of training of doctors and nurses working in the Intensive Care Units on the management of Severe Acute Respiratory Infection and of doctors and nurses working in the transport of critically ill patients.
d. Rolling out of SORMAS in additional Nigeria LGAs and districts in Ghana.
e. Training on risk communication of the National Rapid Response Teams (NRRTs) for COVID-19 and training of health personnel to identify and treat COVID-19 in 5 ECOWAS MS (Nigeria, Togo, Liberia, Sierra Leone, and Guinea).
f. Support to COVID-19 emergency plans in the 5 focus MS via grant agreements with the local WHO offices (150,000 EUR per country, BMZ-funded).

2 METHODOLOGY

The evaluation has been aiming at estimating the relationship between inputs, activities, outputs, outcomes and impacts as its main objective was to provide evidence of results and challenges for the EU-funded component, to EUDs to Guinea, Sierra Leone, Liberia, Togo, Ghana and Nigeria, RCSDC management team and senior officials, ECOWAS and its Member States and main entities, primarily WAHO (managing the RCSDC and the Regional Animal Health Centre – RAHC - the second specialized agency allowing for a full One Health approach), and NCIs. The evaluation covers the entire period of the programme (from 01/01/2019 to 30/08/2021[17]), builds on the reports elaborated by the implementing partners (GIZ, WHO), and aims at providing an independent assessment of the RCSDC programme. Programme results were measured against its expected objectives, lessons learnt, relevant conclusions and recommendations, useful to orient future actions. Due consideration was also given to the peculiarity of the action embedded in the RPPP platform in the modality of a delegation agreement (Financing Agreement No.MZ/FED/040-214, signed on 27.02.2018) eventually readjusted, to contribute to mitigating the COVID-19 pandemic impact on societies and institutions, with three addenda (27.08.2018; 22.06.2020; 01.03.2022).

The Evaluation Report is based on the standard DAC evaluation criteria, namely: relevance, coherence, effectiveness, efficiency, sustainability, and perspectives of impact. In addition, it estimates the EU added value, considering whether gender, environment and climate change were mainstreamed during the programme implementation; whether the relevant SDGs and their interlinkages were identified and whether the principle of Leave No-One Behind and a rights-based approach were followed during the programme implementation, its governance and monitoring.

[14] Coverage was extended to additional 29 Nigeria LGAs.
[15] The programme piloted SORMAS in 10 out of 216 districts in Ghana. Implementation was through the Ghana Community Network Services Ltd (GCNet) with an innovative Public Private Partnership. The PPP was eventually stopped, and the Government of Ghana took over the SORMAS management.
[16] SORMAS implementation was strengthened through operational research (OR). Topics were identified based on the experience gained during implementation. The research findings were shared in the NCI network and presented in international conferences like the Paris Peace Forum in 2020.
[17] The programme was initially commissioned for a period of 2.5 years (January 2019 – June 2021) but due to implementation delays related to the COVID-19 pandemic, it was extended by two months until August 2021, via a Pillar Assessed Grant or Delegation Agreement (PAGoDA).

The evaluation methodology is fully described in Annex 2. Data and information from the Desk Review and those collected during the Field Phase (through focus group discussions, key informant interviews and questionnaires submitted to key stakeholders and beneficiaries) were used to elaborate a scoring system detailed in Annex 3. Concrete recommendations, possibly contributing to driving future interventions were drawn on the evidence generated with the limitations described below.

The process to retrieve and collect information was organized and documents were listed, identified, and analyzed, i.e. reports, minutes of meetings and reports received from GIZ project team at the regional level, from countries' teams, from EUDs, from Donors, and the RCSDC staff. Additional documents were retrieved and downloaded from relevant websites (WAHO, ECOWAS, individual MS' MoH and governmental portals, as well as World Bank, WHO, UNICEF, OCHA, and others as quoted in Annex 8 and Annex 10). The information gained was organized and analyzed following the MATRIX of evaluation questions (Annex 3). The table with evaluation questions is reported below.

RELEVANCE	
Evaluation Question 1a (from ToR)	To what extent did the intervention respond to the evolving needs in the context of the Covid-19 pandemic, and could a continuation of this intervention meet current and expected needs of the ECOWAS region in international health regulations?
EFFECTIVENESS	
Evaluation Question 2a (from ToR)	How well were results achieved according to what was expected from the intervention in its Logical framework Matrix?
Evaluation Question 2b (proposed by ET)	How coordination among countries' institutions and management capacity have adapted to changing conditions?
EFFICIENCY	
Evaluation Question 3a (from ToR)	To what extent were the implementing modalities of the intervention appropriate to the institutional set-up of ECOWAS agencies and Member States?
Evaluation Question 4a (from ToR)	What are the lessons learned from ECOWAS-RCDSC intervention that could improve the monitoring and reporting of other (future) regional projects funded by EU?
Evaluation Question 4b (proposed by ET)	To what extent were the monitoring processes and resources sufficient for planning and achievement of results?
SUSTAINABILITY	
Evaluation Question 5a (from ToR)	How could the commitment, ownership and coordination observed amongst key project stakeholders during the intervention be further strengthened?
Evaluation Question 5b (proposed by ET)	Were activities undertaken to ensure the sustainability of the programme run satisfactorily?
COHERENCE	
Evaluation Question 6a (from ToR)	How could a stronger coordination and complementarity of actions be envisaged in follow-up interventions of EU to support the RCDSC, WAHO and ECOWAS Member States?
EU ADDED VALUE	
Evaluation Question 7a (from TOR)	To what extent did the funds mobilised by EU added (financial and non-financial) benefits to what would have resulted from GIZ/BMZ alone?
PERSPECTIVE IMPACT	
Evaluation Question 8a (from ToR)	To what extent is a contribution of the intervention already perceivable in mitigating the impact of COVID and Ebola outbreak in Guinea?

Table 2 Evaluation questions

2.1 Desk phase

During the desk phase, secondary data were retrieved and analyzed by the EVAL team. The main objectives of this Phase were:

- To retrieve, review, classify and analyse a comprehensive set of relevant documents, reports, reviews, guidelines, SOPs to achieve a full understanding of the programme activities and possible results that were fully documented to draw robust conclusions validated and supported by documental evidence.
- To identify key informants and retrieve their contacts to plan for interviews and focus group discussions based on an agreed format during the Field Phase in different countries. (The collaboration of the Reference Group's members was crucial to contact the main stakeholders.)
- To agree on a standard format for in-country field visits, interviews, and virtual communication.
- To prepare and assemble the evaluation tools.

An Evaluation Matrix and Tools for semi-structured interviews (Key Informant Guide) and FGDs were prepared. The Evaluation Matrix was containing evaluation questions marked with **"a",** those presented in the ToRs and questions marked with **"b",** those proposed by the Evaluation Team. All of them were validated by the Reference Group.

A qualitative mini-survey, through close-end questions (Annex 11), was planned for those stakeholders most difficult to reach or for those countries that wouldn't be visited.

As a point of reference, the EVAL team includes hereby the reviewed Logframe and matrix of indicators showing the programme achievements.[18]

	Intervention logic	Indicators	Baseline (incl. reference year)	Targets (incl. reference year)	Status Sept 2021 (End of the Action)	Sources and means of verification
Overall objective: Impact	The functioning of country specific surveillance and response networks has improved by supporting NCIs, aligning with WAHO-OOAS and AU/ACDC priorities for the implementation of International Health Regulations in the region	Increased level of support by WAHO to the ECOWAS member States in epidemic control, which corresponds to international quality standards according to the international health regulations	75% (2018)	100% (2021)	Current value: 100% (9 out of 9 requests for positively answered since 10/2020; 95% was achieved in the period 10/2019 – 09/2020 based on 35 out of 37 positively answered requests)	Requests for support from Member States, out-break reports, WAHO documentation including COVID-19 support
Specific objective(s): Outcome(s)	Advice provided by the ECOWAS Commission with specialised institutions and agencies to ECOWAS Member States on setting up selected disease control mechanisms in keeping with the International Health Regulations (IHR) has improved	1. Percentage of health risks that are communicated by the ECOWAS Commission, WAHO and specialised agencies analogous to the risk communication strategy and taking into account gender and One Health aspects	0% (2018)	100% (2021)	Current value: 94.5%	Risk Communication Strategy, SOPs, communication protocols or reports, of the ECOWAS Commission, WAHO, RCSDC and others
		2.Number of revised mechanisms for communication and coordination between regional and national level and between NCIs	0 revised mechanism through simulation exercises and/or crisis	3/ Action 1 revised mechanisms through simulations exercises and/or crisis (2021)	Current value: 3/3 revised mechanisms (IICC SOP, RC SOP and ECOsuite) *Preparedness and Response Portal*)	Evaluation reports on simulation exercises, review of revisions based on standard procedures and a comparison of communication and coordination mechanisms and plans, all prepared by WAHO/RCSDC and RPPP
		3. Percentage of support missions of the Regional Rapid Response Team (RRRT) for prevention and control of epidemics	0% of requests filed to WAHO/ RRRT (2018)	75% of requests filed to WAHO/ RRRT (2021)	Current value: 100% (based on one RRRT mission conducted upon request)	Comparison of requests filed to WAHO/RRRT and mission reports by RRRT
		4. Number of LGAs and districts reporting regularly through SORMAS to NCIs in Nigeria and Ghana	155 out of 774 LGAs in Nigeria (2018) 0% of districts in Ghana (2018)	272 out of 774 LGAs in Nigeria (184 out of 774 LGAs in Nigeria (2021) (Action)) + 34 out of 744 in Nigeria (COVID-19) 34 out of 216 districts in Ghana (2021) ,10 out of 216 districts (Action) 43 out of 216 in Ghana (COVID-19)	Current value: 272 LGAs in Nigeria (83 LGAs through regular funds and 34 LGAs through COVID19 emergency funds) and 77 districts in Ghana (34 districts through regular funds and 43 districts through COVID19 emergency funds)	SORMAS reports
Results	Result 1: Improved gender-sensitive	1.1 Availability of a gender-sensitive	0 (2018)	1 (2021)	Current value: 1	WAHO's risk communication

[18]*From: Action: Support to the Regional Centre for Surveillance and Disease Control (RCSDC) in the ECOWAS Zone - Technical Report of Activities carried out from 1 January 2020 – 31 August 2021, December 2021.*

	2.3 Number of successfully supported organisational development processes in WAHO/RCSDC	0 (2018)	2 (2021) (Action)	Current value: 0 (The organizational development review was concluded in August 2021, but the organizational development processes could not be implemented due to time constraints)	Reports, developed technical documents
Result 3: Strengthened human resources in epidemic control of the ECOWAS Commission, WAHO, RCSDC and NCIs	3.1 Number of functional RRRT out of which experts can be deployed on short notice	0 (2018)	1 (2021)	Current value: 1 (RRRT procedures manual developed and expert database established)	Procedures manual, expert database
	3.2Number of staff in the ECOWAS Commission, WAHO, RCSDC and NCIs who have been qualified through ICT-based training in pandemic preparedness and response	0 (2018)	220 (2021) 120 (RPPP) 100 (Action)	Current value: 235 (Online ERC+IICC: 95 Face-to-face ERC+IICC: 95 Simex: 39 One Health: 6)	Training reports, lists of participants;
	3.3 Number of health workers trained by trained trainers on risk communication, SimEx and IICC in 4 ECOWAS member states	0 (2018)	340 (2021) 300 (RPPP) 40 (Action)	Current value: 466 (Online ERC: 98 Face-to-face ERC: 98 Online IICC: 88 Face-to-face IICC: 88 One Health: 94)	Training reports, list of participants;
	3.4 Number of functional NRRTs out of which experts can be deployed at short notice	0 (2018)	4 (2021) (Action)	Current value: 4 (Togo: NRRT available, database available, SOPs available Sierra Leone: NRRT available, SOPs available Liberia: NRRT available, SOPs under elaboration Guinea: NRRT available, SOPs under elaboration)	Procedures manual, expert database
Result 4: Strengthened digitalized surveillance and outbreak management system in Nigeria and Ghana	4.1 Percentage of cases of epidemic-prone diseases integrated in the SORMAS tool are reported by participating LGAs and districts through digital notifications via SORMAS	25% (2018) of LGAs in Nigeria 0% (2018) of cases in involved districts in Ghana (SORMAS not yet implemented in Ghana)	70% of LGAs in Nigeria (2021) 50% of districts in Ghana (Action)	Current value: 88.8% in Nigeria and 73.85% in Ghana	SORMAS reports
	4.2 Number of study reports on the operational research which are shared and discussed within the NCI network	0 (2018)	2 study reports (2021) (Action)	Current value: 2 (2 operational research concluded and reports shared with NCI network in August 2021)	Study report/research paper

Table 3 Logframe and matrix of indicators

2.2 Field phase

The three countries proposed by the EVAL team, for the field visit, were Nigeria, Ghana and Guinea, because of the Ebola component. Finally, Guinea was replaced with Togo since the BMZ evaluation team had just visited Guinea, Togo and Guinea, in fact were the two French-speaking countries among the programme focus countries. Furthermore, Togo belongs to the group of low-income countries while Nigeria is a middle-income country, and Ghana is a lower-middle-income country. Therefore, it was considered that the three proposed countries were representing the MS in ECOWAS. Nigeria was where the Regional Centre for Diseases Surveillance and Control (RCSDC) is located, and the main beneficiary/partner of the programme. Togo and Ghana were respectively representing French and English-speaking countries of ECOWAS.
The Field Phase made extensive use of virtual meetings and digital tools, as for the kick-off meeting, and to contact teams in countries that could not be visited, such as Sierra Leone, Liberia, and Guinea.
The Team leader travelled to Nigeria while the Public Health Expert travelled to Togo and Ghana where physical meetings and interviews were conducted with key stakeholders, namely key informants from line Ministries, GIZ, RCSDC, ECOWAS Commission, WAHO, IHR focal points in the MS, EU delegations, BMZ and other relevant donors.

2.3 Analysis Phase

The analysis was carried out with the following methods:[19]

Quantitative Analysis
Secondary data collected through document analysis were presented both in numbers and in various graphic forms, in the main report and in Annex 8.
Qualitative Analysis
Qualitative questions answered during key informant interviews and focus group discussions provided depth to the validation exercise and provided an opportunity for triangulation with secondary quantitative data. The analysis was done with an inductive approach, moving from the specific to the more general aspects.

3 LIMITATIONS

Limitations and Mitigation Strategies (MS) are described below:

Limitations and Mitigation Strategies
a) Lack of commitment of key stakeholders.
MS. The Team got key stakeholders' commitment reconfirmed during the Desk Phase.
b) The timely availability of all needed consultations with the Evaluation Team might not be guaranteed, so gaps risk emerging in the information available for the assessment of the Programme.
MS. The Nigeria EUD and the Reference Group were informed about the work plan for the Field Phase. Consequently, it was be possible to plan interviews and focus groups through an early engagement with stakeholders (ideally during the Desk Phase).

[19] Details are discussed in Annexes 2 and 3.

c) Some information appeared less relevant for improving concretely the future activities of stakeholders and their planning of future support initiatives.
MS. To increase the relevance of the evaluation work, the Evaluation Team maintained continuous communication with EUD, GIZ and other relevant partners (i.e. ECOWAS-RCDSC). Flexibility was maintained in the planning of activities and in the design of reports so to be able to accommodate emerging needs and demands.
d) The multi countries and multi-languages nature of the Programme require consultations that do not entirely happen due to time limitations.
MS. A complete list of stakeholders to be involved in the evaluation was prepared ahead (during the desk phase) to provide ample time for coordination of interviews and consultation. In this regard, the collaboration of Nigeria EUD and the implementer (GIZ) was crucial.
e) Some stakeholders and beneficiaries may not be aware of the EU Programme (lack of visibility).
MS. The dissemination phase has been taking into account key stakeholders and beneficiaries that appeared not to be aware of the Programme.
f) Difficulties to ensure stakeholders' participation in the evaluation through remote interviews and surveys.
MS. The Evaluation Team has been making efforts in advance to identify and secure stakeholders' participation. The inception meeting as well as the desk review created opportunities for stakeholder identification and mobilization.
g) Lack of sufficient response to the questionnaire.
MS. The ET has been making a specific preliminary effort during the Desk Phase, at first, to contact Key Informants through formal channels. Once delivered the questionnaires, the ET made an appropriate follow up through formal channels but also directly.
h) Possible risks of harming through lack of confidentiality.
MS. There has been a very low risk in this regard. However, the ET ensured a further minimization of this risk through informed consent and special attention to possible contextual sensitivity.

The ET would like also to stress here that there was no risk of actual or potential conflict of interest affecting the team members.

4 Findings and Answers to Evaluation Questions

4.1 Evaluation question 1a

EQ1a: To what extent did the intervention respond to the evolving needs in the context of the Covid-19 pandemic, and could a continuation of this intervention meet current and expected needs of the ECOWAS region in international health regulations? (From ToRs)

The entire programme and several other ongoing projects (see Annex 9 for a review) aimed at strengthening the ECOWAS regional capacity by targeting the development of critical IHR core capacities still not fully implemented at the MS level. The rationale was to support the regional stewardship and coordination functions of the variety of MS, with different settings, systems and resources to move towards a uniform, standard, high-level degree of preparedness and response capacity.

At the COVID-19 pandemic's onset, the programme had already promoted several initiatives in the result areas foreseen by its logframe and had already moved into developing rapid response teams to set ready for mitigation activities. Preparedness had been addressed with a strong emphasis on risk communication. Simulation exercises had been conducted at the national and sub-national levels with trained staff and a major investment In competent human capital development, with several cadres trained in different aspects of epidemic preparedness and management[20]. The programme was flexible enough to respond also the needs highlighted by WAHO at the beginning of the outbreak, incorporating a new result area in its logframe[21].

When assessing data from the 125 WHO/JEE reports, the global average capacity score for risk communication was 52%, compared with 63% for real-time surveillance and 78% for immunization[22]. Despite the importance of this pillar, RCC is typically underfunded, understaffed and inappropriately staffed with community engagement roles and tasks often conflated with risk communications. Along with the lack of standardized RCC processes and integration into the larger emergency response infrastructure, these systemic challenges can lead to delays in interventions that can adversely affect a community's understanding and acceptance of public health emergency interventions. In this sense, the programme filled a clear and neglected area[23].

The following emergency measures were implemented in cooperation with WAHO at the regional level and by involving the WHO country offices of the relevant target MS, in order to achieve a fast mobilization of materials and skilled human resources on the ground:

- Support of the ECOWAS/WAHO emergency fund for the procurement and supply of personal protective equipment (PPE) and laboratory equipment for fifteen ECOWAS MS.
- Training on risk communication in five ECOWAS MS (Nigeria, Togo, Liberia, Sierra Leone and Guinea) including production/duplication of risk communication materials.
- Training of the National Rapid Response Teams (NRRTs) for COVID-19 in five ECOWAS MS (Nigeria, Togo, Liberia, Sierra Leone and Guinea).
- Training of health personnel to identify and treat COVID-19 in five ECOWAS MS (Nigeria, Togo, Liberia, Sierra Leone and Guinea).
- Development/update and partial implementation of COVID-19 emergency plans in five ECOWAS MS (Nigeria, Togo, Liberia, Sierra Leone and Guinea) via grant agreements with the local WHO offices (150,000 EUR per country, BMZ-funded).
- Financial support was provided to WHO addressing the main training areas of risk communication, RRTs' operation, case identification and case management. The total

[20] Field epidemiologists, surveyors, logisticians, press, media, and communication personnel are among some of the professional profiles trained.
[21] The additional funds disbursed were used within the framework of the agreed project objective and the fields of action agreed upon with the partner while also responding to immediate needs. Parts of the additional funds were used to procure protection materials, clinical equipment, and other urgently needed equipment for the fifteen ECOWAS MS. The distribution was carried out by WAHO.
[22] WHO/Joint external evaluation dashboard: https://extranet.who.int/sph/sites/default/files/document-library/document/9789241550222-eng.pdf
[23] https://gh.bmj.com/content/7/3/e008486

number of persons trained through the WHO partnership in the focus MS was calculated at 6,004.

As foreseen by Result area 1 and as part of the measures to support the regional response to the COVID-19 pandemic, the programme sustained specific RC activities requested by WAHO and RCSDC. This included the production of multiple awareness videos promoting COVID-19 prevention and documentary videos on COVID-19 that were aired in three ECOWAS MS (Cabo Verde, Ghana, Senegal).

Within Result area 2, as part of the project's emergency measures to support the response to the COVID-19 pandemic, the ECOWAS Intra-/extranet ECO-Suite[24] was scaled up to establish a direct link between the regional institutions and the NCIs of the fifteen ECOWAS MS for improved communication and coordination, though it was not used at its full potential. The "Preparedness and Response Portal" was already described above and contributed to promote comprehensive information and communication sharing.

From Result area 3, the programme had already generated a critical mass of trained human resources, in place since September-November 2019, a few months before the pandemic declaration. 235 staff had been trained in pandemic preparedness and response; 466 trained by trained trainers on risk communication, and simulation exercises had started in the four focus MS. The relevant 4 NCIs had been supported and had functioning EOCs since September 2019. This contributed massively to the effective mobilization of resources that allowed for quick mitigation of the pandemic in basically all the focus countries and in the Region. The stress test undergone by SORMAS[25] in the beneficiary areas where the package is installed and active was successfully passed and the package showed its powerful features not only in supporting and mapping case findings but also in promoting appropriate mitigation actions during the outbreak.
Of the 15 MS, 13 (86.7%) had the in-country laboratory capacity to test for COVID -19[26]. Also, all MS had documented incident action plans in which they outlined plans for boosting surge capacity through training laboratory personnel, case investigators, contact tracers, increasing the number of testing centres, and stockpiling critical supplies in anticipation of the outbreak spread. Ghana had a drone delivery system for critical medical supplies, blood, and blood products across the country and was ready to adapt this system for the rapid transport of COVID-19 samples and other critical supplies.

JC 1a.1 - Key result areas of the Programme are aligned with the priorities of the ECOWAS Commission and WAHO.
Indicators Analysed *From logframe* *Data management* 4. Number of LGAs and districts reporting regularly through SORMAS to NCIs in Nigeria and Ghana[27]. 2.1 Availability of a regional inter-institutional communication strategy considering One Health approach (including tools, processes, contents, actors)[28].

[24] With guidelines published in: Ecosuite / Pandemic Preparedness and Response in the Ecowas Region Portal Training for NCI's Report, by Jehu Omoruku, March-April 2021. And full description in: Eco-Suite, Final Report, by Chinelo Ebruke and Pilar Hernandez, June 2020.
[25]In Ghana and Nigeria, SORMAS, had been updated with a COVID-19 module and scaled up to cover at least 400 districts of over 85 million population. The Ghana Health Service and the RCSDC were supporting the scale up of this updated version of SORMAS to enhance real time case-base reporting and outbreak response management and assist with accurate mapping of cases and contacts for efficient deployment of field workers and needed response logistics and supplies.
[26] The remaining two (2) which did not yet have the capacity as of March 06, 2020, were Liberia and Cabo Verde. These two countries had engaged infectious substance certified shippers at key laboratories for shipping the specimens abroad for testing in other member countries – Ghana testing for Liberia, and Senegal for Cabo Verde. In the meantime, Liberia and Cabo Verde were preparing their laboratory infrastructure, training laboratory personnel, and procuring essential logistics and supplies to start testing in-country.
[27] Fully analyzed in:

1. *Nigeria Center for Disease Control and Helmholtz Centre for Infection Research: The deployment of the Surveillance Outbreak Response Management and Analysis System (SORMAS) in Nigeria Report 1A - August 2021*
2. *The piloting and nationwide deployment of the Surveillance Outbreak Response Management and Analysis System (SORMAS) in Ghana Report 1B - Ghana Health Service, Ghana Community Network Services Ltd, and Helmholtz Centre for Infection Research, August 2021.*

[28] Confirmed at: Regional Strategy Communication and Coordination between Institutions in the ECOWAS Region for the Control of Epidemics, by Rehmet S., Ablefoni S., Kola Jinadu, and the Core Group for Interinstitutional Communication and Coordination (IICC), July 2019, with an action plan 2019-2023.

3.2 Number of staff in the ECOWAS Commission, WAHO, RCSDC and NCIs who have been qualified through ICT-based training in pandemic preparedness and response[29].

From ET

1. Strategy of ECOWAS for epidemiological surveillance by WAHO in general[30]. See the list of sponsors and participating entities in SORMAS adoption as the reference tool for surveillance in the region (including WAHO). Tob e implemented by the RCSDC[31].

Partners, Sponsors, Advisors and Contractors

Partners

African Field Epidemiology Network (AFENET)
Centers for Disease Control and Prevention (CDC)
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)
Digital Square
Ghana Community Network Services Limited (GCNET)
Ghana Health Service (GHS)
Helmholtz Center for Infection Research (HZI) [lead]
Nigerian Centre for Disease Control (NCDC)
University College London (UCL)
University of Maryland Baltimore, Nigeria (UMB)

Sponsors

Basic Healthcare Provision Fund Nigeria (BHCF)
Bill and Melinda Gates Foundation (BMG)
Centers for Disease Control and Prevention (CDC)
Centre for Infection Research (DZIF)
European Union (EU)
German Federal Ministry for Economic Cooperation and Development (BMZ)
German Federal Ministry for Education and Research (BMBF)
Helmholtz Center for Infection Research (HZI)
Helmholtz Association (HGF)
WHO-Country Office Nigeria
World Bank

Advisors

Africa Centers for Disease Control (Africa CDC)
Centers for Disease Control and Prevention
DHIS2 Design Lab, University of Oslo
Hasso Plattner Institute (HPI)
Kreditanstalt für Wiederaufbau (KfW)
Robert Koch Institute (RKI)
University Braunschweig (TU)
West African Health Organization (WAHO)
World Health Organization (WHO-HQ)

Contractors

Symeda
Scigraphix
Crowdcode
Mirabilia
Elektro- & Datentechnik

JC 1a.2 – Capacities built are instrumental to COVID -19 response and interventions meet International Health Regulations standards

Indicators Analysed

From logframe

Risk Communication & Community Engagement:

2. Number of re-vised mechanisms for communication and coordination between regional and national levels and between NCIs[32].

3.3 Number of health workers trained by trained trainers on risk communication, SimEx and IICC in 4 ECOWAS member states[33].

Health Systems Strengthening:

2.2 Number of NCIs with functional Emergency Operations Centre (EOC)[34].

---

[29] *A full description is available in: Development of blended learning courses in collaboration with the Institut Régional de Santé Publique, Report, June 2021, by GFA Consulting Group GmbH. The number of staff trained in other similar courses was published by GIZ in several lists: Final list Participants ToT, June and Sept 2019 (91 trainees); In Country Final List of Trained Participants (186 trainees); Liberia training (50 trainees); Guinea training (50 trainees); Togo training (50 trainees); Sierra Leone training (50 trainees); One health moodle (71 trainees); One health Zoom (125 trainees), described in: Concept Note One Health blended-learning course in the ECOWAS region, December 2020, by GFA Consulting Group GmbH and followed by a Course review detailed presentation, prepared by Kerba, S., November 2020.Additional information on emergency training delivered by WHO (contracted by GIZ in relation with COVID-19 pandemic) are available in the Final Report by Mulombo W. et al., 31.10.2020. Number of recorded trainees is 6004, 641 from NRRTs.*

[30] *A software for disease surveillance and outbreak response - Insights from implementing SORMAS in Nigeria and Ghana. A publication in the German Health Practice Collection, 06.04.2020. Additionally the World Bank programme REDISSE has built a robust surveillance system in the entire ECOWAS region in the period 2016-2022:https://www.wahooas.org/web-ooas/en/projets/redisse-regional-disease-surveillance-systems-enhancement-project-west-africa*

[31] *As prescribed by the Seventy-Fifth Ordinary Session Of the Council of Ministers, Abuja, 13-14 December 2015, adopting the Regulations C/REG 11.12.15 establishing and stating operating procedures of the ECOWAS Regional Centre for Surveillance and Disease Control (ECOWAS-RCSDC), followed by the ECOWAS Regional strategic preparedness and response plan for public health emergencies, June 2019.*

[32] *Full details are available in: Ecosuite / Pandemic Preparedness And Response In The Ecowas Region Portal Training For NCI's Report, by Jehu Omoruku, March -April 2021, as a follow up of the Regional Strategy Communication and Coordination between Institutions in the ECOWAS Region for the Control of Epidemics, 2019-2024, July 2019.*

[33] *Public Health England supported the programme in conducting SimEx, as described in the Master scenario for Simulation exercise to test communication and coordination mechanisms and platforms between regional institutions and member states before, during and after a public health emergency (PHE), 31/03/2021, with 41 participants.*

[34] *All four were developed and established: see next Section, Result area Table for details, based on RPPP EU Action, Technical Report of Activities carried out from 1 January 2020 – 31 August 2021, by D. Bishop, GIZ team leader, December 2021. Additionally, an EOCs*

Health Staff Capacity Built:
3.1 Number of functional RRRT out of which experts can be deployed on short notice[35]
From ET
2. Strategies and MOH circulars on COVID-19 response in collaboration with NCIs
3. Coordinated transborder initiatives taken on COVID-19
4. Vaccines available and number of people vaccinated by August 2021[36]
COVID-19 (see footnote for reference) is currently monitored at: https://data.wahooas.org/outbreaks/#/; data on vaccination are from https://africacdc.org/covid-19-vaccination/ with the latest figures as follows:

Country	doses available	doses delivered
Ghana	32532950	23088598
Guinea	9450760	8234224
Liberia	5173644	7206205
Nigeria	13137000	102242369
Sierra Leone	6924110	5794776
Togo	6599870	3828859

The EVAL team can conclude that the intervention fully responded to needs and managed to create all the pre-requisites for a full IHR capacity at the regional level and in targeted MS, based on the following documented evidence:

- IHR key components have been addressed (risks are assessed and communicated extensively[37]).
- SIMEX has been implemented[38] leading to a good level of preparedness.
- NRRT are ready and available[39].
- NCIs have been supported to act rapidly with EOCs managed by their respective Incident Management Systems (IMS).
- Communication systems are in place (ECO-Suite) though they need to be better populated to become an attractive tool for MS (and for Donors).
- RCSDC is active, though constrained but ready to take off.
- SOPs on the chain of command and operations are implemented[40].
- National plans are available.
- Labs are available[41] (though not directly linked to the programme).
- Field epidemiologists and other health workers have been trained and are in place in all focus MS.

assessment had been conducted in Liberia 26th to 29th of March 2019, Sierra Leone 21st to 24th of May 2019, Togo 30th of July to 2nd of August and in Guinea 19th to 24th of August 2019 using the WHO Public Health Emergency Management Capacity Development Tool. Togo was the only negative outlier.

[35] *Described at: Standard Operating Procedures for the ECOWAS Regional Rapid Response Team (ERRRT), 19 March 2019.*

[36] *A full discussion is available in Afolabi MO, et al.: Tracking the uptake and trajectory of COVID-19 vaccination coverage in 15 West African countries: an interim analysis. BMJ Glob Health. 2021 Dec;6(12):e007518. doi: 10.1136/bmjgh-2021-007518. PMID: 34906987; PMCID: PMC8718349.*

[37]*Following the trainings, MS developed country-specific tools for COVID-19 case investigation, contact tracing, case management, and risk communication. All MS had trained professionals in risk communication who may be called upon to design and implement risk communication strategies and messages during crisis. Similarly, they all had a coordination mechanism that involved relevant actors in risk communication. The response systems were able to quickly detect and respond to rumors, misinformation, myths, and FAqs through monitoring of the various traditional and social media networks, hotlines, and reports of community workers. The most significant gap was the lack of a risk communication and community engagement (RCCE) plan. Only five (33.3%) of the 15 states viz. Benin, Ghana, Liberia, Mali and Togo had RCCE plans.*

[38]*On 5-6- March 2020, the RCSDC in collaboration with the A CDC, organized a simulation exercise on COVID-19 for a total of 50 members of the ECOWAS Regional Rapid Response Team (RRRT) with representations from all 15 MS.*

[39]*Except for Niger and Cabo Verde, the 13 other MS had trained their NRRTs on contact tracing and conducted simulation exercises on COVID-19 outbreak response using adopted WHO protocols and tools.*

[40]*Four MS (Burkina Faso, Ghana, Liberia, and Mali) had included the legal basis for quarantine and restriction of movement in their plans. Legislative processes were underway in Ghana to give the president additional powers to institute interventions as may be warranted for the control of the pandemic.*

[41]*A regional laboratory training workshop was organized on February 27- 28, 2020. It provided hands-on training for biomedical scientists of MS on how to perform RT-PCR detection of SARS-CoV-2. They were also trained on the operationalization of test algorithms, biosafety, and biosecurity (BSL-3) practice, and sample referral systems within, and among member states. The RCSDC supported MS in capacity building and logistics for screening and laboratory testing of all persons passing through all points of entries including land borders.*

- A specific emergency fund has been financed and released during the COVID-19 emergency showing how it may be better used (see Lessons learnt and Recommendations chapters).
- Surveillance is in place (evidence is limited to the SORMAS countries and Liberia) and staff is trained, with excellent professional skills and knowledge in Nigeria, where personnel was intensively interviewed by the EVAL team.
- Comprehensive procurement was addressed during the COVID-19 emergency, as no stockpile was available for essential PPDs, showing what needs to be done to address supply chain issues that need to be considered seriously and possibly addressed by the forthcoming new programme.

4.2 Evaluation question 2a

EQ2a: "How well were results achieved according to what was expected from the intervention in its Logical Framework Matrix? (From ToRs)

Activities, results, and time of completion are presented and discussed by each programme area:

4.2.1 Result 1

Activity	Description	Milestones	Completed by
Regional Risk Communication Strategy	Availability of a gender-sensitive risk communication strategy by WAHO/RCSDC according to international standards, including the One Health approach and action and budget plan, SOPs	• Technical validation • Elaboration of SOPs • Testing of SOPs	December 2018 March 2020 March 2021
Regional Gender Study	One presentation held at a regional conference on the results of gender-sensitive risk communication research	• Conclusion of the data collection • Final report • Presentation at a regional conference	May 2021 June 2021 19 August 2021

Table 4 Result area 1

The regional Risk Communication Strategy has been elaborated and is available in all 3 ECOWAS official languages; the strategy considers gender aspects[42] and integrates the One Health approach. Importantly, the Strategy was validated by the 15 ECOWAS MS in December 2018.

SOPs on Regional Risk Communication were developed, and National Risk Communication Plans were elaborated or revised in all supported countries. Since 2018, the programme has been promoting the implementation of the related regional Action Plans 2019-23, and:

a. Liberia: National Risk Communication Plan was developed.

b. Togo: National Risk Communication Plan was reviewed/revised and input by RPPP was provided. Financial support was requested for the dissemination of the plan in all health regions and districts. SOPs for Risk Communication were developed, matching one of the key recommendations made by the Joint External Evaluation (JEE) in 2018.

c. Guinea: The National Risk Communication Plan was developed.

The study on Gender-sensitive Risk Communication covered nine ECOWAS MS (Burkina Faso, Cabo Verde, Ghana, Guinea, Guinea-Bissau, Liberia, Niger, Nigeria, and Senegal) and was concluded in May 2021, despite its beginning had to be initially postponed to March 2021 due to

[42] *Published by Aminata Talla-Diop, Stella Odiase in a multicountry Report: Report on the study on gender aspects in risk communication with a focus on COVID-19 – Burkina Faso, Cape Verde, Ghana, Guinea, Guinea Bissau, Liberia, Niger, Nigeria and Senegal, May 2021.*

COVID-19 pandemic[43].

The study outcomes have been incorporated into the regional and national strategies, promoting a gender-sensitive lens in all the RC activities.

Digital handling of RC was promoted at the regional and national levels. Hackathons were implemented, a mobile application for RCSDC was developed, a regional RCSDC RC platform was developed, and webinars covering various RC topics were provided.

4.2.2 Result 2

Activity	Description	Milestones	Completed by
Regional Strategy for Inter-institutional Communication and Coordination	Availability of a regional inter-institutional communication strategy considering One Health approach (including tools, processes, contents, actors)	• Political adoption • Elaboration of SOPs • Testing of SOPs	May 2019 October 2019 March 2021
Support to EOCs of 4 focus ECOWAS countries	4 NCIs with functional EOC	• EOC assessments • Support plans implemented	August 2019 September 2021
Organisational Development	2 successfully supported (**but not implemented**) organizational development processes in WAHO/RCSDC	The assessment concluded and work plan finalized, **but not launched**	**Not completed**

Table 5 Result area 2

SOPs for "Information sharing between countries and regional organizations/structures in public health emergencies (PHE) affecting more than one ECOWAS Member State" were elaborated and validated in a simulation exercise delayed due to the pandemic closures and conducted at the end of March 2021, also validating SOPs for RC coordination (developed in 2020) and the ECO-Suite Preparedness and Response Portal. The ECO-Suite at the ECOWAS Commission was strengthened and extended to WAHO/RCSDC, to the RAHC promoting coordination with the animal health sector, and all the fifteen ECOWAS MS. Despite its functionalities, the platform is not used at its full potential and may rapidly deteriorate unless properly revitalized.

Emergency Operations Centres (EOCs) in four focus countries were assisted, improving their legal framework, supporting the development of strategies and plans, strengthening capacities through equipment, SOPs, and training. An assessment was conducted in Liberia, Sierra Leone (where a new Public Health Bill was promoted), Togo, and Guinea (where subnational EOCs were also supported, such as in Nzérékoré for Ebola) in 2019, using the WHO Public Health Emergency Management Capacity Development Tool: a re-assessment confirmed their improved operational capacity in September 2021, with a note on Togo EOC successfully built from level zero. The COVID National Response Plans were supported in the focus MS, addressing mainly COVID training, risk communication and awareness-raising activities, coordination, and communication, besides procuring and distributing essential screening equipment.

Activities for the Organizational Development at RCSDC never started, however a thorough assessment of the structures and capacities of the centre was carried out and working packages for future development were elaborated, this being considered the first step in the process. The relevant reports with clear and feasible recommendations are available and indications should be implemented as a pre-condition for further support, focusing also on the revision of administrative

[43] *In addition to COVID-19 pandemic, the ECOWAS region was affected by outbreaks of Lassa fever, yellow fever, vaccine-derived polioviruses, measles, cholera, and Monkeypox during the programme life. This challenged ordinary procedures but also offered an opportunity to filed practice the programme supported skills and capacities, moving from simulation exercises into real life mitigation and control activities. There was also a renewed Ebola outbreak and a case of Marburg virus in Guinea, which was the first ever case in West Africa. The high burden on regional and national public health institutions confirms the relevance of the programme and the validity of its logic in a highly vulnerable context. RC on outbreaks of COVID-19, Ebola, Lassa and Marburg fever followed the traditional channels of communication (fliers, posters, billboard, video and radio spots) as well as interventions on digital platforms, including the development of mobile apps.*

and logistic procedures pertaining to the effective and timely deployment of the RRRT[44].

4.2.3 Result 3

Activity	Description	Milestones	Completed by
Training of regional and national staff in pandemic preparedness and response	220 staff in the ECOWAS Commission, WAHO, RCSDC and NCIs qualified through Information and Communication Technology (ICT) based training in pandemic preparedness and response	Trainings of trainers concluded	September 2019
Training of NCI staff in 4 focus ECOWAS MS	340 health workers trained by trained trainers on risk communication, Simulation Exercise (SimEx) and IICC in 4 ECOWAS MS[45]	Cascaded trainings concluded	November 2019
Strengthen the capacity of NRRTs	4 functional NRRTs out of which experts can be deployed at short notice	• SOPs developed • Databases set up	

Table 6 Result area 3

SOPs for the Regional Rapid Response Team were elaborated and formally endorsed.

Training of RRTs members (a large cohort of hundreds overall) was implemented using grant agreements stipulated with WHO offices in Guinea, Sierra Leone, Liberia, Togo, and Nigeria to support the national response to the COVID-19 pandemic, with variable success: e.g., Togo and Liberia have a functional NRRT with an established expert database and SOPs; Sierra Leone has a NRRT but lacks structured SOPs and a database; Guinea has adopted the relevant SOPs, but the NRRT is not in place yet[46].
Trainings were conducted (as training of trainer courses) with a MoU with the Regional Public Health Institute (Institut Régional de Santé Publique, IRSP), in Ouidah, Benin to ensure sustainable continuity. More than one hundred trainers were trained, including national trainers to provide further training to 372 trainees. Simulation exercises were conducted before and after the COVID-19 peak. Additional capacity-building activities were implemented in the supported countries[47] and NRRTs are now operational in all focus MS.
Community surveillance was mainly addressed in Liberia, with specific training (including medical students) for Emergency Risk Communication, Interinstitutional Communication and Coordination, and Simulation Exercises in collaboration with the Regional Public Health Institute (IRSP) in Ouidah. WAHO/RCSDC, RAHC, ECOWAS Commission and the fifteen ECOWAS MS also participated. A long-term business plan for the Institute was elaborated by GFA Consulting Group, contracted by the programme to ensure technical and financial sustainability for training and course delivery.
A One Health online course was developed and is available to all relevant staff in the ECOWAS region, at the regional and national levels[48].

[44] *The first technical document was elaborated in 2021: "Evaluation of the organisation and functionality of the RCSDC": an organizational analysis and proposals for organization development focusing on structures & roles; steering; management and leadership; cooperation & horizontal connections; human resources; infrastructures; core & support processes; culture". The second: "Elaboration of an Organisational Development Plan" included templates, graphics, overviews, and action plans and made use of specific professional methods for each working area (eg, process charts, role descriptions, and team set-ups).*
[45] *Latest reported figures on trained staff are: 235 from the ICT-based training in pandemic preparedness and response; 466 trained by trained trainers on risk communication, SimEx and IICC in the four focus MS.*
[46] *To be noted: the Regional Rapid Response Team (RRRT) of WAHO were funded by the BMZ bilateral grant while the National Rapid Response Teams (NRRTs) of the focus countries were EU-funded and were indicated as an initiative of visible success. Their training was impacted heavily by the COVID-19 restrictions, but the programme managed to provide trainings for teams already in place via the grant agreements with the local WHO offices.*
[47] *In Liberia: 53 staff were trained in Public Health Emergency Management; 10 Medical Students in Public Health Systems and Emergency Response; in Sierra Leone: 219 members of RRTs were trained in COVID-19 surveillance, case definition and contact tracing.*
[48] *With additional COVID-19 funding, the course was scaled up to a blended-learning format including both online and presence-based modules and the first edition conducted from April to June 2021. The One Health course's quality and sustainability are under review for the programme second phase.*

4.2.4 Result 4

Activity	Description	Milestones	Completed by
Deployment of SORMAS in Ghana and Nigeria	272 LGAs in Nigeria and 77 districts in Ghana reporting regularly through SORMAS to NCIs in Nigeria and Ghana	• Pilot in Ghana • Expansion in Nigeria • Expansion in Ghana	August 2021
Application of SORMAS in Ghana and Nigeria	70% of cases of epidemic-prone diseases integrated in the SORMAS tool are reported by participating LGAs and 50% of cases by participating districts in Ghana.		August 2021
Conduct operational research	2 study reports are shared on the operational research and discussed within the NCI network	• Studies concluded • Studies presented in a regional conference	July 2021 August 2021

Table 7 Result area 4

SORMAS was expanded to the Akwa-Ibom, Niger, and Imo states. It was pilot tested in the Upper West region and in Greater Accra in Ghana[49] (EU-funded) and operational research was successfully conducted after the initial delays due to the pandemic lockdowns[50].

In Nigeria, 52 LGAs in Imo and Niger States and 31 LGAs in Akwa Ibom were covered with SORMAS by August 2020. 17 LGAs in Enugu and Abia states were covered eventually as part of the COVID-19 emergency measures. For this purpose, a corresponding contract extension was concluded with the Helmholtz Centre for Infection Research (HZI)[51]. The measures included the procurement of hardware (440 android tablets and training of the relevant staff in the use of SORMAS). In Ghana, 31 districts of the Greater Accra Region and 11 districts of the Upper West Region were covered between December 2019 and August 2020. 43 more districts in the Ashanti region were covered later. 20 laptops and 300 Android devices were handed over to Ghana Health Service in June 2021.

In conclusion, the EVAL team confirms the full achievement of all expected results apart from the RCSDC full development, which was only proposed with an initial process that was not fully implemented, nor adequate staffing was seriously considered by WAHO and ECOWAS during the programme duration. The ECO-Suite tool is operational but poorly accessed and used by end-users, showing that it needs reshaping once a quick survey among potential users is conducted to understand what their expectations are and what have been constraints.

JC 2a.1 - Percentage of achievement of the desired results in the specified time according to targets and indicators described in the logical framework of the EU component of the project.
Indicators Analysed All project logframe indicators.

JC 2a.2 – Logical framework is designed with SMART indicators and a monitoring plan is available
Indicators Analysed All project logframe indicators.

[49] The Ghanaian implementing partner – Gcnet - became insolvent in mid-2021. Responsibility for SORMAS management was transferred to the government, which now deals with all recurrent costs. With regards to server hosting, IT management and software development, Ghana will need additional financial support to be able to apply SORMAS in the longer term with the right level of knowledge and full ownership.

[50] SORMAS is now implemented in France, Germany, and Fiji, with several other expressions of interest within a very innovative South to North cooperation. The new programme will continue to support the implementation of SORMAS in Nigeria and Ghana and add a new regional dimension by anchoring a SORMAS dashboard at RCSDC. SORMAS is also interoperable with other digital tools such as DHIS2 (District Health Information Software 2).

[51] https://www.helmholtz-hzi.de/en/

4.3 Evaluation question 2b

EQ2b: How coordination among countries' institutions and management capacity have adapted to changing conditions? (From ET)

The components of Result area 2 aimed at improving the coordination and communication lines between the different levels (regional with MS and among MS) to ensure proper circulation of information and relevant facts, tools, evidence, and rumours whose knowledge, understanding, and analysis are vital when dealing with epidemics and epidemic intelligence. In the ECOWAS region, coordination is a clear challenge, as also outlined by the evaluation report on the bilateral programme implemented by Heidelberg University.

Closures, travel schedule interruptions, lockdowns, and quarantine procedures challenged the timely implementation of activities but also offered real-life ground to practice preparedness, response, and mitigation. The programme had to change strategies and implementation modalities (e.g., in the procurement of goods and provision of sub-grants) but managed to achieve results within a reasonable time. For example, within Result area 2, as part of the project's emergency measures to support the response to the COVID-19 pandemic, the ECOWAS Intra-/extranet ECO-Suite was scaled up to establish a direct link between the regional institutions and the NCIs of the fifteen MS for improved communication and coordination[52].

However, it must be noted that the additional budget granted to cover the new Result area (5) to assist ECOWAS in the fight against COVID-19 was not fully used, leaving about 3,4 M € unspent (out of a total of 4 M €), reported to be caused by delayed procurement.
Poor coordination had been identified by WAHO as one key priority of intervention[53]. In fact, the JEE report on eleven of the 15 ECOWAS MS indicated a generally weak level of internal coordination and coordination with partners, with the notable exception of Liberia and Sierra Leone, which have capitalized their recent experiences with Ebola. The area of coordination was addressed also by Result area 1 with a focus on risk communication coordination, and this was found particularly successful by the EVAL team, and so confirmed by all interviewed stakeholders, and supported by evidence identified from several reports and papers, as well as by indirect evidence gained from an external database, such as the GHSI Report and the WHO SCORE system, presented in Annex 8. Additionally, the programme trained almost 7 thousand staff from ECOWAS, WAHO, RCSDC, NCIs whereas the target was set at 1060. Training of Trainers and cascade training in focus countries addressed mainly – but not only - risk communication and communication and coordination in a very efficient modality, with useful materials and relevant curricula that facilitated the exchange of experience by trainees and built on common standards. However, the issue of coordination is just too important and calls for formalized means and mechanisms to facilitate intercountry dialogue and to overcome, e.g., the lack of confidence that MS showed in the RRRT's ability to provide relevant support. This was addressed by the draft IICC strategy (2019)[54] accompanied by a comprehensive training package[55], recommending, among others, that RCSDC, NCIs and RAHC develop strong platforms for surveillance, events analysis and response aiming at interoperability and harmonization of systems for the human, animal, and environmental health, using One Health approach and that the three regional networks of the three sectors involved (human health, animal health and environment) use the same platforms for communication and coordination.

The latter is a key value built by the programme confirming that coordination has been duly addressed, though not fully implemented as it takes time, relevant and connected legal frameworks

[52] *Based on the Preparedness and Response Portal already mentioned under Result area 2 above.*

[53] *WAHO has published the Regional Strategy Communication and Coordination between Institutions in the ECOWAS Region for the Control of Epidemics, 2019.*

[54] *The Regional Strategy Communication and Coordination between Institutions in the ECOWAS Region for the Control of Epidemics, published in 2019 with support from GIZ, with a comment: 'One of the most striking features during the assessment was the existence of "parallel universes" meaning that each organisation has its own perception on its importance and mandate while this does not correspond necessarily to the views of the others.'*

[55] *Emergency 'Risk communication' and 'Communication and coordination' training packages manual, February 2020, GFA Consulting Group GmbH.*

at the MS and at the regional levels and sustained political support by ECOWAS. The tools provided are relevant and appropriate, but the EVAL team believes that a strong political commitment is essential to translate technical evidence of success on single episodes – as shown by the programme - into a true change of paradigm.

JC 2b 1 - Degree (examples) of flexibility and adaptability to changing conditions in coordination and programme management
Indicators Analysed *From ET* 1. Catch up on delayed activities during lockdown periods[56]. 2. Programme No Cost Extension available[57]. 3. Responsiveness of programme to national and regional new requests[58]. 4. Rapid adaptation of tools and procedures due to unforeseen situations[59].

4.4 Evaluation question 3a

EQ3a: To what extent were the implementing modalities of the intervention appropriate to the institutional set up of ECOWAS agencies and Member States? (From ToRs)

One of the key programme results, namely a fully operational RCSDC, was not achieved and was possibly the only evident programme's failure. A second, less evident aspect of challenges related to institution building was the programme's reluctance to rely on regional and national experts and consultants coming from local accredited professional and academic entities.
More factual and analytical knowledge is needed on the potential outbreak drivers and a true One Health approach may improve the regional ability to prevent and detect risks: while this is in theory within reach, given WHAO's role and mission, a sound and strong engagement with the animal health and the environmental health sectors is needed and should be supported with dedicated financial and human resources. This is not fully evident from the documents reviewed and from stakeholders' opinions: a functional RCSDC might have addressed this in a more effective and sustained way.
While the programme results are very appropriately documented on the operations and technical aspects side, the EVAL team believes that the programme performed less well in institution building and counterparts' empowerment, with clear implications on the technical sustainability of the programme results. The very limited use of regional consultants and experts was a missed opportunity to strengthen reciprocal confidence and encourage intercountry peer collaboration, which should become a true priority for a regional programme of this dimension and ambitions. Some degrees of disconnect were perceived by the EVAL team between the national and the regional strategies and operational plans: national plans should complement regional plans and vice versa (especially if funded by the same EU) and should not compete to achieve similar objectives and results, especially considering the different volume of resources channelled through the regional and the national programmes that may like to identify procedures to improve their collaboration and

---

[56] The programme suffered from closures due to the COVID-19 pandemic. It was able to resume activities very quickly and to catch up to generate the expected results both at country and at regional level, as described in the report: Action: Support to the Regional Centre for Surveillance and Disease Control (RCSDC) in the ECOWAS Zone. Technical Report of Activities carried out from 1 January 2020 – 31 August 2021, December 2021.

[57] The programme was initially commissioned for a period of 2.5 years (January 2019 – June 2021) but due to implementation delays related to the COVID-19 pandemic, it was extended by two months until August 2021, via a Pillar Assessed Grant or Delegation Agreement (PAGoDA). Negotiations with the EU for further co-funding options to support the response to COVID-19 in the region were concluded in 2020 and the PAGoDA amendment signed. Despite the delays, most activities under the Action could be completed and the corresponding indicators achieved as detailed in the above Report to the EC.

[58] A Result area 5 was added and funded by the EC aiming specifically at responding to needs identified by MS in five ECOWAS beneficiary countries (Nigeria, Togo, Liberia, Sierra Leone, and Guinea), where additional training was offered (with a focus on NRRTs), essential COVID-19 related medical supply procured (extended to fifteen MS), financial support provided to WHO to update COVID-19 emergency plans and train local health staff, as already documented above.

[59] The programme supported the ECOWAS/WAHO emergency fund for the COVID-19 response in the region, under the assumption that this arrangement would have facilitated procedures and added flexibility to meet urgent and unexpected needs. However, there were delays in the delivery of batches and different underspends. This was partly due to the bureaucracy of international supply chains and exchange rate fluctuations, partly to prolonged decision-making processes on the side of the partners, concerns regarding the quality of the equipment available and complex procurement rules and processes.

convergence, preventing any duplication. The EVAL team's opinion is that this area should be carefully reviewed and amended.

JC 3a.1 - Consistency of implementation modalities with the institutional set-up of ECOWAS agencies and the Member States.
Indicators Analysed *From programme logframe:* 1. Number of revised mechanisms for communication and coordination between regional and national levels and between NCIs[60] 2. Percentage of support missions of the Regional Rapid Response Team (RRRT) for prevention and control of epidemics[61] 3. Number of LGAs and districts reporting regularly through SORMAS to NCIs in Nigeria and Ghana[62]

JC 3a.2 - Ability to accomplish key programme activities and produce relevant material within planned timeline and available resources with competence.
Indicators Analysed *From ET* 1. Existing agreements between the programme, WAHO at a local and regional level and with NCIs 2. Type and Number of coordination meetings held at a national and regional level 3. Acceptability of modalities of intervention by ECOWAS, WAHO, NCIs and Members' States 4. Level of disbursements of funds for specific activities and satisfaction of sub-recipients[63]

4.5 Evaluation Question 4a

EQ4a. What are the lessons learned from ECOWAS-RCDSC intervention that could improve the monitoring and reporting of other (future) regional projects funded by EU? (From ToRs)

There is a disconnect between the title, logframe and scope of work (which is based on a Delegation Agreement whereas there is an agreed division of responsibilities and a clear identification of activities being funded by the EU grant and those implemented with bilateral German funding): the title is not representing the logframe and may be misleading. Additionally, there is an ambiguity in terminology between RCDSC and RCSDC[64].

The programme logframe was appropriately designed but did not include those more ambitious results-oriented indicators expected in a programme of this dimension. Indicators need to go beyond the process and the execution of activities. For instance, a minimum set of indicators should consist of those guiding the JEE (Fig. 7) ensuring also that all relevant information is collected and stored in one data warehouse that is fully accessible with an open data procedure[65].

The EVAL team spent much time in the effort to identify useful data from several sources not reported by the programme that could be connected to the descriptive narrative and support the evidence of what were the programme's successes and challenges on the ground. In conclusion, though the programme achieved what was on paper, the EVAL team believes that more ambitious and carefully

[60] *The ECOWAS intra-/extranet ECO-Suite was adapted to link the regional institutions and the NCIs of the 15 ECOWAS MS for improved communication and coordination during the pandemic. A "Preparedness and Response Portal" was designed, and back-end users and administrators of WAHO and RCSDC trained in November 2020. Trainings were also offered to the NCIs in Nigeria, Liberia, and Sierra Leone in March 2021 and for Guinea and Togo in April 2021. The team periodically reported in detail: Report on RPPP country-level activities: October 2020; November 2020; February 2021; March 2021; April 2021; May 2021; June - August 2021; December 2020 - January 2021.*

[61] *One request and deployment from the MOH, Liberia was on record and presented to the Steering committee, November 2019.*

[62] *272 LGAs in Nigeria and 77 districts in Ghana are reporting regularly through SORMAS to NCIs in Nigeria and Ghana, as confirmed by the Action: Support to the Regional Centre for Surveillance and Disease Control (RCSDC) in the ECOWAS Zone. Technical Report of Activities carried out from 1 January 2020 – 31 August 2021, December 2021.*

[63] *Grants and contracts were issued by the programme to support activities. The grant agreement with WHO in Result area 5 on COVID-19 had an excellent impact that was documented in the above reports.*

[64] *Clarified by the EUD: RCDSC (Regional Centre for Disease Surveillance and Control) is the Decision title and "umbrella project" while RCSDC (Regional Centre for Surveillance and Disease Control) is in the title of the Contract with GIZ to support implementation of the RCDSC decision.*

[65] *Benchmarks and a complete standard description is available at: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/ihr-coordination-and-national-ihr-focal-point-functions.*

designed indicators should be adopted to reflect the actual investments done and the breadth of activities planned and executed

The alignment with the JEE mainstream indicators and the current global efforts towards the full implementation of the IHR may also help minimize useless bureaucracy and duplications of M&E systems.

The programme aimed at improving directly Prevent 2; Detect 2, 3, 4; Respond 1, 5, which are deeply interlinked also with other dimensions and should therefore be considered in the future:

The JEE evaluates 19 technical areas that are classified according to three core objectives of the IHR and other IHR hazards:

PREVENT	DETECT	RESPOND	Other IHR related HAZARDs and PoEs
1. National legislation, Policy and Financing	1. National Laboratory System	1. Preparedness	1. Point of Entries (PoEs)
2. IHR Coordination, Communication and Advocacy	2. Real Time Surveillance	2. Emergency Response Operations	2. Chemical Events
3. Anti-microbial Resistances (AMR)	3. Reporting	3. Linking Public Health and Security Authorities	3. Radiation Emergencies
4. Zoonotic Disease	4. Workforce Development	4. Medical Countermeasures and Personal Deployment	
5. Food Safety		5. Risk Communication	
6. Biosafety and Biosecurity			
7. Immunization			

Figure 7 JEE technical areas related to IHR core objectives

JC 4a.1 - The model of ECOWAS-RCDSC intervention is an example of how to monitor regional projects
Indicators Analysed *From programme logframe* All Indicators of the project logical framework

JC 4a.2 - Lessons learned are there to improve monitoring and reporting for other future regional projects.
Indicators Analysed *From ET* 1. Existence of a Monitoring Plan[66] 2. Modality and frequency of measuring selected indicators 3. Pro and Cons of M&E and Reporting modalities of the programme

4.6 Evaluation question 4b

***EQ4b. To* what extent were the monitoring processes and resources sufficient for planning and achievement of results? (From ET)**

There were no specific provisions for mid-term reviews and no monitoring (ROM) indicators had been developed; no specific budget or timeline for monitoring was agreed with the implementing partner. It is well understood that a Delegation Agreement of this type relies on the implementing agency's workplan and adopted monitoring systems. However, the M&E systems can still be negotiated differently.

[66] *A monitoring plan was in place for the BMZ funded activities and was reported, including the EC funded set of activities in the three Steering Committees held: 8th February 2018, Freetown; 25th November 2019, Abuja; 29th March 2021. In addition, Planning Workshops were conducted in Ouagadougou, 3rd May 2017 (limited to the bilateral project) and on 15th April 2019 including the EC funded action, with modifications in the M&E system.*

The EVAL team managed to retrieve annual reports duly compiled as prescribed, with a comprehensive and complete set of information that was very useful to document the programme progress and challenges, but not usable to provide the timely support possibly needed to remove those challenges and the few constraints described.
An intensified involvement of national EUDs in monitoring local achievements/failures and proposing remedial actions - if and when needed - and a proper feedback mechanism have to be established. The EVAL team contacted each EUD in the six target countries to get their opinions and indications as well as comments on the coordination and mutual support possibly in place between national programmes funded by the EU in their MS and the regional action. Only one reply from Ghana, besides the EUD Nigeria managing the regional activities, was received and no other staff than officers from Ghana and Nigeria EUDs participated in the several debriefings offered. Incidentally, these are the two SORMAS countries, and SORMAS is one of the values of excellence implemented by the programme.
Besides the monitoring aspects, though, the EVAL team believes that the volume of financial resources made available was more than sufficient as witnessed also by the substantial budget funding the COVID-19 response that remained unspent. This indicates that a prior estimate of the implementing agency's absorption capacity by activity type may be conducted, and alternative solutions identified.

JC 4b.1 - The monitoring processes and resources are adequate to reach targets and results.
Indicators Analysed *From the programme log frame* All Indicators of the project logical framework *From ET* 1. Existence of a Monitoring Plan 2. Modality and frequency of measuring selected indicators 3. Prompt and sufficient availability of financial and human resources for M&E

4.7 Evaluation question 5a

EQ5a How could the commitment, ownership and coordination observed amongst key project stakeholders during the intervention be further strengthened? (From ToR)

Awareness has been raised by the programme's continuous work complemented by a real-life experience (such as the COVID-19 pandemic) on the importance of pandemic preparedness and response. Both the regional and the national authorities are improving their capacities in this field, though at a different pace.

The main objective should become the RCSDC institutional development, based on the organizational analysis and recommendations already prepared and endorsed, using also creative operating modalities (such as a rotation system for professionals coming from MS). A proxy condition may be the provisional recruitment and assignment of GIZ staff to assist and mentor new staff in the RCSDC, as proposed by the programme management but not accepted. RCSDC reputation may be built also by advisers temporarily located in that institution (also considering the availability of a few Donors to supply technical assistance). The ECO-Suite platform needs to be populated systematically with items and services that are needed and perceived as unique opportunities attracting users and positioning the regional institutions as key service providers.

SORMAS and/or similar accredited platforms should be considered as prerequisites for the project activities and not simply one result area. In other words, MS and the region need solid, robust, reliable data for interinstitutional operations, risk communication, for all the initiatives that the regional and the national level will decide to share and implement, according to the published SOPs and their specific mandates.

The implementation and operability of a regional One-Health platform were only marginally addressed by the programme. There is a need to invest in the necessary pre-requisites mainly from the animal health side, mobilizing veterinarians and environmental experts in the focus MS, using

also the opportunities given by the quadripartite agreement in the UN system (WHO, FAO, OIE, UNEP[67]) and by the climate change/planetary health vision, promoting access to additional resources made available at the global level[68]. The shift towards One Health may be accompanied by a detailed investment case supported by the programme, given the economic value of animal and environmental health for the food industry and more. In this sense Ministries of agriculture may be involved in formulating and implementing their regional strategic vision. This should be also linked to the newest UN AMR multistakeholder platform, connecting the region to the global AMR community and beyond[69].

The programme has promoted a few legislative initiatives at the national level, such as in Sierra Leone. Legislation that allows moving authority and chain of command to the regional level in case of cross-boundary emergencies due to communicable diseases may be studied: this may imply, but not be restricted to, bulk procurement and coordinated distribution of essential medical equipment from designated UN ports, overcoming the constraints experienced by the programme during the COVID-19 crisis. In fact, a substantial amount of money allocated for COVID-19 remained unspent due to procurement delays. This is an issue, as it relates both to the implementing agency and WAHO's absorption and procurement and logistics capacity, and should be considered in detail, as there may be several justifications not related to the programme that may be useful to know to prevent possible mistakes.

The EVAL team believes that the COVID-19 pandemic has stressed the still embryonic epidemic management system. Preparedness was incomplete but the region and NCIs managed to cope, and the response was rapid and to the point. The programme was instrumental in providing essential tools and support to WAHO and the RCSDC in their leadership role. The programme was implemented despite the severe disruption caused by the closures and suspension of several routine activities and plans. Programme staff were based in each of the six focus MS and managed to support the NCIs and their national counterparts, while the RCSDC was focusing on risk communication and related activities, lacking the necessary staff in other areas. The paradoxical side effect was that this challenged the weak RCSDC's credibility and role in assisting the NCIs and did not contribute to building its reputation and capacity, which should become the key priority for the future. Unless there is a change in the ECOWAS political commitment to build the RCSDC institutional credibility, to draft regional legislation that allows the scaling up of the chain of command in case of PHEIC and unless this commitment creates a solid ONE health ecology, the programme success will be limited to its immediate objectives. The good dialogue with partners and MS may be lost unless the programme stakeholders manage to generate and promote the evidence needed to drive political decisions as briefly described.

JC 5a.1 – Level of commitment, ownership and coordination in the implementation of the project.
Indicators Analysed *From ET* Understanding of sustainability by the programme Modalities of implementation were planned in view of sustainability?[70] Increased level of support by WAHO to the ECOWAS member States in epidemic control, which corresponds to international quality standards according to the international health regulations. Sub-granting modalities were thought in view of given sustainability? Understanding of sustainability by ECOWAS, WAHO and NCIs[71]

[67] https://www.who.int/news/item/29-04-2022-quadripartite-memorandum-of-understanding-(mou)-signed-for-a-new-era-of-one-health-collaboration.

[68] *E.g.: https://www.greenclimate.fund/ and https://www.planetaryhealthalliance.org/planetary-health.*

[69] https://www.fao.org/antimicrobial-resistance/quadripartite/the-platform/en/

[70] *The document Operational Plan 2019-2021: Overview of Planned Activities per Output addressed all actions and related indicators and provided a time and service volume framework that was suspended during the COVID-19 closures but revitalized eventually to catch up fully with the exception of the RCSDC organizational development restructuring.*

[71] *The interventions funded with the EC contribution are aligned with the existing regulations and policies of the ECOWAS Commission and WAHO, e.g. with the WAHO Strategic Plan 2016-2020 and in particular with their priority programme three on epidemics and other health emergencies as well as the Action Plan of RCSDC. The programme was designed to support the ECOWAS Commission and its MS in adhering to the IHR. The programme was not only aligned with regional regulations and policies but was designed to support and strengthen these structures and institutions regarding pandemic preparedness and response. The need for such actions has been proved by the 2014 Ebola outbreak, and confirmed by other outbreaks, such as notably COVID-19 in all the MS and Ebola recrudescence in Guinea. Specifically, the programme has supported the development and implementation of indigenous strategies (e.g., gender-sensitive risk communication strategy and IICC strategy under Result 1 and 2), standards, procedures and SOPs (Result 1) and tools such as*

JC 5a.2 –Model for strengthening commitment, ownership and coordination of regional disease surveillance is satisfactory compared to before the study
Indicators Analysed *From Programme Log Frame* Main results Indicators from a logical framework of the project

4.8 Evaluation question 5b

EQ5b Were activities undertaken to ensure the sustainability of the programme run satisfactorily?

The programme aimed at creating the building blocks of the regional and countries' IHR core capacities filling identified gaps. Country ownership was rather weak since the programme was mainly regional. Yet the regional coordination was not very effective in promoting MS' true participation and sharing of allocations, such as, e.g., co-funding. While SORMAS (Result area 4) was very active and performing well at the national level, the regional added value of other result areas was not fully perceived. SORMAS in Ghana was well-functioning but still piloted in a couple of regions. A plan to scale it up at the national level was elaborated by the MOH but is still embryonic. Programme management was perceived as very centralized with the country level not being fully aware or involved in decision making especially on budget allocation and priority setting. Technical Advisors were sometimes acting as country coordinators with very little, if any, involvement in budgeting and resource allocation. Some improvements were noted in 2022.

The regional level seems to be the main (unresolved) challenge: the RCSDC is fragile, its reputation variable (risk communication being an area of excellent performance and of clearly appreciated value for NCIs), and it is still understaffed. The recruitment freeze within ECOWAS has been ongoing since 2010. In 2020, ECOWAS underwent a staff skills audit which further blocked new recruitments and was also extended to WAHO and RCSDC. WAHO has turned to the ECOWAS Commission and the Council of Ministers for support in the full operationalization of the RCSDC. The response was reported to be negative. P5 positions and directors with managerial responsibilities are recruited by the heads of institutions and the president of the ECOWAS Commission. Based on the recommendations made by the programme, the commissioning parties have brought this topic up in negotiations with the ECOWAS Commission on multiple occasions since the establishment of the RCSDC. Under the current situation, the RCSDC technical sustainability is a challenge: being it a functional department of WAHO, it is included in the annual workplan elaborated by WAHO. The financial support to the RCSDC is therefore assured by the annual allocation of the Commission to WAHO and does not seem to be an issue. As an example, in 2020 workplan activities to sustain and promote the RCSDC have been listed and costed. The budget necessary for the activities has been clearly defined, as well as the source of funding. The partners' commitments have been identified; where there was no external support, WAHO allocated its funds, which for the Year 2020 amounted to 770,000 USD. The recruitment process of the RCSDC Executive Director as well as of technical Directors (Surveillance and Early Warning, Training and Research) is still ongoing, but at the time of this Report, an acting Executive Director was appointed by the new WAHO DG, who took service in September 2022.

A few challenges were identified in the reports and mitigation strategies designed and adopted by the programme management addressing especially the RCSDC operationalization. The direct support provided to MS by the programme, including advisors, did not promote the visibility and credibility of the regional entities entitled to interact with and improve, the national settings. In fact, the RCSDC was supposed to fulfil its mission in this respect but was too understaffed and under-dimensioned to act promptly and at the needed level. The programme had to mobilize resources and

SORMAS-open (Result 4). Capacity development activities were carried out with public health institutions in the ECOWAS region, specifically IRSP, to further ensure the programme induced results sustainability.
A key factor was the partners' engagement in programme design. A workshop was carried out in May 2018 with active participation of the ECOWAS Commission, WAHO, RCSDC and other stakeholders. The programme was further implemented by the ECOWAS Commission as the lead executing partner and WAHO and RCSDC as main implementers.

deliver technical assistance and training, while waiting for ECOWAS to remove obstacles. A second challenge was the inadequate stakeholders' coordination with poorly documented evidence of the integration of programmes and activities, especially within the Donors' community. Travel restrictions and delays due to the COVID-19 pandemic were partially resolved by the virtualization of events and training delivered whenever feasible. This contributed also to solving some of the issues raised on discrepancies in travel allowances, considering the high mobility of staff in the region.
Real-life assessment of capacities built on pandemic management allows drawing conclusions on the regional situation[72].
The regional and the national IHR core capacities were limited, but some positive developments were documented[73]. These weaknesses reflect the chronic poor financing of health systems, described as "an epidemic of weak public financing" because most MS still spend below their former Abuja commitment of 15% public revenues on health – thereby hindering the establishment of resilient health systems capable of adequately responding to epidemics[74].
In a nutshell, the EVAL team can conclude that the programme contributed to completing the IHR building blocks, filling areas that would have been otherwise neglected. The current availability of dedicated funds and competent staff is also encouraging full ownership by MS.

Given the selected modalities for implementation, a particularly important communication and visibility plan was designed[75] - as prescribed by the delegation agreement - addressing the ECOWAS

[72] Lokossu, V.K. et al: COVID-19 Pandemic Readiness Status of West Africa, Posted Date: July 27th, 2020 DOI: https://doi.org/10.21203/rs.3.rs-42172/v1

[73] Overall, there were established multisectoral response mechanisms for epidemics coordinated by national public health institutes in each MS. Except for Niger, the remaining 14 MS had national preparedness and response plans for public health emergencies that could manage respiratory diseases, and these plans were being adapted to include COVID-19. Additionally, four countries namely: Burkina Faso, Ghana, Liberia, and Mali had linked these plans for managing infectious disease to include securing the legal basis for quarantine and restriction of movement. Legislative processes were undertaken in Ghana to give the president additional powers to institute interventions as may be warranted for the control of the pandemic. Apart from Cabo Verde, each of the other 14 had a Public Health Emergency Operation Centre (EOC) managed by their respective Incident Management Systems (IMS) (Gambia was not functional due to unavailability of the information, and communication technology personnel to operate the installed equipment). In the wake of the COVID-19 outbreak, all national public health institutions held planning meetings involving the human, animal, and environmental sectors to create a common understanding of the COVID-19 outbreak. The MOH political leadership had also held multidisciplinary coordination meetings at the national and subnational levels with representations from other ministries and international partners, notably US CDC and WHO. Following recommendations from these meetings, governments from some MS had dedicated funds to support emergency response preparedness activities. In non-outbreak times, three MS (Cabo Verde, Liberia, and Togo) had no dedicated financial support for surveillance, preparedness, and response to emerging diseases. As said above, 13 MS had the in-country laboratory capacity to test. Mali had four accredited laboratories, Guinée (Conakry) had three, and Ghana had two. All MS had documented incident action plans. as already described. With the exceptions of Burkina Faso, Cabo Verde, and Liberia, the remaining 12 MS had pre-existing respiratory disease surveillance systems for influenza-like illnesses which they leveraged to establish their respective full surveillance systems. All MS had also a cadre of trained staff to manage detection, contact tracing, data management, case management, risk communication, and community engagement. Except for Ghana and Mali, all the other 13 MS had already included the private sector. In Ghana and Nigeria, SORMAS was updated and scaled up to cover at least 400 districts of over 85 million population. The Ghana Health Service and the RCSDC were supporting the scale-up of this updated version of SORMAS to enhance real-time case-based reporting and outbreak response management and assist with accurate mapping of cases and contacts for targeted and efficient deployment of field workers and needed response logistics and supplies. All 15 MS had functional NRRTs. Except for Niger and Cabo Verde, the 13 other MS had started training their RRTs on contact tracing and conducted simulation exercises on outbreak response using WHO protocols and tools. The NRRTs of all MS were multidisciplinary and included: epidemiologists, surveillance officers, public health practitioners, physicians, nurses, paramedics, veterinary doctors, biomedical scientists and technicians, environmental health officers, risk communicators, psychologists, and health administrators. All MS had trained professionals in risk communication and a coordination mechanism that involved relevant actors in risk communication. The list of partners, their contact details, roles, and responsibilities were available from their national incident action plans. The most significant gap was the lack of a risk communication and community engagement (RCCE) plan, as only five of the 15 MS (Benin, Ghana, Liberia, Mali, and Togo, notably mainly the programme beneficiary countries) had such plans. On operational readiness, EOCs are only partially functional though improvements have been evident. The conduct of surveillance and contact tracing are still largely paper-based.

[74] Otu A, Ebenso B, Labonte R, Yaya S. Tackling. COVID-19: Can the African continent play the long game? J Glob Health [Internet]. 2020 Apr 20 [cited 2020 Jun 19];10(1). Available from: http://www.jogh.org/documents/issue202001/jgh-10-010339.htm.

[75] The communication and visibility plan agreed upon in the DoA was designed to inform the beneficiaries and other stakeholders about the Action, its results and impacts, the role of the partners as well as EU's support and funding to the programme. GIZ RPPP is responsible for coordinating all communication and visibility activities with the ECOWAS Commission, WAHO, RCSDC, the Regional Animal Health Centre (RAHC) and other partners and beneficiaries, such as the NCIs and other public and private stakeholders involved in programme implementation. Activities implemented included the recruitment of an expert. During the inception three public launches were carried out: a. January 2019 in Bobo Dioulasso/Burkina Faso: Official launch of the Action during the partner forum with the presence of official authorities from Bobo, the EU and other partners with a press conference together with EU and WAHO and a press release to relevant media; b. February 2019 in Bruxelles, Belgium: Presentation of the new programme during an EU/DG DEVCO lunchtime conference entitled Ebola in West Africa: Health Security Challenges – 5 years later; c. an inception workshop took place on the 15th-16th April 2019 in Abuja/Nigeria, combining the official launch of the RPPP-EU programme with the operational planning 2019-2021 workshop with representatives of WAHO, ECOWAS Commission, RAHC and relevant development partners. A press release was communicated to relevant media. Information on the programme were published also on WAHO and GIZ websites. Information leaflets, factsheets, brochures, videos, were published and disseminated. in French and English. Materials for use in the workshop(s), such as folders, notebooks and pens in line with EU and GIZ visibility requirements were produced and distributed. Regular steering committee meetings were held. MS were informed through the WAHO partner forum: in May 2019, during the Assembly of Ministers of Health in Cotonou/Benin,

Commission, WAHO, RCSDC, RAHC, and other partners and beneficiaries, such as the NCIs, as well as other public and private stakeholders involved in the implementation of the programme activities financed by the EU. Besides several handover events, organized at the delivery of goods, eg, those procured during the COVID-19 emergency, including short videos[76], a few workshops were also organized at the launch of the programme and some of its components. Leaflets, factsheets, and similar media tools were disseminated also via social media to ensure visibility, including specific press releases at each main event and a regular newsletter published by the programme. There are also records of conferences (such as the Paris Peace Forum, 2020) and seminars, Partner Forums presentations, and studies (on SORMAS implementation in Nigeria and Ghana[77]). Other visibility materials, such as folders, stickers, notebooks, and pens were also produced and distributed widely. However, the EVAL team found no evidence of any assessments of the impact of this plan and some criticisms and doubts about its validity and full implementation were collected from interviewed stakeholders.

The specific focus on One Health is yet to be fully captured and translated into action despite the evidence of repeated outbreaks of infectious diseases of zoonotic origin. The programme's second phase will be based on a full One Health approach and address six focus MS (Burkina Faso, Guinea, Mali, Liberia, Sierra Leone, and Togo) and Nigeria and Ghana for SORMAS implementation, building on the achieved results and developed products. The EVAL team believes that the planned RPPP2 offers considerable potential for the continuation of the co-financing agreement if the EU contribution is integrated into the existing programme structure and output areas with tailored activities aiming at increasing coverage, improving quality and sustainability, and promoting objectives consistent with the Team Europe[78] strategy for the region. Added value may be achieved in supporting the full operationalization of the RCSDC, extending the digitalized surveillance and outbreak management tools at regional and MS levels, proposing twinnings and including focus MS in the wider EU-supported development agenda.

Finally, hackathons have been a very popular and well-designed initiative. However, the EVAL team found no evidence of follow-up or implementation of the winning proposals. The lack of dedicated resources was indicated as the main reason for this, suggesting that hackathons[79] may be more complex and requesting more resources than originally planned. A partnership with the national and international private sectors may help in translating ideas into concrete actions, fostering local startups.

JC 5b.1 - Measures are in place to ensure durability
Indicators Analysed *From the programme log frame* 2.1 Availability of a regional inter-institutional communication strategy considering One Health approach (including tools, processes, contents, actors)[80] 2.2 Number of NCIs with functional Emergency Operations Centre (EOC) 2.3 Number of successfully supported organisational development processes in WAHO/RCSDC

JC 5b.2The programme is designed in a way to leave capacities and structures behind, able to respond to eventual epidemics in ECOWAS area.
Indicators Analysed *From ET*

a presentation on the programme including the EU contribution was held. Notably a newsletter was established and regularly published and disseminated by the programme management.

[76] *Team Europe Supports West African States in the Fight Against COVID-19 - YouTube*

[77] *Results and lessons learned from the implementation of SORMAS in Nigeria and Ghana were presented in a regional technical meeting chaired by WAHO/RCSDC and attended by representatives of the NCIs of the 15 ECOWAS Member States on 31 August 2021*

[78] *https://europa.eu/capacity4dev/wbt-team-europe, accessed 21 October 2022.*

[79] *A complete description of the initiative is available at: Final Report on Hackathons and Mentorship Programmes in Liberia, Sierra Leone, Nigeria and Guinea, April 2020.*

[80] *Several documents and training initiatives were recorded, with a specific focus on Sierra Leone, with its One Health National emergency risk communication strategy. Training was also implemented, based on the One Health blended-learning course in the ECOWAS region, prepared by the GFA Consulting Group GmbH in December 2020. One Health was also addressed in the Development of blended learning courses in collab-oration with the Institut Régional de Santé Publique Report, GFA Consulting Group GmbH, June 2021. GFA contributed also in mapping the One Health and environmental main actors in the Region as well as in suggesting a dedicate One Health coordinating framework, and finally building an ECOWAS Regional One Health platform, with proposals for follow-up implementation (in: Final Report of a Technical Cooperation Module, by D. Bishop, 22.11.2021 (in particular Annex 3 and Annex 4).*

Activities undertaken by WAHO and NCIs to ensure sustainability[81]
Regional and national plans for ensuring the sustainability of Programme activities.

4.9 Evaluation question 6a

EQ6a How could a stronger coordination and complementarity of actions be envisaged in follow-up interventions of EU to support the RCDSC, WAHO and ECOWAS Member States? (From ToRs)

All consulted stakeholders confirmed the vital need to interact more with the international community in an attempt to prevent duplications (and competitions) between and among Donors, which is a possible challenge. This may need some corrections to improve WAHO's leadership role in convening partners in a credible format ensuring managed coordination and support for its new strategy's full implementation. A convergence of objectives and pooling of at least technical resources may be needed to achieve the best rapid results and promote the recruitment of experts and advisors from the ECOWAS region first, also by means of secondments from national and international bodies. Other Donors in the region focused on a range of IHR core capacities and supported the laboratory network, the national public health emergency preparedness and response plans, human resources development, surveillance systems, and coordination strategies. Risk communication was an orphan yet a fundamental area that the programme addressed, recognizing its importance and position within the IHR framework, based also on the past Ebola epidemic management experience. These arrangements would have justified intensified donor coordination that did not materialize, besides a virtual dialogue organized by USAID in its partner fora. Mapping of Donors' support and areas of collaboration may help WAHO in implementing efficient perspective coordination. The EVAL team is deeply concerned in noting that no clear and effective coordination mechanism seems to be active and no forum for high-level public health policy dialogue among Donors and between Donors and regional entities is apparently established. The EU is perfectly placed to address these issues and promote stronger and better coordination at the national and regional levels, as part of its new global strategy. The implementing partner should be aligned and supported operationally and on the day-by-day activities.

JC 6a.1 - Sufficient activities undertaken through RCDSC and WAHO EU to ensure stronger coordination and complementarity.
Indicators Analysed[82] *From the programme log frame* 2.1 Availability of a regional inter-institutional communication strategy considering One Health approach (including tools, processes, contents, actors) 2.2 Number of NCIs with functional Emergency Operations Centre (EOC) 2.3 Number of successfully supported organizational development processes in WAHO/RCSDC

[81] In terms of technical and political sustainability, WAHO Vision 2030 strategic plan indicates the following key priority axes, where n. 3 is based on the programme activities and achievements:

- *Axis 1: Healthcare and well-being. Facilitating access to affordable, safe, quality, and sustainable health services and improving utilisation of quality preventive, curative, and restorative health services.*
- *Axis 2: Health information and research. Advancing the public health practice, education, training, and research; through strengthening the health information system and research to produce, analyse, disseminate, and use reliable and timely information for decision making.*
- *Axis 3: Health security and emergency preparedness. Ensuring regional preparedness for health emergencies and prevention and management of epidemics by continuing to build on capacities and structures set up for the Ebola and COVID-19 response and improving on other aspects of the International Health Regulations (IHR).*
- *Axis 4: Leadership, governance, and resource mobilisation. Advocating for and promoting the adoption of strategic policy frameworks, combined with effective oversight and accountability; and to increase funding for health programmes.*
- *Axis 5: WAHO Institutional Capacity Strengthening (ICS) and organisational excellence: strengthening WAHO's institutional processes and promoting organisational excellence in effectiveness and efficiency, conducive work environment and culture, productivity, and delivery.*

The five cross-cutting themes of Gender; Climate change; Innovation; harmonization and coordination of policies and stakeholder engagement and networking; and sustainability are also based on the programme outputs (gender and one health in particular).

[82]See above.

JC 6a.2 – Lessons are learnt on strong and innovative modalities for coordination and complementarity
Indicators Analysed *From ET* Plans made by EUDs, ECOWAS member States, WAHO, NCIs and other counterparts on programme coordination and development of complementarity[83]

4.10 Evaluation question 7a

EQ7a To what extent did the funds mobilised by EU added (financial and non-financial) benefits to what would have resulted from GIZ/BMZ alone? (From ToRs)

The EU-added value was one of the basic issues considered as a Delegation Agreement modality was selected for funding and implementation. The integration of EU support into existing projects implemented by EU MS, such as France (initially) and Germany (throughout) is logically leading to added values if the project is consonant with the EU strategies and objectives, which is exactly the case for the programme under evaluation. The financial volume made available allowed the programme to extend its coverage and amplify its possible impact adding human and economic resources needed to support focus countries and the regional level. Additionally, the contribution was increased and very rapidly became operational providing other skills, equipment, and essential goods in support of the regional response to the pandemic to the extent that not only the initial programmatic objectives were largely achieved, but also the newly emerged challenges were addressed. The capacity of regional and national structures in the implementation of the IHR 2005 is reported to have significantly improved, though dysfunctional NCIs may still jeopardize effective collective pandemic preparedness and control unless better stakeholders' coordination and Donors' community integration are achieved with the regional leadership of WAHO and its RCSDC.
In the visited MS, the EVAL team found that the programme is mainly known as a GIZ bilateral programme. Neither UN, nor WHO, nor its partners seem to know exactly the modalities of EU participation and funding and what the activities supported by the EU are. In Ghana, no stickers with the EU logo were observed neither at the counterpart's level nor with private partners working on SORMAS extension. In Togo, a few stickers were noted in the boarding room equipped with the EU

[83] As an example, a few agreements were drawn to gain efficiency and ensure sustainability, such as: Result 1 contained a grant in the form of a grant agreement to conduct research on gender-sensitive risk communication. Result 1, 2 and 3 encompassed a consulting contract for capacity development and ICT related activities. Result 3 contained a MoU with the IRSP in Benin and Grant Agreement with 5 WHO country offices. Procurement of basic ICT equipment was ensured under the RPPP. Result 4 encompassed a grant agreement with HZI to support the roll out of SORMAS-open. Additionally, the programme was designed to complement other EC funded programmes and projects, such as: Burkina Faso, Guinea, Guinea Bissau, Niger, Nigeria, Sierra Leone, Mauritania received support from the 11th EDF in the field of health, with a focus on health system strengthening.The EU/LUX-WHO UHC Partnership, managed by DEVCO B4, offered expertise through the WHO country teams to support policy dialogue and coordination among health sector partners. The ECOWAS MS which benefitted from this partnership were Burkina Faso, Cape Verde, Guinea, Guinea Bissau, Liberia, Mali, Niger, Sierra Leone, Senegal, and Togo. At the Tokyo International Conference on Africa's Development "Universal health coverage in Africa: a framework for action", the WHO strategy for UHC fully endorsed health security as part of UHC. This underpinned the coherence between DEVCO support to health systems strengthening towards UHC and integrated approaches to health security. The EU project "Improved regional management of outbreaks in the CBRN Centres of Excellence Partner Countries of the African Atlantic Facade" proposed to improve preparedness and response to epidemics in countries belonging to the excellence Centre of the Atlantic coast. The geographical coverage from Morocco to Gabon included up to nine ECOWAS MS (Benin, Côte d'Ivoire, Gabon, Guinea, Liberia, Senegal, Sierra Leone, Togo, and most recently Nigeria). Moreover, OIE and its consortium partners (Centre de coopération International en Recherche Agronomique pour le Développement, Institut de Recherche pour le Développement, Institut Pasteur and its International Network) implemented the project "Capacity building and surveillance for Ebola Virus Disease (EVD) in Africa" funded by EU DEVCO C1. The project had a highly operational approach and aimed at improving local capacities to detect, control and respond to EVD, focusing on a One Health approach on animal health, with OIE sitting in the ECOWAS RCSDC Governing Board. Finally, the programme complemented other development partners' projects in the region being part of the extensive engagement of multinational and bilateral institutions aimed at improving disease prevention.The World Bank, US CDC, USAID, French development cooperation and the African Development Bank supported institution building in the IHR domain. US CDC provided extensive financial support and personnel input for disease surveillance and activities in diseasecontrol. USAID also provided financial support. The World Bank supported WAHO with US$ 300 million including a project to support the reporting system for infectious diseases, laboratories and furthertraining in field epidemiology. The WB-funded REDISSE project (Regional Disease Surveillance Systems Enhancement) started its operations in 2016 at regional level with WAHO and in 9 countries at national level, among them are Guinea, Sierra Leone, Liberia and Togo.
WHO supported the establishment of RCSDC at sectoral and coordination level with an inter-country task team. The newly established WHO emergency hub in Dakar was supporting emergency operations in the 15 ECOWAS MS, in collaboration with WAHO. French development cooperation (AFD) implemented RIPOST programme to support the network of national public health institutes and to strengthen WAHO's capacity to coordinate procedures. It worked with a bottom-up approach in six French speaking ECOWAS MS (Benin, Burkina Faso, Côte d'Ivoire, Guinea, Niger,Togo).

funds at the MOH Surveillance Programme. The EUDs were not involved in the programme development and implementation, apart from its formal launch. The health and/or social sector focal points did not know the respective country coordinator. GIZ tried to compile and disseminate newsletters describing the programme's activities and achievements. However, providing information did not promote full involvement. For instance, the Public Health Institutes' staff reported that if EUDs had been more involved they could have advocated much better for NCIs at the Ministry and ECOWAS level, preventing critical situations such as in Togo, where the NCI was never opened.

Almost all the interviewed stakeholders highlighted the need for better communication and improved visibility. A few respondents said they would have welcomed more intensive participation by local EUDs in the focus MS, and that the information on the programme may need some improvement especially in making clear what the scope of work is, who are the partners in the programme formulation and implementation, and what are the strategies to complement other Donors' projects. IEC activities also need improvement, though they were successful on average. A better communication plan may be formulated, and more EU visibility ensured by means of coherent messages and a sustained collaboration by EUDs in focus MS. The EVAL team feels that added value was provided but was not properly documented and improved with some degree of creativity and flexibility considering the changing environment of communicable diseases in the region.

JC 7a.1 - Relevant results that could not be achieved without EU Action.
Indicators Analysed *From ET* 2. Comparison of results achieved by the programme with BMZ Funds and with EU Funds

JC 7a.2 – Added value of EU funds is recognized by relevant stakeholders as making the difference
Indicators Analysed 1. Added value of EU Funds according to ECOWAS, WAHO, NCIs and other counterparts

4.11 Evaluation Question 8a

EQ8a To what extent is a contribution of the intervention already perceivable in mitigating the impact of COVID and Ebola outbreak in Guinea? (From ToRs)

The latest outbreak of Ebola in Guinea was declared on 14th February 2021, when 3 cases were identified in Gouécké, a village in N'zérékoré province, in the southeast of the country. As soon as the virus was confirmed, the EU's contribution was fundamental in mobilizing resources, providing rapid and effective assistance to patients, and containing the disease. EU partners with recognized expertise were already operational in N'zérékoré: the medical NGO ALIMA, GIZ, the French and Guinean Red Crosses, and Search for Common Ground.

The EU also provided a fast procurement and delivery of life-saving medical equipment from France, Germany, and Belgium through the European Union's Civil Protection Mechanism. This helped renovate the Gouécké Epidemic Treatment Centre, a critical resource in the outbreak clinical management.

This rapid reaction supported the immediate treatment of confirmed Ebola cases with new and more effective drugs, and the prevention of further transmission through personal protection kits and risk communication activities. Staff were well trained and capable to translate into action skills and experience addressed by SOPs[84] and guidelines that had been used to drive simulation activities on cross-border emergencies.

In contrast to 2014, when the response was slow to take hold, the national health authorities quickly implemented response measures with the support of national and international partners, drawing on expertise gained from the fight against recent epidemics in the country and in the Democratic

[84] *As addressed by the: Manuel de Procedures Operationnelles standard relatives a l'equipe nationale de reponse rapide aux urgences de sante publique, Juillet 2021, Ministère de la Santé, Agence National de sécurité sanitaire.*

Republic of the Congo, as well as from the improvements in the IHR core capacities promoted by several programmes in the region.
Responders immediately implemented infection prevention and control measures, strengthened epidemiological surveillance, and provided human and material resources for the treatment of patients. Because of rumors spreading through communities and social networks, many people did not believe in the resurgence of Ebola in N'zérékoré. A key aspect of the response was communication, based on a complex mix of media and semantics, such as dialogue sessions, educational talks, interactive broadcasts, home visits or participatory theatre - always respecting the barrier measures enacted by the health authorities[85]. In fact, a major change since 2016 has been an explosion in the use of mobile phones and people's access to the internet and social media. This has greatly facilitated communication among health professionals and with people. The youth was easily reached out with social media messages that had been tested while responding to COVID-19, and community initiatives were encouraged to curb the spread of coronavirus and debunk rumors about it[86]. In addition, Atingi, a BMZ-supported e-learning platform, was used to provide training also to the most remote health workforce and communities in the country.
Additional training included risk communication[87], training of the NRRT and training on communicable diseases' diagnosis and treatment as well as the development of a national response plan were all extremely useful.
On 19 June 2021, the Guinean MOH announced the end of the Ebola epidemic: 23 people had contracted the disease during the resurgence, of which 11 recovered.
The reasons for this clear containment success are various: there was a high degree of investment in health system strengthening and outbreak preparedness post-2016, at the community, prefecture and regional levels, including the establishment of a specialized centre to treat diseases with epidemic potential in N'zérékoré. The centre was supported by the programme in its functional role of subnational EOC[88]. Recent reports from the field highlight, however, that at many health centres both infrastructure and material resources are still lacking (e.g., water, buckets, disinfectant), IPC measures remain limited and the knowledge and competency levels of health staff regarding Ebola are varied. In addition, only a small number of alerts are being made, listing contacts and contact tracing are not comprehensive, and only a few laboratory tests are being conducted each day.
Despite these limitations, community participation was strengthened, and adequate communication led to true engagement, promoted thanks to the programme and its approach.
Attribution from local stakeholders valued the post-crisis action leading to WAHO strengthening and to the creation of the RCSDC commenting that it facilitated the early detection of disease outbreaks and boosted regional cooperation.
The emphasis on activities targeting people and made accessible to them, such as primarily risk and crisis communication, contributed to overcoming the challenges faced during the previous outbreak showing that risk assessment and proper communication contribute to changing behaviours in the affected population reducing the personal risk of infection and transmission.
During the 2014 Ebola epidemic, for example, not enough was done to explain measures such as "contact tracing" and to understand and consider the concerns, fears, culture, and practices of the local population. Proactive, forward-looking health risk and crisis communication are also vital because rumours and misinformation spread particularly rapidly in crisis situations.
Guinea's response to Ebola received strong support from international partners, and certain assets from that earlier epidemic are still available to strengthen the response to COVID-19. Another resource is the significant number of epidemiologists and laboratory technicians trained during Ebola who can also face the challenges of the COVID-19 pandemic. Further support to Guinea was granted by the programme[89] and via WHO, contracted with a specific project to improve human resources

---

[85] Detailed in: Elaboration des messages sur les maladies sous surveillance, Conakry, du 1er novembre au 15 décmbre 2020.
[86] Cartographie des médias en République de Guinée – Décembre 2020 contributed to identify media and media related mechanisms to promote debunking and the fight against fake news.
[87] Based on the: Plan Stratégique de Communication de Risques pour la République de la Guinée, Septembre 2021.
[88] Since 2019, when the Rapport d'evaluation du centre des operations d'urgence de sante publique de la Republique de Guinee, 19-24/08/ 2019 was drafted to guide further and targeted assistance
[89] Several activities were implemented: 1. La mise à jour du plan national de communication sur les risques en considération des éléments des droits de l'homme et du genre; 2. Séances de sensibilisation sur Ebola (émissions dans les médias, dans les médias de proximité (public et privé); 3. 100 professionnels de média sur la MVE à Conakry et à Nzerekor; 4. Révision du guide de mise en place et de fonctionnement des COU-SP déconcentrés; 5. Dissémination du guide révisé de mise en place et de fonctionnement des COU-SP déconcentrés; 6. Révision des Concepts des Opérations du COU-SP du niveau central (CONOPS); 7. Disséminiation des Concepts des Opérations révisés du COU-SP du niveau central (CONOPS); 8. Dotation des matériels de Visioconférence a la Direction Provinciale de

dedicated to preparedness and response[90]. Guinea managed to respond quickly and effectively even though it lags behind other MS in the region for UHC coverage and government investments in health (mitigated by complementary international contributions).
This situation suggests that the IHR capacities built during the Ebola and COVID-19 outbreaks have improved in a fragile health environment and may rapidly deteriorate unless they are sustained by a policy dialogue aiming at proposing a health care investment case to the political decision-makers to let them understand the value of preparedness and mitigation from one side but also the value of a proper PHC system where all the health system pillars are addressed by sufficient public financial resources.

JC 8a.1 - Positive lessons learned from Ebola together with RPPP project enhanced COVID-19 impact mitigation in Guinea.
From the programme Log Frame[91] 1.1 Availability of a gender-sensitive risk communication strategy by WAHO/RCSDC according to international standards, including the One Health approach and action and budget plan, SOPs 2.2 Number of NCIs with functional Emergency Operations Centre (EOC) 3.1 Number of functional RRRT out of which experts can be deployed on short notice 3.4 Number of functional NRRTs out of which experts can be deployed at short notice

5 CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

The programme is very well documented with a wealth of reports, technical and policy briefs, and a financial audit has cleared all financial issues at the time of this Report. There is an identified formal disconnect as the title is not representing the logframe, as already discussed above in the section on Evaluation Question 4a.
A certain degree of subjectivity was inevitable in the evaluation process, and therefore conclusions must be considered as indicative of areas for improvement: in general, visibility and coherence deserve much more attention in the future (with a better and more organized visibility plan and improved coordination with other Donors, while encouraging in-country collaboration with local EUDs

Sante (DPS) de Nzerekore; 9. Fourniture d'equipment pour le COUSP; 10. Formation de membres de l'INC sur l'utilisation de la platforme ECO-Suite de l'OOAS; 11. Manuel de procedure de l'equipe nationale d'intervention rapide; 12. Organisation d'un atelier de validation du manuel de procedure de l'equipe d'intervention rapide et Formation de l'equipe nationale d'intervention rapide; 13. Amelioration de la base de donnees de la ENIR, as presented in the Country Activity Plan, 2021.

[90] *Projet de preparation et la riposte a l'epidemie du COVID-19 en Guinee, préparé par OMS Guinee, 31 Octobre 2020.*

[91] *Support to the National Risk Communication Programme of the ANSS through the employment of 3 consultants to 1. elaborate a comprehensive map of the media in Guinea; 2. to develop messages on the priority diseases under surveillance; 3. to develop operational procedures for rumors management.*
The first document lists all the mass media operating in Guinea or which have an editorial line focused on Guinean news, providing a clear overview of the media as well as a database of journalists working on health subjects. The purpose of the second document is to provide the ANSS with messages on diseases with epidemic potential under surveillance, including priority zoonoses (Anthrax, Brucellosis, Dengue, Ebola virus disease, Yellow fever, Lassa fever, Rift Valley fever, Avian influenza, Rabies) identified in Guinea by the ANSS. A guide with simple, clear, easy to understand information addressing rural communities was produced. The third document describes ANSS operations, in respect of quality of standards, effectiveness and efficiency, impact and sustainability, in management of rumors, allowing ANSS to avoid panics during epidemics and better control communication. Digital communication in response to COVID-19 was strengthened through the publication of awareness-raising content; the design and development of a mobile application (available on Google play store and Apple store) called ANSS; the production and publication of 100 infographics on social networks; the sponsorship of 100 publications on social networks. Risk communication on EVD was enhanced by interactive radio transmissions in the affected areas and 50 media professionals were trained in Conakry and Nzérékoré regions around key concepts and terminology related to EVD and gained a better understanding of the role of media coverage during public health emergencies.
Laptop computers (procured through HQ) and videoconference equipment (locally purchased) have been donated to the EOC that was also equipped with basic furniture: and a videoconference equipment for the Regional Health Direction (DRS) of Nzérékoré. A National Rapid Response Team was established with the ANSS and SOPs drafted and adopted. 10,000 locally produced masks were distributed to protect people from COVID-19 and community awareness-raising against COVID-19 conducted through the production and dissemination of audio and video messages developed (in French and the local languages of Kissi, Guerzé, Toma, Mano, Kono, Koniagui and Malinke), validated and broadcasted for 30 days. The audio and video messages have been followed by a 1-hour interactive programme. 81 health workers from the five country's regions on COVID-19 intensive care, 120 religious leaders (8 sessions) and 30 journalists (2 sessions) in 5 municipalities of the capital and the urban municipality of Kindia were trained with 100 members of the Prefectural Epidemic Alert and Response Teams (EPARE) through workshops organized on the 3rd edition of Integrated Disease Surveillance and Response (IDSR) guide. Through 4-day training sessions a total of 100 health workers were also trained in IPC.

and with other ongoing projects), efficiency has some potential for improvement (especially on WAHO's procurement and supply chain that may need specific support by the programme), the impact will be assessed with time but it seems quite promising and the Evaluation Questions section has highlighted how, e.g., Guinea was enabled to manage very appropriately an EVD recrudescence. Relevance is confirmed very high, with an acceptable degree of effectiveness and a fairly good sustainability trend. This trend must be considered in light of findings presented in the Evaluation Questions section, where a more complete analysis is discussed on its several dimensions, looking at this crucial area from technical, to political, financial, and cultural angles: the programme may not be financially sustainable at the current pace, but there are recovery strategies that should be explored and implemented within a detailed and urgent handover plan including a thorough cost-benefit analysis for the policy-makers.

The key conclusions of the bilateral component evaluation were substantially similar:

- *Relevance: very good alignment with stakeholders` policies and strategies.*
- *Coherence: good synergy with other international and regional initiatives.*
- *Effectiveness: module supported WAHO in assisting countries with disease control mechanisms.*
- *Impact: ECOWAS countries improved disease control, but challenges are still present.*
- *Efficiency: balanced distribution of funds, but not all products are being used by beneficiaries.*
- *Sustainability: capacity of partners still needs to be improved.*

The evaluation considered three different perspectives: questions addressed to stakeholders who were requested to compile the questionnaire presented in Annex 11; the results of a thorough desk review of all documents reported in the evaluation questions section and in Annex 10; the EVAL team's judgement that included the quantitative review of available data, presented in Annex 8. Spider graphs were elaborated for each evaluation dimension, comparing the bilateral evaluation results, kindly provided in a draft format by Heidelberg University's colleagues. The following global spider graphs illustrate how the EVAL team assessed each dimension based on a scoring system and the triangulation of sources. Subcomponents were also considered, analyzed and scored. Detailed analysis is offered in Annex 3. A comparison with the bilateral scores is given with some differences due to different methodological approaches and calculations.

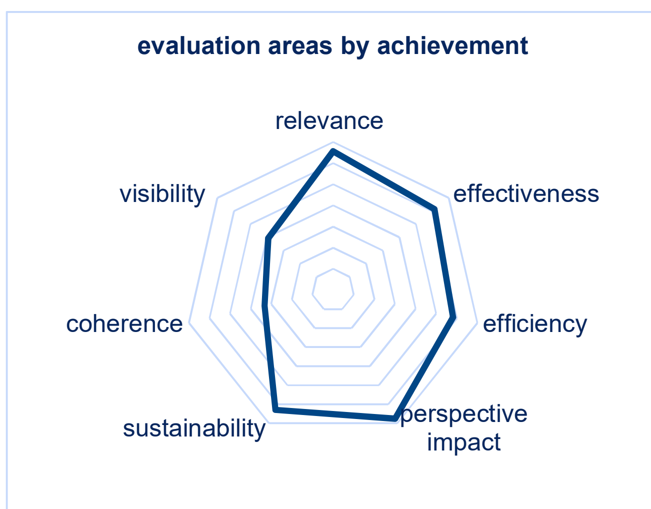


Figure 9 Spider diagram of DAC evaluation dimensions (EU contribution)

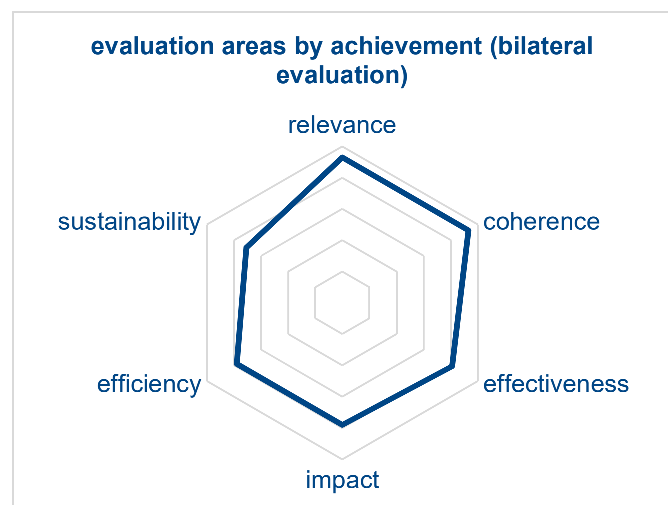


Figure 8 Spider diagram of DAC evaluation dimensions (bilateral programme)

5.1.1 Conclusion 1 (EQ 1a): Relevance

All reports, indicators, and evidence reviewed by the EVAL team converged into a very positive assessment of this dimension and of the EU-chosen modality to support via a contribution agreement. The programme addressed fundamental issues in a proper way and format, being its objectives essential for the region and the MS. The programme was designed in line with and contributed to, the achievement of SDG3, “good health and well-being”. It aimed at four result areas (coordination, risk communication, human resources, and surveillance capacities) which are among the essential IHR core capacities enabling MS to manage public health emergencies of international concern (PHEIC). Those capacities had not been addressed by other Donors, apart from surveillance, but not at the level of the advanced digital approach proposed by SORMAS.

The risk communication result area was a key pre-condition for all the others and was successfully implemented as documented extensively.

Based on the evidence collected and analysis performed, the programme relevance is confirmed. However, overall, the strengths of pandemic readiness of the region were estimated as follows: the capacity to test 86.7% (13/15) of MS; functional incident management systems (100%); rapid response teams 100%, and at least two of the three tiers of field epidemiology workforce (100%). None of the member states had stockpiles of COVID-19 test kits, laboratory supplies, and personal protective equipment: therefore, the programme may consider supporting WAHO and the RCSDC in this crucial aspect of preparedness[92].

The programme assisted WAHO, RCSDC, and the NCIs in developing their human resources with variable success already described. There are also other marginal issues related to additional IHR core capacities that the new programme may like to address, such as cross-country coordination and viable triggers leading to the release of the emergency fund currently with WAHO, coordination with border MS not belonging to ECOWAS, improvement of border surveillance. Minor criticisms concern a rather rigid organization with some difficulties in identifying the final beneficiaries among the most vulnerable, with a monitoring and evaluation procedure that can be improved. A specific set of technical skills in preparedness and response in the region were built for the scope and can now be scaled up if properly linked to other EU or German-funded projects or to other Donors’ support (especially the World Bank REDISSE and the French activities to promote community-based surveillance, that is complementary to the programme.

One Health dimension is still only occasionally addressed: a few activities have been documented, but a true shift in the approach, including normative support, may be needed, strengthening the proposed ECOWAS regional platform. The UN quadripartite agreement may offer a proper reference for a solid investment in generating a comprehensive, feasible, concrete, and sustainable action plan. The same approach may be considered to address risks of climate change aggravating the invisible but large population moving in the region towards the central Mediterranean area[93]. This is already a huge political and humanitarian problem that cannot be neglected also for its intrinsic health hazards for both the receiving communities and the mobile groups. There is a concrete risk that they are exposed to and carry, serious diseases as they usually escape vaccination campaigns and routine vaccination schedules as they are invisible. IDPs in the region are another population group at high risk that the programme may like to address[94]while recognizing the challenge.

The successful response to COVID-19 has confirmed the programme's validity and highlighted the need to abide by the regional standards in the different dimensions of IHR that the programme has contributed to establishing. In general, it can be said that once all the MS have achieved the same level of capacities and the existing volumes of human capital are improved and increased to meet

---

[92] *Lokossu, V. K., et al.: COVID-19 pandemic in Economic Community of West African States (ECOWAS) region: implication for capacity strengthening at Point of Entry. Pan Afr Med J. 2021 May 25;39:67. doi: 10.11604/pamj.2021.39.67.29089. PMID: 34422190; PMCID: PMC8363963.*

[93]*https://parl.ecowas.int/5618866-internally-displaced-persons-in-the-ecowas-region-in-2022/ and https://egrisstats.org/workshop/ecowas-statafric-egriss-workshop-series/*

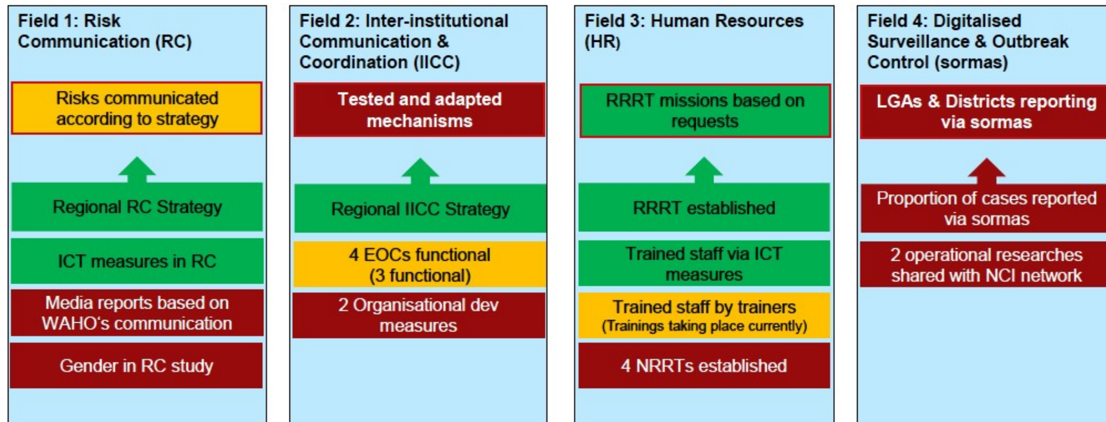
[94]*Based also on previous actions, such as: https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/1_21.%20IPC%20support%20to%20West%20Africa.pdf ; https://story.internal-displacement.org/2022-mid-year-update/index.html, and current programmes, mainly managed by the IOM: https://publications.iom.int/system/files/pdf/ecowas_region.pdf; https://publications.iom.int/system/files/pdf/iom_ecowas_guidelines_2018.pdf*

minimum standards, the entire region will be fully equipped and capable to manage similar emergencies.

5.1.2 Conclusion 2 (EQ 2a, 2b): Effectiveness

The programme achieved progressively (and this should be noted as it confirms the credibility of reports and other papers generated by the programme) the targets identified in the logframe and was able to regain momentum after the closures imposed by the pandemic, basically leaving behind only the (critical) reorganization of the RCSDC (Fig. 10a, b, c):

Figure 10a RCSDC November 2019



Green: completed / Yellow: almost completed / Red: not completed, in progress

Figure 11b March 2021

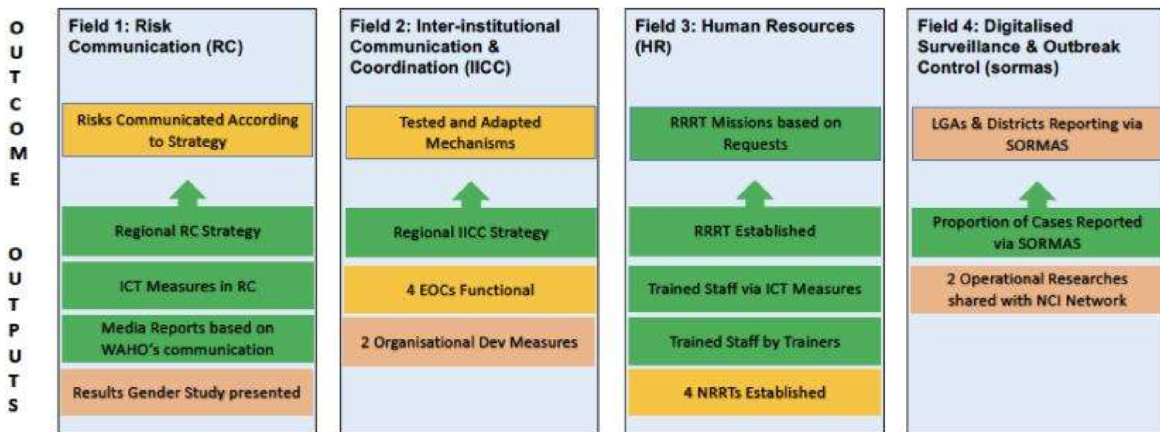
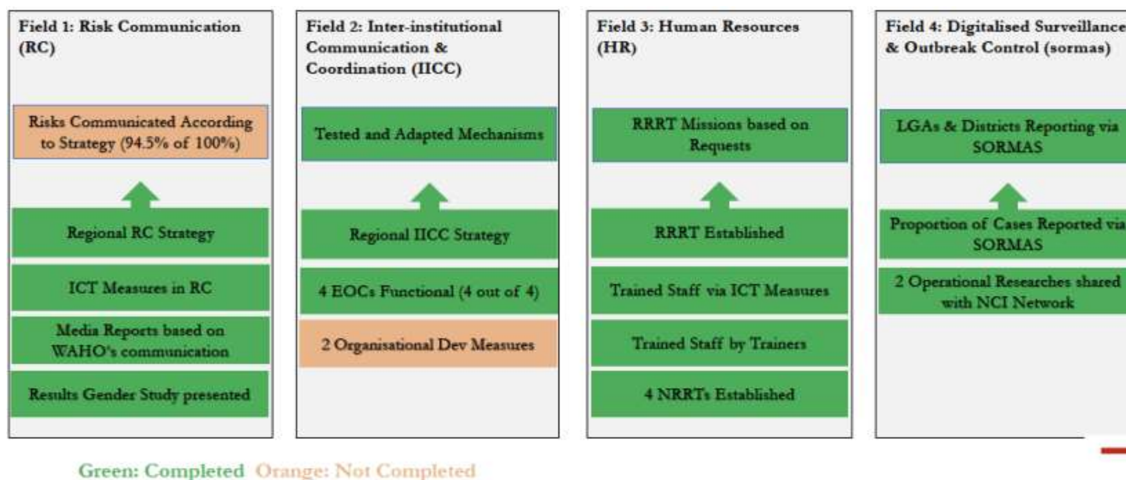


Figure 12c November 2021



The programme acted in four focus countries, following the extension of SORMAS coverage in an additional two, with staff based in six countries (Nigeria with the RCSDC; Burkina Faso with WAHO headquarters; and the four focus countries). There were clearly different interests, different resources, background experiences (on the Ebola outbreak for instance), and levels of development, demography, and epidemiology. Strategies had to adapt to local settings and the programme was successfully showing the needed flexibility in identifying the NCIs as the key players to ensure at least interinstitutional coordination. Focusing on local entities at the right level benefitting of equivalent SOPs and sharing training opportunities facilitated the building of what can easily become an active regional community of practice, as observed during the COVID-19 pandemic.
Once the RCSDC capacity is fully structured, coordination will be further facilitated as shown, e.g., in Result area 1, with RC procedures, techniques, and technologies being fully captured by all MS and extensively and successfully practiced during the outbreak with the RCSDC support: that model should be expanded to cover other IHR core capacities, investing substantially on digital communication platforms.
Donors did not play a major role in strengthening institutional communication, each one focusing on their areas of work, without an entrusted regional body capable to promote full coordination and complementarity of efforts. WHO's role was appreciated in conducting extensive training at the country level, but their potential coordinating role in the health sector is still to be fully exploited[95].

Much was achieved in the risk communication area and in intra-country coordination, with NCIs being now strong and acknowledged leader with competent (trained) staff. Some frictions have been reported between EOCs and their MOH as reciprocal roles are not always well defined and clarified. Inter-country coordination seems to have improved only recently and partially, with the development/update and partial implementation of COVID-19 contingency plans in 5 MS (focus countries and Nigeria).

When considering the overall programme design, some better degree of local staff participation and empowerment may be promoted in the next phase, possibly building on those professionals already trained whose skills may be used more extensively, especially at the regional level. The only partial building of the RCSDC capability and the limited use of the ECO-Suite platform, two of the more impactful programme's planned results, stimulate some questions on the extent to which ECOWAS decision-makers were informed, aware, and supportive of the implicit reforms linked to a fully functional RCSDC, and whether were all the staff at each level (from regional to subnational) aware of the platform contents and access modalities there is no evidence that they were involved in the identification of contents and support materials needed to assist them in their daily practice.

[95] *A joint programme – World Bank manual for RRRT, an occasional involvement of Public Health England in M&E activities, and the WHO grant agreement for COVID-19 emergency provide evidence of scarce level of collaboration among Donors, as they are the only quoted areas of collaborative work identified.*

WAHO was supported in their mission to assist countries in designing and implementing disease control strategies compliant with the IHR. Assistance was given directly to NCIs of focus countries (Liberia, Guinea, Sierra Leone, and Togo) and to “SORMAS countries” (Nigeria and Ghana), to strengthen their capacities to cope with outbreaks: some issues on the balance between providing direct assistance or strengthening WAHO (and the RCSDC) capacities to interact with the NCIs may be further discussed[96].
Regional Rapid Response Teams (RRRTs) need to be reviewed and repositioned as their actual utilization was poor, possibly linked also to the insufficient utilization of ECO-Suite and other regional tools available on demand. Better awareness and especially a reignited RCSDC credibility will help ensure a proper flow of assistance and support to MS, as witnessed during the early days of the COVID-19 pandemic.

5.1.3 Conclusion 3 (EQ 3a, 4a, 4b): Efficiency

The EVAL team felt that promoting solid coordination of all the partners targeting different projects and adopting GHSI or JEE indicators, as appropriate, may allow WAHO to act as the regional leader providing the needed level of capacity also to the MS’ level. The programme may become the regional catalyzer for the entire set of IHR-related activities, coherently with the logic driving the programme strategy and extending its potential impact into other IHR core capacities. This can only be achieved by means of a drastic reorientation of priorities towards a full One Health approach.

Efforts should be coordinated with all other Donors and initiatives in the sector and Donors’ coordination and a standing committee established. It is very difficult to justify one individual programme considered in isolation from all the others providing support to the entire set of functions and capacities needed to enable the regional and national level to act effectively to prevent, detect, and respond to complex emergencies.

In particular, the World Bank, the US CDC, the USAID, ACDC, the bilateral programmes implemented in individual MS should converge to ensure added value and prevent duplications or unnecessary competition. WHO’s role as the usual chair of the health sector cluster in MS may serve as the point of reference for information sharing and support to MS authorities to reorient potential duplications in a managed environment. Forming a Donors’ committee chaired by WAHO with WHO or ACDC acting as a secretary at the regional level may also facilitate similar activities at the MS level. The future programme may want to invest in promoting and assisting this apparently neglected activity. In this way the programme has the potential to engage in and advocate for, a political and technical dialogue given its regional approach with the possibility to strengthen ECOWAS and WAHO’s roles.

Increased efficiency may also be gained by relying more on regional and national consultants and experts, beyond their inclusion in the NRRT and RRRT databases. They can be mobilized quickly; they have the experience and contextual knowledge which may be required to be able to act fast and effectively. They may ensure continuity and contribute to sustaining results achieved. Investing in their skills and developing their abilities will contribute to strengthening the human capital in the Region and retaining competent experts that may otherwise be attracted elsewhere.

Monitoring is an essential component to ensure and promote efficiency. It has to be based on specific and explicit time-sensitive indicators and a mid-term review exercise implemented for at least two reasons: the programme complexity and the programme magnitude and ambitions. A ROM system is worth establishing, possibly considering also the available manuals related to the IHR core

[96] *The programme management apparently opted for efficiency and the need to perform within the Donors’ prescribed timetables, rather than for the slow process of institution building (in particular with the RCSDC) and creating the two entities’ capacity to perform optimally. WAHO’s strategies on risk communication and coordination and communication, as well as related SOPs and other tools were successfully delivered, and their quality appreciated. 7000 people at regional (WAHO and RCSDC staff), national, and subnational levels were trained in different IHR topics. In Nigeria and Ghana, more than 7000 users (national and subnational health staff) are reported to be connected to SORMAS.*

capacities compliance[97] beside the usual EC instructions[98]. The ROM exercise may be jointly conducted with the German bilateral team of monitors and evaluators in order to achieve better coordination and possibly a joint assessment and joint conclusions, although it is appreciated that different methodologies and criteria may need to be applied for the two components and their expected synergistic activities.
Management in all its dimension is assessed as good and efficient, though its full alignment with the regional entities' mission can be improved. Information on implementation steps (and procurement in particular) should be better shared and communicated timely to all interlocutors and stakeholders at the regional as well as at the national level, most likely to prevent speculative expectations and promote ownership and participation. A positive note is on the EU inputs, provided according to plans.

Monitoring is again subject to improvement and no side effects (either positive or negative) were retrieved, indicating that the process was plane, understandable, and efficiently operated, but creativity was limited. The allocation of funds by result area (Tab. 10) is relatively balanced, with an apparent excess cost in result area 3, due mainly to consultancies related to the extensive training provided. In the future, this budget may be better invested locally, facilitating twinnings between EU-based academies and ECOWAS-based universities and training institutions. SORMAS confirms being rather expensive and may need to be considered separately at least from the financing viewpoint and with a perspective of financial sustainability that can be gained in different ways.

Result area 1	Result area 2	Result area 3 (mainly GFA trainings consultancy)	Result area 4	COVID-19 Intervention[99]
808.893,85	841.430,06	1.155.635,32	1.067.318,99	801.324,88

Table 8 Budget allocation by result area

A question raised by the EVAL team and addressed also by the bilateral programme evaluation team is the missing information on how much and how well procured goods and provided training were used by end beneficiaries. The main examples are the RRRT's poor performance, as it was not requested by MS and was prevented to act due to border closures and cessation of airline operations, and the evidence of insufficient use of the ECO-Suite, besides the programme capacity to reshape action and related indicators in consideration of the EU extra-funding to support COVID-19 emergency response that should have been considered and improved timely.

5.1.4 Conclusion 4 (EQ 5a, 5b): Sustainability

NCIs, WAHO and RCSDC's capacities must be further strengthened to increase their technical sustainability and organizational credibility. The programme invested massively in the improvement and scaling up of competent regional and national human capital, particularly with intensive training in risk communication and interinstitutional communication and coordination. All the interviewed stakeholders and staff reported (and evidence from desk review confirms) good ownership of the programme-supported strategies on risk communication, communication, and coordination, and SORMAS. These results are likely to last over time. RCSDC, the unfinished programme component, seems now ready to take off: the new WAHO DG has already appointed an executive director a.i and recruitment of other key profiles may start soon[100].
More emphasis on advocacy is needed with the aim at improving visibility and political support by ECOWAS and MS. Disbursement conditionalities in relation to meeting RCSDC staffing standards may help. GIZ has replaced the regional entities in providing relevant and to some extent excellent quality services, but this was at the detriment of the RCSDC technical sustainability and technical

[97] http://apps.who.int/iris/bitstream/10665/84933/1/WHO_HSE_GCR_2013.2_eng.pdf
[98] It is probably worth revitalizing manuals prepared for the REACT programme, managed by GIZ and funded by the EC a few years ago: https://webgate.ec.europa.eu/chafea_pdb/assets/files/pdb/2007211/2007211_react_wp_6_toolkit_for_ihr_implementation.pd f
[99] Residual funds for COVID-19 interventions were about 3,4 M €, reported to be caused by delayed procurement.
[100] The implication is that the RCSDC will have to host, populate, and implement the ECO-Suite as a working tool and receive delegated authority over the 2 million USD emergency fund created at the ECOWAS level and currently managed by WAHO.

and political credibility. Furthermore, this direct assistance modality cannot last for longer periods of time and should be promptly replaced by the deployment of indigenous talents from throughout the region.
ECO-Suite utilization can be scaled up quickly if the platform is properly populated and capable to channel One Health issues as a new area of work. A survey among potential users may help identify priorities and customize services, while keeping a Q&A section permanently open to offer experts' solutions and assistance to end users, exploiting the power of digitalization (and possibly providing second opinions by peers and by the regional level to support national decision-makers). A good reference for relevant content is the ECDC website (offering true European added value to the programme), but also the ACDC and WAHO's websites are full of potentially useful content that need to be reoriented to become accessible services for the MS institutions and their health personnel.
Creating a community of practice may be supported by information, news, educational opportunities, links to other websites, such as WHO and WHO Academy[101], the World Bank, the UNU[102], and others providing guidelines and manuals in support of implementation and capacity building. One specific function may become an NCIs' peer accreditation process based on the JEE procedures[103]. Peers may become part of the RRRT that can be mobilized not only for emergency and rapid response actions but also for preparedness and system-building activities during peace times. Should WAHO be willing and capable to embark on such a process, NCIs may also be subcontracted to elaborate on their areas of good performance ('stories from the field', 'tales of good practices'' or similar) in a peer-managed environment that may stimulate a more intensive and rewarding use of the ECO-Suite platform and a truly collaborative climate.

SORMAS is currently implemented at a cost, and the e-ecology of different MS may not facilitate its scaling up. Therefore, a massive investment may be needed to improve the e-communication infrastructure, e-services and digital opportunities, also for data collection and interoperable regional surveillance and reporting systems. Strengthening this may also contribute to decreasing the need for labor-intensive activities at poorly staffed entities (such as the RCSDC) and improve their penetration and coverage. A better and more consistent investment in the interoperability of systems, rather than focusing on single platform solutions, may also be promoted, setting a minimum standard for accreditation (benchmark being SORMAS).

Financial and managerial sustainability will need to be addressed in the new programme to better prepare for handover when international assistance expires. The programme may like to consider moving immediately into setting a specific plan promoting early ownership and handing over the relevant responsibilities to the revitalized RCSDC and to the NCIs. This may take time and may need dedicated resources to build managerial (and not only technical) skills possibly based on the stakeholders' participation as prime actors and not as mere beneficiaries. ECOWAS MS seem to be now quite engaged in pandemic preparedness and response and are improving their technical skills and capacities as documented by the programme. Therefore, NCIs, WAHO and RCSDC's roles need to be further strengthened to increase the sustainability of the developed strategies and the actual effectiveness of generated SOPs. The programme has massively contributed to strengthening human resources, with robust training in risk communication and communication and coordination. However, the essential RCSDC institution-building activities were not as successful: the programme may consider acting more on governance and leadership and prepare managers, not only technicians, for the final handover. Managers can be supported by EU universities and local academic entities in building their skills and credibility. Strategies of risk communication and communication and coordination, and the SORMAS component and activities are well nested and have proved to generate behavior changes and changes in organizations at the national and possibly subnational level. IT solutions developed by the programme (ECO-Suite platform, hackathons), operationalization of SOPs, and the RRRTs may not survive the programme unless specific plans are designed and implemented for their support and handover as appropriate.

[101] *https://cdn.who.int and https://openwho.org*
[102] *https://unu.edu/*
[103] *https://www.who.int/emergencies/operations/international-health-regulations-monitoring-evaluation-framework/joint-external-evaluations*

5.1.5 Conclusion 5 (EQ 6a): Coherence

There is a clear need to interact more with the international community in an attempt to prevent duplications (and competitions) between and among Donors that the EVAL team identified as a possible – though not too serious – risk. This may need some corrections to improve WAHO's leadership role in convening partners in a credible format ensuring managed coordination and support for its new strategy's full implementation.

The EU is perfectly placed to engage the regional entities as well as the Donors' community in a high-level policy dialogue addressing the entire IHR ecosystem, while directly supporting some priority areas with a clear institution-building perspective. It will be essential that the various EUDs involved in each MS coordinate their efforts and move with inbuilt coherence, while predicating coordination and joint action to all the other international partners. The leading EUD (Nigeria) may like to promote a specific function in WAHO and the RCSDC aiming at facilitating a Donors' standing committee and a partnership forum with dedicated resources.

Other aspects of coherence relate to the clarity of roles and positions of each stakeholder. As said, institution building is complex and takes time. However, the speed of action required in times of outbreak indicates the opportunity to move with a governance model that can be progressively improved with time and experience if full flexibility is allowed. Stronger collaboration between the EUD and the implementing partners may be achieved also in addressing the emergency-development nexus and promoting a full One Health Approach, whose multisectorality is a challenge in itself.

5.1.6 Conclusion 6 (EQ 7a) Visibility and EU added value

Almost all the documents analyzed by the EVAL team highlighted the need for better communication and improved visibility aiming not only at filling a contractual obligation but also at setting an advocacy campaign in favor of the programme and its results, bearing in mind the need to protect the RCSDC organizational development and role promotion. Continuous political support is needed and can only be achieved by a sustained advocacy strategy.

More intensive participation by local EUDs in the focus MS would have been a true added value. The information on the programme may need some improvement especially in making clear what the scope of work is, who are the partners in the programme formulation and implementation, and what are the strategies to complement other Donors' projects. IEC activities also need improvement, though they were successful on average. A better communication plan may be formulated, including policy briefs for political decision-makers and more EU visibility ensured by means of coherent messages and a more productive collaboration by EUDs in focus MS. The EVAL team identified several opportunities for visibility while conducting the desk review and interviewing stakeholders, but they were not part of a credible and high-level plan to promote the programme at all levels. This may need more than deploying one consultant, but rather a robust procedure and dedicated time and resources. Some improvements were noted at the end of the programme, with a very clear and attractively designed newsletter that should have been circulated extensively via any media, including social, targeting politicians and parliamentarians.

5.1.7 Conclusion 7 (EQ 8a) Perspective impact

This section is to be read in conjunction with Annex 8 on quantitative evidence of results during the pandemic (years 2019-2020). In general, the programme managed to achieve what it aimed at, but there were some areas for improvement that may be considered during the next phase. It is well understood that true impact can only be achieved with time and with a constant dedication to strengthening weak health systems in the region beyond the specific issues related to the IHR, epidemic preparedness, and health security in general. The identification of vulnerable and fragile groups and communities may be improved, and better targeting can contribute to increasing the programme's impact on those who are at the highest need. Now that the system pillars have been duly built in the region and the focus MS, the next phase may be dedicated to achieving a substantial impact on the preparedness and mitigation capacities and eventually on the relevant epidemiological profile of the beneficiary MS. Specific and results-oriented indicators are needed to ensure that

impact is measured and quantified given the new time and financial frames of the second phase. The ECOWAS MS are now implementing prevention and control measures under constant outbreak threats. Since the programme's inception, three PHEICs were registered in the area: the vaccine-derived poliovirus infection in Nigeria, the COVID-19 pandemic, and the recent Monkeypox (July 2022) affecting multiple MS, besides an EVD resurgence. The programme contributed to an improvement of disease control mechanisms with better surveillance, increasing SORMAS coverage in Nigeria and Ghana to monitor 220 million people. The risk communication improvement is a clear success and should be considered a positive best practice. However, WAHO's advisory capacities (and RCSDC's assistance to MS) are still weak due to internal challenges that seem now ready to be overcome. This becomes crucial when devising the new programme logframe as specific indicators are needed and a proper monitoring system installed to alert all partners in case of persistent failure.

5.2 Recommendations

5.2.1 To ECOWAS

1. RCSDC may expand its human capital also by accepting advisers from USAID (two already in place), USCDC, ACDC (one in place) and GIZ. RCSDC may also support the RRRT's pool and the ECOWAS repositioning strategy to balance expertise in individual MS (eg, veterinarians, aiming at One Health strategy implementation, and other needed and rare professionals). Positions, rather than individuals, may be funded. Ensuring two-year rotations of national staff on secondment, with basic salary paid by sending institution and benefits paid by WAHO may contribute to overcoming current challenges. This may also allow for institution building throughout the region, keeping a regional identity, and building a network and a community of practice based on qualified national experts.
2. Legislation that allows moving authority and chain of command to the regional level in case of cross-boundary emergencies due to communicable diseases may be studied and eventually proposed to MS for endorsement: this may imply, but not be restricted to, bulk procurement and coordinated distribution of essential medical equipment from designated ports.
3. Engage in a high-level dialogue with the EUD and with the Donors' community to identify epidemic risks and mobilize resources needed for preparedness in peaceful times.
4. Ensure full and continuous political support to the initiative and promote the adoption of simplified bureaucracy and decision-making procedures, incompatible with emergency and outbreak situations.

5.2.2 To WAHO (and RCSDC)

1. Staff turnover at NCIs was high and rightly identified as a critical vulnerability. One possible mitigation strategy may be a series of workshops for all national coordinators and partners at the national and regional level organized by WAHO/RCSDC with the programme's support aiming at pro-actively promoting coordination and identifying the set of indicators assigned to each implementing agency to report to WAHO/RCSDC quarterly.
2. A regional forum may be established with the participation of all the sectors involved in the development of One Health strategy to map and identify available human resources: academies to increase the number of veterinarians and qualified environmental professionals and to adopt a contingency plan to establish specific curricula and fast track training for veterinarian assistants to progress towards full degrees, once recruited and deployed in the system. Fast tracks aim at filling gaps quickly with qualified intermediate staff that may be granted academic and

professional career development subsequently as seen for human health professionals in many countries.

3. Create and lead a Donors' standing committee on epidemic preparedness and response. If meeting at least quarterly, this may prevent duplications, increase the budgetary space, ensure capable and skilled human resources are properly deployed and the RRRT is staffed also with available international experts, increasing its credibility with MS. Ensure WHO's coordinated support as a standing secretariat for the health and security sectors at MS level. Keep and circulate notes and decisions to all members and beyond, via the ECO-Suite and regional websites.
4. Establish a transparent and quantitative trigger mechanism to release the epidemic emergency fund and move its management to the RCSDC level for quick disbursement.
5. Strengthen the procurement and logistic capacities to ensure the availability of skilled human resources, overcoming unnecessary bureaucracy, enabling the rapid mobilization of resources in case of emergency and build a regional stockpiling capacity of essential protective equipment.
6. Additional IHR core capacities may be addressed, such as cross-country coordination, coordination with border MS not belonging to ECOWAS, and improvement of border surveillance.
7. Intensify simulation exercises involving also international partners and partners from different countries and outside the region. This may be done using the SORMAS database and algorithms, modelling outbreaks of different nature.
8. Invite politicians and decision-makers from the regional and the national level to participate actively in simulation exercises, that should cover cross-border activities within the region and between the region MS and external MS, as well as national settings.

5.2.3 To MS

1. NCDC: focus on SORMAS, approach Microsoft or other international companies providing technical support through a wider community of practice.
2. NCDC: elaborate a business plan to attract Donors and ensure financial support (possibly developing a start-up or a company if the business environment is mature).
3. All MS: consider cost-sharing and co-funding of a rota system to ensure staffing of the RCSDC with qualified national personnel.
4. Design and organize simulation exercises and review systematically the national capacity by means of realistic self-assessments as prescribed by WHO.
5. Track, review and amend if necessary relevant legislative actions in support of preparedness and response, and coherently with the regional efforts and responsibilities.
6. Build a stockpiling capacity at the national level for essential equipment to mitigate outbreaks.

5.2.4 To the EUD

1. Include a Mid Term Review (ROM) to identify implementation challenges and suggest timely amendments and reorientation when needed.
2. Clear and monitor closely the communication and visibility plan proposed by the implementing agency before adoption and participate in its implementation.
3. Focus on SORMAS improvement and distribution in MS and provide a specific dedicated budget based on a comprehensive business plan.

4. Ensure the active involvement of all EUDs in each focus MS and ensure that the programme is duly advocated for at the national level. Sub agreements at national level between EUD, GIZ and line Ministries would help in this sense.
5. Liaise with other major Donors in the sector, such as the World Bank, the AfDB, USAID as well as with technical agencies, such as WHO, UNICEF, USCDC, ACDC focusing on complementarity of the programme plans and activities and on mutual strengthening, possibly reinforcing WHAO's convening power to manage a better-organized Donors' committee. This may be even more critical once a strong One Health approach is actively pursued and fully implemented, given the inevitable implied challenges of promoting innovative intersectoral activities of this kind.
6. Disbursement conditionalities may be explored and agreed upon with ECOWAS and WAHO in relation to staffing and support to the RCSDC to fully engage with MS: GIZ has replaced the regional entities in providing relevant and to some extent excellent quality services, but this was at the detriment of the RCSDC's technical sustainability and technical and political credibility. The main objective should become the RCSDC institutional development, based on the organizational analysis and recommendations already prepared and endorsed, using also creative operating modalities (such as the rotation system for professionals coming from MS).

5.2.5 To GIZ

1. Support the discussion around the RCSDC full implementation with existing evidence and an updated business case.
2. NCIs should be prioritized by the programme as they are the main pillar of the preparedness and response architecture. They will also facilitate regional coordination and will stand as a long-term sustainable achievement.
3. An investment in peer support to individual MS may be needed, aiming also at a possible peer accreditation system based on the JEE procedures[104]. Peers may become part of the Regional Team that can be mobilized not only for emergency and rapid response actions but also for preparedness and system-building activities during peace times.
4. Explore the feasibility of SORMAS being assisted in their technical development by companies such as Microsoft, with the model of a community of practice and community of developers, mirroring the MOODLE platform from within the academic world[105].
5. Enhance the programme analytical capacity to conduct a thorough analysis of the several indicators that may allow priority setting, eg. the fragility index[106] and the GHSI, but also more innovative areas coming from a systematic review of international publications, such as the standardized infection rates approach, with trends in standardized infection per capita and infection-fatality ratios, as applied to COVID-19[107], or new metrics used to assess resilience and preparedness/prevention of countries to cope with pandemic threats[108].
6. Populate the ECO-Suite with all the above, disseminate evidence-based solutions, and launch regional surveys based on shared documents and strategies, using standardized tools such as the RUHSA[109] that may be used in urban areas of the region, which bear a substantial risk of outbreaks dissemination, as shown during the Ebola crisis.

[104] https://www.who.int/emergencies/operations/international-health-regulations-monitoring-evaluation-framework/joint-external-evaluations.
[105] https://moodle.org/?lang=en.
[106] https://fragilestatesindex.org/
[107] https://www.sciencedirect.com/science/article/pii/S0140673622001726
[108] https://www.sciencedirect.com/science/article/pii/S0013935121009725
[109] https://www.researchgate.net/publication/342208235_Rapid_urban_health_security_assessment_tool_A_new_resource_for_evaluating_local-level_public_health_preparedness/link/5ef25b1792851cba7a42aedd/download

7. Design and implement a proper communication, visibility and advocacy plan to be used at launch, during, and at the end of the implementation to mobilize ECOWAS and focus MS on programme support, ownership of outcomes and cost-sharing, and draft policy briefs for decision-makers.
8. Identify available EU MS' institutions to provide technical advice to the regional and national organizations, focusing on WAHO, RCSDC, RAHC.
9. Identify one or more academic institutions in MS ready to elaborate and launch postgraduate degrees providing specialization opportunities to staff working in the main programme result areas and suggest twinnings as offered in the Erasmus+ and Erasmus Mundus programmes. Promote international links and collaborations to include NCIs in public health and One Health networks.
10. Provide support to NCIs to pilot action at subnational (community) level in at least two MS (anglo- and francophone), focusing on the development of surveillance, early detection, and containment capacities.
11. Focus on One Health and reorient all activities addressing systematically animal and environmental health, by also including the economic value of, eg, a healthy food industry and develop policy briefs documenting the relevant programme challenges and disseminating its achievements.
12. Reorient hackathons towards specific areas of interest, such as SORMAS development and extension and embed them into the academic and research world to make sure that start-ups can be created and sustained. Explore the feasibility to promote startups in support of promising initiatives.
13. Map vulnerable and fragile groups in focus MS, survey their composition, identify their needs, and provide targeted assistance through NCIs.
14. Consider including more ambitious results-oriented indicators aiming at providing evidence of institutional impact as well as quality indicators assessing outcomes (eg, not the only number of staff trained, but also the number of capacitated and skilled staff in place resulting from training). The programme should develop indicators measuring the (achieved) capacity level of counterparts (ie, results), not only the programme's ability to implement specific actions (processes).
15. Design a specific plan with an acceptable and realistic timetable to promote early programme ownership and handing over to local counterparts.

5.2.6 To GIZ and the EUD

1. Adopt result indicators reflecting the programme's scope of work and are comparable with the internationally recognized dimensions addressed by JEE, such as[110]:

Prevent 2: IHR Coordination, communication, and advocacy

- A functional mechanism is established for the coordination and integration of relevant sectors in the implementation of IHR; National IHR Focal Point functions are available, and staff are assigned.
- Multisectoral coordination mechanisms have been formalized and implemented.
- Strategic planning for IHR, preparedness or health security is done, and strategy costed, funded, and implemented.

Detect 2: Real-time surveillance is available

- Surveillance systems are available at the national (and regional level) and are interoperable throughout the region.

[110] *Reference is made to Evaluation Question 4a. From: https://extranet.who.int/sph/sites/default/files/document-library/document/9789241550222-eng.pdf, accessed 11 November 2022, critically reviewed for the African region in: https://gh.bmj.com/content/4/6/e001312 and updated at: https://www.who.int/publications/i/item/9789240051980, WHO, Third edition, 2022.*

- The use of electronic tools is fully implemented, and a regional data warehouse is funded and utilized as a repository and as a working tool.
- Analysis of surveillance data is done locally and regionally on aggregated data. Reports are generated and disseminated according to a communication plan to decision-makers, professionals, and to the general audience.
- An early warning surveillance function is available and data flow is managed timely.
- Event verification and investigation are done by accredited teams with a clear chain of command and reports are generated for decision-makers and professionals.

Detect 3: Reporting

- System for efficient reporting to FAO, OIE and WHO is managed at the country and regional levels.
- In-country reporting networks and protocols are formalized, assigned, and implemented addressing decision-makers, professionals, general audiences according to a formal communication protocol.

Detect 4: workforce development:

- An updated multisectoral workforce strategy is in place and funded.
- Human resources are available to effectively implement IHR and are deployed to manage services with the full delegation of authority according to their scale.
- In-service trainings are available and delivered systematically according to a staff accreditation and re-accreditation procedure (possibly acknowledged by the regional level to facilitate staff mobility in the region).
- FETP or other applied epidemiology training programmes are in place and delivered periodically, with follow-up mechanisms assessing staff performance.
- A multisectoral workforce strategy is drafted and adopted at the national and regional level within the One Health paradigm.
- Human resources for the implementation of IHR are quantified, localized, trained, equipped, deployed, and supervised.
- IHR dedicated workforce training is offered continuously with an accreditation mechanism for different professional profiles.
- Workforce surge during a public health event is facilitated and simulation exercises are done and assessed periodically.

Respond 1: preparedness

- Strategic emergency risk assessments are conducted, and emergency resources are identified and mapped.
- National multisectoral multihazard emergency preparedness measures, including emergency response plans are developed, implemented, and field tested.
- Emergency risk assessment and readiness infrastructure are implemented, tested, and updated regularly.
- Public health emergency operation centres (PHEOC) are identified, funded, equipped, and staffed to serve as a hub for better coordinating preparedness, response, and recovery for public health emergencies.
- SOPs are developed, adopted, and field-tested for health emergency response management.
- Health personnel are inventoried and mapped that must be mobilized in a public health emergency with a clear definition of a chain command and trigger mechanisms to launch and conclude the emergency.
- Emergency logistic and supply chain management with related SOPs, addressing the regional emergency fund are improved and field tested.
- Research, development, and innovation are conducted by academic and research centres adequately funded and supervised.

Respond 5: Risk communication

- Risk communication systems are in place and tested for unusual/unexpected events and emergencies.

- Internal and partner coordination for emergency risk communication is formalized and implemented.
- SOPs for public communication during emergencies are adopted and a communication plan is developed accordingly.
- Communication engagement with affected communities and with relevant media staff is addressed.
- Perceptions, risky behaviors, and misinformation are addressed, and staff are trained to recognize and manage them.
- Risk communication and community engagement (RCCE[111]) systems for emergencies are planned, funded, staffed, implemented, reviewed, and simulation tests are done periodically.
- Risk communication is planned, and competent staff is assigned to support national strategies.
- Community engagement is planned, and staff is trained and assigned to support subnational strategies.

Within each indicator area, additional operational indicators may be adopted, aiming at measuring:

- Number and profile of staff trained and deployed (rather than a number of trainings offered).
- Financial resources are budgeted and allocated per service, function.
- Essential equipment is identified, provided, and available at the point of service.
- Reports are drafted and made available.
- SOPs are available and checked during regular and documented supervision visits.
- Number, type, and location of simulation exercises implemented.
- Number, type, and location of community engagement tests.
- Number and type of communication equipment available at the point of service.
- Number and type of peer supervision visit done and documented.
- Staff performance assessments are documented, and remedial actions are implemented in case of need.

2. The new plan may also like to include two additional areas of work in the relevant logframe, given the evident links between the building blocks developed at this stage that may translate into effective operations as shown during the COVID-19 crisis[112]:
   a. Respond 2: Emergency Response operations (EOC)
      - Emergency response coordination is formalized and subject to stress tests.
      - EOC capacities, procedures and plans are formalized and updated systematically.
      - Emergency exercise management programmes are operated mobilizing also the response coordination mechanism put in place.
   b. Other IHR related Hazards and PoEs 1: Point of Entries
      - Routine capacities are established at PoEs.
      - Effective public health response at PoEs is established, staff trained and deployed with a clear chain of command, supervision, and reporting systems in place.
      - Core capacity requirements at all times for PoEs (airports, ports and ground crossings) are defined with relevant SOPs and accredited staff trained and deployed.
      - Public health response at PoEs is formalized with regional involvement providing intercountry supervision and support. Equipment and staffing profiles are defined, and resources are allocated accordingly.
      - Simulation exercises are done regularly and supervised with an intercountry peer mechanism.
      - A risk-based approach to international travel-related measures is addressed and field-tested.

[111] See on the matter: https://gh.bmj.com/content/7/3/e008486
[112] Reference is made to the JEE set of indicators as addressed in EQ4a section.

5.3 Lessons learnt

The programme has achieved a lot in a very complex and unstable situation, addressing the regional as well as the national levels at the same time and aiming at building the regional institutions' (in particular the RCSDC) credibility and capacity to promote a coordinated network of first-line NCI/EOCs capable to fully implement the IHR, interact with national decision-makers and stakeholders to promote preparedness and respond to epidemics. The EVAL team converged with the bilateral programme evaluation on identifying the two main issues to prioritize for future action:

1. Staffing WAHO and the RCSDC with the right volume of skilled and capable staff, who enjoy the needed credibility with MS and NCIs.
2. Building the RCSDC according to the available organizational development indications, that will facilitate the adoption of more consistent, transparent, and traceable procedures leading to rapid operations and deployment of staff and mobilization of essential resources in case of need.

The programme has managed to deliver all foreseen outputs (eg, ECO-Suite Platform, Risk Communication Platform, SOPs). Now ECOWAS commission, WAHO and RCSDC need to make relevant resources and essential workforce available to continuously update and fully implement all tools and processes built. They will also need to populate the One Health platform and start drafting strategies and deliver services taking advantage of the UN quadripartite agreement to address human and animal health, as well as environmental protection, at higher risk of deterioration also given climate change-related factors already impacting on, e.g., the migration routes in the region.

The EVAL team felt that the expected regional architecture pillars have been created and that a few areas for improvement are now identified. Addressing system changes based on a major behaviour change by all partners – not only by the regional and national providers, but also by the Donors' community – requires time, longer perspectives, and consistent efforts. Given the regional complexity, the diversity of MS languages, cultures, digital competence, populations and governance, the multiple interests that the EVAL team was able to identify, a second phase will need to concentrate on the full implementation of those changes that were duly addressed and actively promoted by the programme but whose agenda remains unfinished. Action and results-oriented indicators will be essential in ensuring that the programme stays aligned with its excellent values and that the EUDs ensure all the support which may be needed, interacting with their counterparts not only on the programme activities but also engaging them in a wider policy dialogue aiming at strengthening the IHR and the regional and national levels' capacities in this fundamental area of health security. The programme is more relevant than ever, and the building blocks identified and established are very promising. They need to be documented and disseminated via active advocacy addressing political decision-makers, the relevant regional and national entities, the international community, and the academic and professional world of each MS.

Several lessons which are deemed to be useful for the future regional projects funded by the EU were learnt:

Lesson 1: *a final review of bureaucratic documents can ensure coherence between titles and contents, preventing misunderstandings and challenges in M&E: this is due to the identified disconnect between programme title and logframe.*

Lesson 2: *proposed programme components may qualify as prerequisites for implementation that may be addressed better during the political negotiation process and as such may become conditions, rather than result areas (e.g,, RCSDC role and staffing procedures and the full implementation and adoption of digital surveillance based on SORMAS achievements). The preliminary policy dialogue between the regional counterparts and the EU is fundamental and should be based on a Team Europe's approach, involving the EC competent technical bodies, such as the ECDC, EMA, EFSA and the newly established HERA to provide also a strong European added value. Planning at the beginning may help improving the sense of partnership as well as the quality of intervention.*

Lesson 3: *institution building is a long and difficult process especially at the regional level, where cultures and system organization are different, with a variety of human ecologies and epidemiologies. The required time frame may be incompatible with the short-, mid-term perspective of a single programme and may call for separate, parallel support organized differently, possibly linked to local entities providing comprehensive academic, professional and scientific collaboration to ensure long-term assistance. This is especially true when the process is further challenged by persistent outbreaks and by a major PHEIC, such as COVID-19. Sustainability too becomes a key aspect of institution building as it encompasses not only financial aspects but mostly technical, scientific and political elements that need to be addressed with a specific and detailed strategy. Mobilizing the universe of European academic and public health associations (with the collaboration of Erasmus+ or Erasmus Mundus financial support) in support of any such programme design and implementation may channel technical and scientific skills otherwise difficult to activate. Collaborating with local institutions may require the mobilization of adequate and similar resources from the European side. Project teams may facilitate this dialogue but not replace it.*

Lesson 4*: even when appropriate organizational development plans are drafted full implementation may be difficult to achieve (as in the case of RCSDC). A feasibility plan needs to be agreed with the regional decision-makers and the process owned by the regional management with full support by the Donors' community through a participatory process. In any future programme of this calibre, it is essential that Donors converge to support building the local institution's credibility, especially if dealing with life-threatening events and other emergencies of regional relevance. The relevant EUD in charge of operations should be sustained by the entire EC organization in providing leadership by means of a structured dialogue with all the Donors ensuring a collaborative ecology since the programme identification and formulation stages.*

Lesson 5*: When dealing with human resources a comprehensive and detailed plan needs to be endorsed addressing TORs, recruitment, employment/ deployment, retainment, requalification procedures as a pre-requisite to any knowledge and skills transfer activity, ensuring technical sustainability. Granting an academic title to attract and motivate staff working in non-traditional areas such as surveillance and risk communication (or communication in health) may be done by funding a credible university as well as a number of scholarships or facilitating the enrollment in the UNU system (https://unu.edu/) and making use of the newly established WHO Academy (https://cdn.who.int and https://openwho.org). Good*

opportunities may also be mobilized through the Erasmus+ and Erasmus Mundus programmes.

Lesson 6: *The extensive use of digital technologies was encouraged by the pandemic-related travel restrictions and closures, indicating the need to invest further in such technologies and content areas that can be successfully and timely channelled to a variety of entities and qualified individuals, extending the range of services and increasing the programme's impact, especially in rapid communication and data and information sharing. The Digital Europe Programme DIGITAL may be mobilized to assist in the development of digital technologies at the regional and continental level, learning from Connecting Europe Facility, for instance, coherently with provisions made by the EU Multiannual Financial Framework 2021-2027. Investments may be organized also to promote specialized Companies' support and/or establishing a start-up to ensure financial and technical sustainability to R&D in the health sector, especially on AI and machine learning to develop algorithms assisting in decision-making for emergencies and in developing digital outbreak intelligence.*

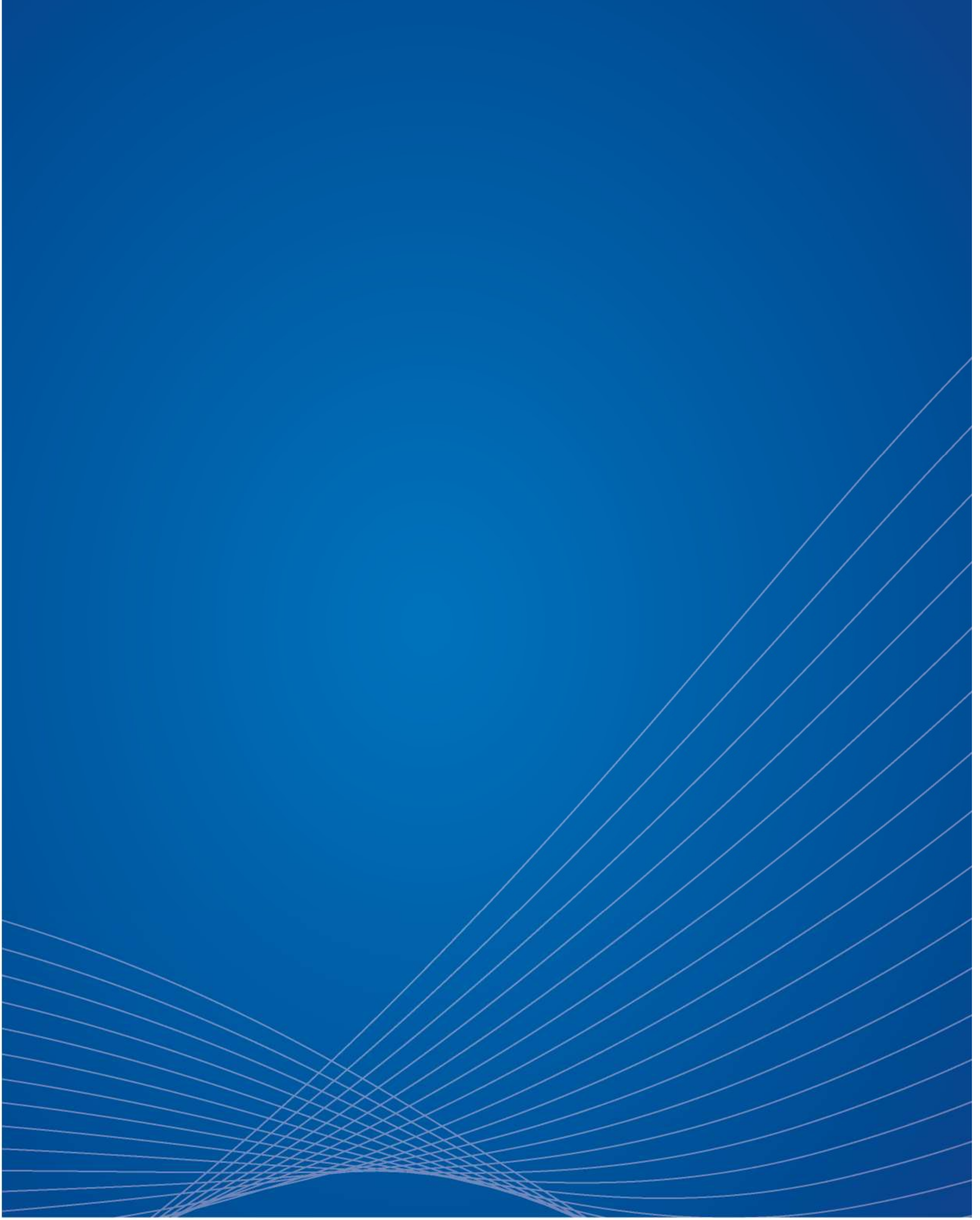
Lesson 7: *procurement during emergency situation is a complex and highly professional task that requires specific competencies and the capacity to make appropriate use of all international mechanisms and resources, such as those available in Brindisi (https://www.ungsc.org/Brindisi), with OCHA (especially the Dakar hub, https://centre.humdata.org/our-locations/), at the International Humanitarian city in Dubai (https://www.ihc.ae/), and from UNICEF Clearinghouse in Copenhagen (https://www.unicef.org/supply/warehousing-and-distribution). A specific analysis of the supply chain and simulation exercises on its capacity under crisis conditions should be foreseen and technical assistance provided if needed whenever designing projects with logistics and procurement components. There is a tendency to neglect logistics which is instead a vital aspect of the outbreak and emergency response, as seen during the COVID-19 crisis everywhere. Investing in the supply chain may also contribute to improving efficiency as material outputs will be identified and delivered following a more appropriate and managed procurement line. This will indirectly contribute to other sectoral good procurement, such as medicines, vaccines, and equipment[113].*

Lesson 8: *only through a One Health approach the full range of IHR core capacities can be achieved, whenever similar programmes are conceived and funded. Veterinarians and environmental experts must participate in any such programmes' implementation. This is not an area of work, but rather a pre-requisite to have a real impact on health security profiles in any assisted region. It may also be relevant to include an assessment of the current regional antimicrobial resistance situation, considering that prescription habits and antibiotics availability and consumption data in both the human and animal sectors are very often unknown. Reference is also made to the WHO global surveillance system GLASS[114], that should incorporate data from each MS and region-assisted.*

Lesson 9: *adequate communication and visibility plans are important not only to promote advocacy and ensure attribution but also to share knowledge and promote participation and awareness of the programme's principles and objectives. EUDs need to network and protect the achievements and scaling up the potential of any programme following the EU team approach.*

[113] *Stakeholders' absorption capacity by type of expected and funded service should be pre-estimated when providing additional financial resources targeting areas of work that the implementing partner may not be familiar with.*
[114] *https://www.who.int/initiatives/glass*

Lesson 10*: Regional relevant entities need to be identified and systematically supported in their role to ensure proper Donors' coordination. This will need continuity and dedicated resources. Coordination mechanisms take time to be developed, tested, used, and strengthened especially in multilingual and multicounty environments, where national sovereignty remains a major issue even in the case of emergencies. Formal procedures based on the development of legislative initiatives may be needed since the beginning of regional programmes as they can mitigate the risk of overlapping of responsibilities and activities and ambiguity in governance that are incompatible with, e.g., emergency situations.*



ibf
INTERNATIONAL
CONSULTING